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.
   1. For each activity, IEHP has identified the documented reporting requirements and delegated activities (See Attachments, “Delegated IPA Delegation Agreement – Medi-Cal” and “Delegated IPA Reporting Requirements Schedule – Medi-Cal” in Section 25).
25. DELEGATION AND OVERSIGHT

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1. Delegated Activities

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. This meeting can take place at a specific meeting called 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 Members.

POLICY:

A. IEHP delegates certain Utilization Management (UM), Care Management (CM), Credentialing/Re-credentialing activities and activities for Quality Management (QM) and Compliance to contracted IPAs that meet IEHP delegation requirements and comply with the most current National Committee for Quality Assurance (NCQA), Department of Health Care Services (DHCS) (when applicable), 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 (QM), Preventive Health, Medical Records, Compliance or Member’s Rights and Responsibilities to non-NCQA accredited entities; however, IEHP does require contracted IPAs to perform specific activities related to these areas.

C. IEHP monitors IPA performance in QM, UM, Credentialing/Re-credentialing, Compliance, CM and Claims their implementation of 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 delegating to IPAs applying for participation with IEHP.

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

G. Focused audits may be performed as indicated whenever a quality issue is identified or at the discretion of the Delegation Oversight Committee, Compliance Officer 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 IPA that fail to meet IEHP requirements.

PROCEDURES:

A. IEHP audits each IPA prior to contracting and at least annually to verify compliance with IEHP requirements and continued ability to perform delegated functions.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   2. Audit

B. IEHP is responsible for performing the Delegation Oversight Audit utilizing the most current NCQA, DHCS, DMHC, CMS and IEHP standards.

C. The Delegation Oversight Audit evaluates the PA capabilities in UM, CM, Credentialing and elements of QM and Compliance.

D. IEHP is responsible for coordinating and scheduling the audits with IPA staff.

E. IEHP notifies the IPA in writing, at least four (4) weeks in advance of the scheduled audit. The IPA 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. IPA Biographical Information (See Attachment, “IPA Biographical Information Sheet” in Section 25).

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

3. QM documents:
   a. Program, Plan, and Description;
   b. Committee and subcommittee meeting minutes, agenda, sign in sheet, and signed confidentiality statement from the last twelve (12) months for:
      1) Quality Management Committee, and
      2) Subcommittees.
   c. Annual Work Plan;
   d. Annual Program Evaluation;
   e. Semi-Annual Health Plan Reports for the last twelve (12) months;
   f. Notification of Termination policy and evidence that Members were notified of practitioner termination;
   g. Studies, Audits, and surveys completed during the last twelve (12) months; and
   h. Standards of Medical Care Access Policies and Procedures.

4. UM documents:
   a. Program, Plan and Description;
   b. Annual Work Plan;
   c. Annual Evaluation;
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

d. Policies and Procedures;
e. Referral Universe for audit file selection;
f. Committee meeting minutes from last twelve (12) months for:
   1) Board of Directors;
   2) Utilization Management Committee; and
   3) Subcommittee meeting minutes.
g. Annual Inter-Rater Reliability Audit;
h. Semi-Annual Health Plan Reports for the past twelve (12) months;
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;
k. Fifteen (15) Approved, Denied, and Cancelled files selected by IEHP;
l. Utilization Management statistics from last twelve (12) months;
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 last twelve (12) months; and
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.

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. Thirty (30) CM files;
   d. Five (5) CCS files; and
   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;
   b. Committee meeting minutes including date and voting attendees from the last twelve
      (12) months, including:
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

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

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

7. Compliance Documents:
   a. Compliance Policies & Procedures;
   b. Fraud, Waste and Abuse (FWA) Policies & Procedures;
   c. Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Policies & Procedures; and
   d. Standards of Conduct
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

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

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

I. At the time of the audit, IEHP reviews:
   1. The IPA policies and procedures for completeness and compliance with NCQA, 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:
      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;
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2. Audit

   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 Carry 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;
   c. All credentialing and re-credentialing packets have been approved by the IPA’s 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;
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2. Audit

f. Processes are in place to ensure documentation on subcontracted organizational Providers is verified at time of contracting and at least every three (3) years thereafter;
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 IPA’s Quality Management Department. IPA’s assessment process and assessment criteria for each non-accredited Provider with which it contracts will include a process for ensuring that the Provider credentials its Providers, in accordance to NCQA guidelines. A CMS or state review may be used in lieu of a site visit and may not be greater than three (3) years old at the time of verification/approval.

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

A. Delegation Oversight

2. Audit

K. The IPA 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 IPA 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 IPA receives written notification of the results. The written notification includes a cover letter and a completed audit tool noting any deficiencies found during the audit. The cover letter notes the timeframes for corrective action, and any other pertinent information.

M. Scoring categories for each of the Delegation Oversight Audit are as follows:
   1. Full Compliance 90-100%
   2. Partial Compliance 80-89%
   3. Non-compliance <79%

N. All IPAs 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 IPA 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 requirements noted in Policy 25D3, “Quality Management - Corrective Action Plan Requirements.”

O. Focused audits may occur between annual audits in the following circumstances:
   1. Deficiencies noted as a result of the annual audit, as applicable;
   2. Review of documents submitted to IEHP indicates potentially significant changes to the IPA program; and
   3. Any other circumstance or quality issue identified that in the judgment of IEHP, requires a focused audit.

P. If the IPA is unable to meet the requirements at the second focused re-audit, IEHP may do one (1) of the following:
   1. Immediately freeze the IPA to new Member enrollment, as applicable;
   2. Send a thirty (30) day contract termination notice with specific cure requirements;
   3. Rescind delegated status of IPA, as applicable;
   4. Terminate the IEHP contract with the IPA; or
   5. Not renew the contract.
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Audit

Q. IPAs 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 IEHP Chief Medical Officer. IPAs must cite reasons for their appeal, including disputed items or deficiencies.

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

REFERENCES:

A. California Health and Safety Code § 1367.27.
B. Senate Bill (SB) 137.
25. **DELEGATION AND OVERSIGHT**

A. Delegation Oversight
   2. Audit
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

3. Delegated IPA Performance Evaluation

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Delegated IPA.

POLICY:

A. Annually IEHP evaluates each contracted Delegated 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 Delegated 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 a Delegated IPA’s contract should be renewed and to determine the length of term of a Delegated IPA’s contract with IEHP, if applicable.

PROCEDURES:

A. IEHP evaluates each Delegated 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. Delegated 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, “Delegated IPA Performance Evaluation Tool” in Section 25 for a sample tool).
   2. The categories related to measures of a Delegated IPA’s competence and quality of Member care (e.g., Delegated IPA Reporting and Member Access Audit)
25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

3. Delegated IPA Performance Evaluation

Delegated IPA Delegation Oversight Audit Results) are weighted more heavily to ensure the Delegated IPAs maintain IEHP’s quality standards and meet regulatory requirements.

3. The data collected throughout the contract year is comprised of reports, summaries and scores of each Delegated IPA’s performance and ability in meeting its delegated and non-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 Delegated IPA. Term lengths are based on the following:

<table>
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<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>
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<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>

E. IEHP meets with each Delegated IPA to discuss the results of its score and presents 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 a PET is completed for each contracted Delegated IPA, IEHP presents a summary to the IEHP Governing Board along with all relevant supporting documentation. This includes any Delegated IPA whose contract is not being renewed as a result of the PET score.

G. Delegated 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 in accordance with Policy 16C, “Delegated 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 Delegated IPA PET are at the sole discretion of IEHP.

INLAND EMPIRE HEALTH PLAN

<table>
<thead>
<tr>
<th>Chief Approval: Signature on file</th>
<th>Original Effective Date:</th>
<th>April 1, 1999</th>
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<tr>
<td>Chief Title: Chief Operating Officer</td>
<td>Revision Date:</td>
<td>January 1, 2020</td>
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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. Delegate’ policies and procedures must ensure that it only contracts with physicians who have not opted out.
F. Delegates must have policies and procedures that prohibit employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners or entities found on Office of Inspector General (OIG) Report)
G. Delegates must have policies and procedures that they do not contract with Practitioners who are precluded from receiving payment for Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries.

PURPOSE:

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

1. Credentialing Policies

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

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

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

DEFINITION:

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

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

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

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

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

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

G. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to
B. Credentialing Standards
   1. Credentialing Policies

   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 recredentials. Credentialing requirements apply to:
   a. Practitioners who are licensed, certified or registered by the State of California to practice independently (without direction or supervision)
   b. Practitioners who have an independent relationship with the organization.
      1) An independent relationship exists when the organization directs its member to see a specific Practitioner or group of Practitioners, including all Practitioners whom Member can select as Primary Care Providers.
   c. Practitioners who provide care to Members under the organization’s medical benefits.
   d. The criteria listed above apply to Practitioners in the following settings:
      1) Individual or group practices
      2) Facilities
      3) Telemedicine
   e. Delegates are required to contract with and credential all of 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 or not credential:
      1) Doctor of Medicine (M.D.)
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

   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) Chiropractors (D.C.) who are contracted to treat Members and fall within the Delegates scope of authority and action
  14) Psychiatrists (M.D.)
  15) Licensed Marriage and Family Therapists (L.M.F.T.)
  16) Licensed Clinical Social Workers (L.C.S.W.)
  17) Psychologists (Ph.D., Psy.D.)
  18) Doctor of Chiropractic (D.C.)
  19) IEHP does not require covering Practitioners and locum tenens that do not have an independent relationship with a Delegated IPA to be credentialled.
  20) IEHP does not require Delegated IPAs to credential Practitioners that are hospital based and do not see Members on a referral basis.
  21) IEHP does not require Delegated IPAs to contract with the following Provider types, where services rendered by these Practitioners are covered by IEHP: are covered by IEHP, however, must utilize the network contracted by IEHP; therefore, credentialing and recredentialing of these Providers will be completed by IEHP.

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

   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 criterion listed below. All verification sources must be included in policy to ensure compliance with IEHP.

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

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

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

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

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

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

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

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

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

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

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

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

4) Below are acceptable sources for physicians (M.D., D.O.) to verify graduation from Medical School:
   - AMA Physician Master File.
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   - Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

Below are acceptable sources for physicians (M.D., D.O.) to verify completion of residency training:

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

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

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

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

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

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

8) For Psychologists (Ph.D., Psy.D.).
   - 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 five (5) years of malpractice settlements through one of the
   following sources:
   1) Malpractice Insurance Carrier
   2) National Practitioner Data Bank Query
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   3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS)). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.

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

   1) For Practitioners with federal tort coverage, the Practitioner must submit a copy of the federal tort letter or an attestation from the Practitioner of federal tort coverage.

   h. Hospital Admitting Privileges: IEHP must verify that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be confirmed with the Hospital, in writing, via approved website or verbally.

      1) If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in “good standing.”

      2) If the Practitioner does not have clinical privileges, the IEHP must have a written statement delineating the inpatient coverage arrangement documented in the Provider’s file. (See Policy 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:
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   one hundred-eighty (180) calendar days prior to Credentialing decision).

   1) Verification sources for sanctions or limitations on licensure include:

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

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

      1) OIG must be the one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS.
         • 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.
         • 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.
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8) State Medicaid Agency or intermediary and the Medicare intermediary.

9) For delegate’s using the Continuous Query (formerly Proactive Disclosure Service (PDS))

k. NPI Number: Practitioners must hold and maintain a valid and active individual National Provider Identification Number (NPI) that can be verified through the National Plan & Provider Enumeration System (NPPES) website.

   1) Group NPI Numbers may be requested by IEHP, in addition to the mandatory individual NPI number.

l. 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.

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

   a. Provider must submit an application or reapplication that includes the following:

      1) Reasons for inability to perform the essential functions of the position;

      2) Lack of present illegal drug use;

      3) History of loss of license and felony convictions;

      4) History of loss or limitation of privileges or disciplinary actions;

      5) Current Malpractice Insurance coverage; and

      6) Current and signed attestation confirming the correctness and completeness of the application.

   b. All Primary Care Provider (PCP) and Urgent Care Providers must meet the Facility Site Review (FSR)/Medical Record Review (MRR) Guidelines. See Policy MC06A, “Facility Site Review and Medical Records Review Survey Requirements and Monitoring.

      1) 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

      2) All PCPs must pass a required initial facility review performed by IEHP prior to receiving IEHP enrollment and treating Members.
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- IEHP has ninety (90) days from the submission of all required credentialing information to complete the facility site review.

c. 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. Advance Practice Practitioners must be practicing at a site assigned to their supervising physician.

d. Practice within IEHP’s service area

e. Education and Training: Practitioners must be board certified in the specialty and/or subspecialty they are credentialed and contracted for, if applicable.

1) 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.

f. 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.

1) 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.

g. IEHP specific specialty requirements: Medical Doctors (M.D.) and Doctor of Osteopathic (D.O.) must meet the education and training requirements set forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) and additional criterion set by IEHP and noted below, if applicable. All IEHP specific specialty requirements are subject for review by the IEHP Medical Director or Chief Medical Officer. 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.

1) Bariatric Surgery requirements effective January 1, 2019. Meet the education and training requirements for General Surgery; and one of the following criteria:
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- Completion of an accredited bariatric surgery fellowship;
- Documentation of didactic training in bariatric surgery (IEHP recommends the American Society for Metabolic and Bariatric Surgery Course). This information will be verified through:
  - Bariatric training certificate and/or supporting letter from supervising bariatric surgeon, which will be verified by Credentialing. Supporting letter will include the minimum criteria:
    - Supervising bariatric surgeon qualifications;
    - Supervising bariatric surgeon relationship with applicant;
    - Duration of relationship of supervising bariatric surgeon with applicant; and
    - Assessment of applicant’s competency to perform bariatric surgery by supervising bariatric surgeon.
  - Attestation of bariatric surgery case volume signed by applicant (See Attachment, “IEHP Bariatric Surgery Attestation” in Section 5) to include the following:
    - Indicate volume of:  
      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.

- 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.

2) 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:

- Family Practice 1: Family Practice that includes Outpatient OB services must:
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   - Provide a copy of a signed agreement that states Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
   - The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted hospital linked with that IPA network.
   - Family Practice 2: Family Practice that includes full OB services and delivery) must:
     - Have and maintain full delivery privileges at an IEHP contracted hospital.
     - Provide a written agreement for an available OB back up Provider is required.
       ▪ The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP hospital linked with the Family Practice Provider; and
       ▪ Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc).

3) 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, post graduate/residency training, etc.); and
     - Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.).

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

4) 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 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.

5) 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.

6) 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);

7) 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.

8) Urgent Care Providers must:

- Meet the education and training requirements set forth by ABMS or AOA for at least one (1) of the following Specialty boards:
  - American Board of Pediatrics
  - American Board of Family Practice
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   - 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

   h. Practice Parameter expansion(s) or reduction(s). Providers are required to submit a request that includes a detailed explanation when requesting a change in practice parameters such as an expansion or reduction in Member age range or specialty care privileges (i.e. addition of specialty). All Practice Parameter expansions and reductions are subject for review by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

   IEHP will consider all relevant information including practice site demographics, Provider training, experience and practice capacity issues before granting any such
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change. At a minimum, Provider’s written request must include:

1) Documentation of any relevant training (e.g., Continuing Medical Education, post graduate/residency training, etc.); and

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

i. A current and valid, unencumbered license to practice medicine in California.

j. Current and valid DEA registered in California

k. NPI: Must confirm Provider has an active Individual NPI with a Primary address that must be registered to an address in California.

   1) Group NPI may be submitted to IEHP in conjunction to the Individual NPI.

   2) Telehealth Providers are not required to have an NPI registered with a primary address in California.

l. Malpractice Insurance Coverage: Must have current and adequate malpractice insurance coverage that meets the following criteria:

   1) Minimum $1 million per claim/$3 million per aggregate.

   2) Coverage for the specialty the Provider is being credentialed and contracted for.

   3) Coverage for all locations the Provider will be treating IEHP patients.

m. Appropriate admitting privileges or arrangements with IEHP’s contracted hospitals, if applicable. (See Policy 5D, “Hospital Privileges”).

   1) Providers are not required to maintain hospital admitting privileges if they are only practicing at an Urgent Care.

n. Adverse History Guidelines: IEHP must carefully review the oversight process for the Delegates review of all Practitioners with evidence of adverse history are presented to Credentialing Committee for review and documented in the meeting minutes, that may include, but is not limited to Providers who have:

   1) Restrictions on licensure

   2) Restrictions on DEA

   3) Loss of Clinical privileges or negative privilege actions

   4) Identified on any of the following 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 credentialed or contacted, and terminated from our network if they are existing Providers.

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

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

5) Other negative actions may include, but are not limited to:

- Use of illegal drugs
- Criminal history
- Engaged in any unprofessional conduct or unacceptable business practices.

6) 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) Grievance History

- Trend in grievances
- Higher than average grievance rate
- Patient Age ranges
  1) Patient age ranges for Primary Care Physicians (PCP) must be specifically delineated as part of the Delegated credentialing process. The guidelines for PCP
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   age ranges are provided below:

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<th>SPECIALTY</th>
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<td>Family Practice</td>
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<td>Obstetrics/Gynecology</td>
<td>• 14 and above; restricted to females</td>
</tr>
<tr>
<td>General Practice</td>
<td>• All Ages, if evidence of pediatric training, experience and/or CME is present</td>
</tr>
<tr>
<td></td>
<td>• 14 and above</td>
</tr>
</tbody>
</table>

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

2) 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.

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

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

Delegates must ensure and obtain the appropriate documentation for all Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) between the Advance Practice Practitioner and
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

1. Credentialing Policies

Supervising Physician are present at each site. Therefore, sites must ensure that these documents are available at the time of audit and are readily available upon request.

1) 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

- 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.

2) Nurse Practitioners and Nurse Midwives are required to have Standardized Procedures. Standardized Procedures must be on-site site specific and:

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

B. Credentialing Standards
   1. Credentialing Policies

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 IEHP's 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.

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

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 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.

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.

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

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

11. Delegates’ policies and procedures describe the Delegates’ process for ensuring that
B. Credentialing Standards

1. Credentialing Policies

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

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

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.

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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies

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

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

   4. The security controls in place to protect the information from unauthorized modification.
      a. Policies and procedures describe the process for:
         1) Limiting physical access to the credentialing information, to protect the accuracy
            of information gathered from primary sources and NCQA-approved sources.
         2) Preventing unauthorized access, changes to and release of credentialing
            information.
         3) Password-protecting electronic systems, including user requirements to:
            • Use strong passwords
            • Avoid writing down passwords
            • Use different passwords for different accounts
            • Change passwords periodically
            • Changing or withdrawing passwords, including alerting appropriate staff
              who oversee computer security to:
              o Change passwords when appropriate
              o Disable or remove passwords of employees who leave the organization
            • If the Delegate contracts with an external entity to outsource storage of
              credentialing information, the contract describes how the contracted entity
              ensures the security of the stored information.
              o Contract will require review if outsourcing

   5. How the organization audits the processes and procedures in factors 1-4.
      a. The policies and procedures must describe the audit process for identifying and
assessing risks and ensuring the specified policies and procedures are followed. The description includes:

1) The audit methodology used, including sampling, the individuals involved in the audit and audit frequency.

2) The oversight of the department responsible for the audit.

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

E. Delegates’ policies and procedures must ensure that it only contracts with 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.

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.

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.

REFERENCES:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 1.

B. Medicare Managed Care Manual, Chapter 6 § 60.2, 60.3.

C. DHCS All Plan Letter (APL) 19-004 supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment”.

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   1. Credentialing Policies
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 lines of business.

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. 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);

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 credentialled or recredentialled 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.

   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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   2. Credentialing Committee

   - 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.

REFERENCE:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 2.
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).

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
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

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.

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

PURPOSE:

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

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

DEFINITION:

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

B. Each file contains evidence of verification, defined by NCQA as “Appropriate documentation.” IEHP documents verification in the credentialing files using any of the following methods or a combination:
   1. Credentialing documents signed (or initialed) and dated by the verifier.
   2. A checklist that includes for each verification:
      a. The source used.
      b. The date of verification.
      c. The signature or initials of the person who verified the information.
      d. The report date, if applicable.
   3. A checklist with a single signature and a date for all the verifications that has a statement
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

3. Credentialing Verifications

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.

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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

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 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 subdelegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for subdelegation 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.)
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

3. Credentialing Verifications

- 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)
- 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.

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.

   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...
DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate.

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

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

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.
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Below are acceptable sources for Physicians (M.D., D.O.) to verify completion of residency training:

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

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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- 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.).
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   - American Board of Professional Psychology (ABPP).

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

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

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

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

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

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

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

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

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 five (5) years of malpractice settlements through one of the following sources:

   1) Malpractice Insurance Carrier

   2) National Practitioner Data Bank Query

   3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.
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b. A minimum the five (5) years claim history must be reviewed for initial credentialing and all claim history activities after the previous credentialing decision date, will be reviewed for recredentialing.

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

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:

      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.

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

C. Delegate applications for credentialing and recredentialing 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.
   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.
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.
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(VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner’s participation with IEHP).

1) All Practitioners must have current and adequate malpractice insurance coverage that is current and:

- Meets IEHP’s standard of $1 million/$3 million, as well as the IPAs standards. Professional Liability Insurance coverage and amounts of coverage must be verified with the insurance carrier or through the Practitioner via a copy of the policy and the signed attestation completed by the Practitioner. The copy of the Practitioner’s certificate must be initialed, and date stamped to show receipt prior to the credentialing decision and to show it was effective at the time of the credentialing decision.

- Must include coverage for the specialty the Practitioner is being credentialed for and for all locations the Practitioner will be treating IEHP patients.
  - If the specialty coverage and/or the locations are not identified on the malpractice insurance certificate, the coverage must be verified with the insurance carrier and documented in the Practitioner’s file.

- For Practitioners with federal tort coverage, the Practitioner must submit a copy of the federal tort letter or an attestation from the Practitioner of federal tort coverage.

- 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.

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

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

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

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

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

5. Specialists (MDs, DOs and DPMs) may not have Hospital privileges, documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).
   a. These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider profile, admitter report or attachment.
      1) These arrangements are subject to IEHP review and approval.
      2) IEHP may request for inpatient coverage arrangements for the Practitioner, if IEHP identified that specialty as a specialty that requires Hospital admitting arrangements.

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

9. Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Physician 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.

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.

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
      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
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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.
4. Practitioners that have a group NPI number may submit that information to IEHP, in addition to the required individual NPI number.

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.

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 IEHP’s requirements and they remain compliant while they continue participation in IEHP’s network. This would apply to, but not limited to:
   a. Prior to participating in the IEHP network as a Primary Care Physician 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
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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.

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

J. Delegates 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.
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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.

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”).

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

1. Primary Care Physicians
   a. Pediatrics
      1) PCPs that have members assigned ages 0-14 must enroll in the Vaccines for Children (VFC) Program.
      2) 0 – 18
      3) 0 – 21
   b. Family Practice
      1) PCPs that have members assigned ages 0-14 must enroll in the Vaccines for Children (VFC) Program.
      2) All Ages
      3) 14 and above
   c. Internal Medicine
      1) PCPs that have members assigned ages 0-14 must enroll in the Vaccines for Children (VFC) Program.
      2) 18 and above
      3) 21 and above
   d. Public Health and General Preventive Medicine
      1) 18 and above
      2) 21 and above
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e. Obstetrics/Gynecology
   1) 14 and above; restricted to females

f. General Practice
   1) PCPs that have members assigned ages 0-14 must enroll in the Vaccines for Children (VFC) Program.
   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 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 Physicians 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 (0-14) must enroll in the Vaccines for Children (VFC) Program;
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5) Malpractice coverage for the age range provider is requesting for that oversees 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);

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 (0-14) must enroll in the Vaccines for Children (VFC) Program;

5) Malpractice coverage for the age range Provider is requesting for that oversees 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.)

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

1. Physician Assistants (PAs) may act as an agent of the supervising Physician in which they have an agreement (See Attachment, “Delegation of Services Agreement and Supervising Physician Form”, in Section 5). Physician Assistants and Supervising Physicians must have the following documents current, in place, and readily available on-site subject for review:

   a. 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.

      1) Both the Physician and PA must attest to, date and sign the document;

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

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

      4) The agreement must be reviewed, dated and signed annually; and provided to IEHP, upon request.

       • The Delegation of Services Agreement authorizes a PA to provide or perform the following activities as long as there is documentation evidencing the activity was actually performed:

         o Physician examinations, including interscholastic athletic program examinations;

         o 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.

         o Routine visual screenings, which includes non-invasive, non-pharmacological, simple testing for visual acuity, visual field defects, color blindness and depth perception.

   b. Nurse Practitioners (NPs) and Nurse Midwives (NMs) may perform the following procedures if a standardized procedure is in place:

      1) To diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissue of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions.

      2) Standardized Procedures must be on-site site specific:
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   3. Credentialing Verifications

- 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.
- 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 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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

3. Credentialing Verifications

REFERENCES:

A. NCQA, 2019 HP Standard and Guidelines, Credentialing and Recredentialing (CR) 3.
B. Medicare Managed Care Manual, Chapter 6 § 60.3.
C. DHCS All Plan Letter (APL) 19-004 supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment”.
F. Title 16, California Code of Regulations (CCR) § 1379, 1399.540, 1474.
G. Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474.
H. Medical Board of California, Title 16, CCR Section 1379.

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B. Credentialing Standards

4. Recredentialing Cycle Length

APPLIES TO:

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

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 subdelegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for subdelegation 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.
B. Credentialing Standards
   4. Recredentialing Cycle Length

   2. On medical leave (e.g., maternity leave).
   3. On sabbatical.

   Delegates must document this and recredentials 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.

REFERENCE:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 4.
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 line of business.

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:

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

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   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 subdelegation, and the organization would be considered a subdelegate. The Delegate will be responsible for subdelegation 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
25. DELEGATION AND OVERSIGHT

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5. Ongoing Monitoring and Interventions

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.

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:

1) BreEZe Online services online or directly with the licensing board via phone or mail:
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- 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.

   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.
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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/collection and reviewing adverse events are not delegated and events are forwarded to the Health Plans, as applicable.
   c. Policy and evidence may be found in the Quality Department

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 situation.

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.
   2. 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;
25. DELEGATION AND OVERSIGHT

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3. Delegate may print the parts of the list that are applicable; or
4. Delegate can print the entire list
   b. 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.

2. 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.
   b. Delegates are required to screen their Provider network against the Preclusions List monthly, within thirty (30) days of its release.
   c. 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
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

5. Ongoing Monitoring and Interventions

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:
  - Name of board/entity
  - Date of query
  - Date of report
  - 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 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
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   5. Ongoing Monitoring and Interventions

   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:
   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.
25. **DELEGATION AND OVERSIGHT**

B. **Credentialing Standards**

5. **Ongoing Monitoring and Interventions**

- 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.
  - 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.
  - 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;
   - b. Any filing with the NPDB; and
   - c. The notification must include the Delegate’s proposed action and/or resolution.

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

1. Delegate is responsible for notifying IEHP of any licensure and DEA changes within thirty (30) days of the change. The notification must include:
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   5. Ongoing Monitoring and Interventions

   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
      Any follow-ups scheduled

REFERENCES:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing (CR) 5.
B. Medicare Managed Care Manual, Chapter 6 § 60.3
C. DHCS All Plan Letter (APL) 19-004 supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment”.

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B. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

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.

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.

2. For automatic administrative terminations based on the Practitioners not meeting specific contractual obligations for participation in the network.
25. DELEGATION OVERSIGHT

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

**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” meets 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 is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

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

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

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

B. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

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

PROCEDURES:

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

1. The range of actions available to the Delegate, that they may take to improve the Practitioner performance before termination, to include, but not limited to:
   a. Profiling
   b. Corrective actions(s)
   c. Monitoring
   d. Medical Record Audit

2. The Delegates policies and procedures must give the Practitioners the right to appeal and must include the following steps within the appeal process:
   a. Provide written notification when a professional review action has been brought against a Practitioner, including reasons for the action.
   b. Allow Practitioners to request a hearing/appeal and the timing for submitting the request.
   c. Policy must state that the Delegate cannot have an attorney, if the Practitioner does not have attorney representation, to ensure compliance with CA Business & Professions Code 809.3(c).

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
25. DELEGATION OVERSIGHT

B. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

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.

4. Delegates must have policies and procedures that describe when and how reporting occurs, to whom incidents are reported and what specific incidents are reportable. The policy must address what is expected of the Delegates staff and outline accountability so that staff understand their responsibilities in order to perform their functions correctly. When the Delegate decides to suspend or terminate a Practitioner’s contract, there must be procedures notifying the appropriate authorities (including state agencies, as appropriate) of the action, that includes, but is not limited to:

a. 805 Reports.

1) Delegate is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason.

   • If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a Physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

   • If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of 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
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- Any other relevant information deemed appropriate by the reporter.

3) Delegates must file an 805 report with the relevant agency within fifteen (15) days after the effective date on which any of the following occur as a result of an action of a peer review body:
   - A licentiate’s application for staff privileges or membership is denied or rejected for medical disciplinary cause or reason.
   - A licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
   - Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reason.

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

b. 805.01 Reports

1) Delegate must file an 805.01 within fifteen (15) days after a peer review body makes a final decision or recommendation of termination, suspension or restriction of staff privileges, membership or employment due to an investigation, for at least one (1) of the following reasons:
   - Incompetence, or gross or repeated deviation from the standard of care
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   involving death or serious bodily injury to one (1) or more patients in such manner as to be dangerous or injurious to any person or the public.
   - The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
   - Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
   - Sexual misconduct with one (1) or more patients during a course of treatment or an examination.

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

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

B. Delegates policies and procedures regarding suspension or termination of a participating physician require the Delegate to ensure that the majority of the hearing panel members are peers of the affected Physician.
   1. A Peer is an appropriately trained and licensed Physician in a practice similar to that of 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.

REFERENCE:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 6.
B. California Code, Business and Professions Code § 809.3(c).
C. Medicare Managed Care Manual, Chapter 6 § 60.4.
D. California Evidence Code § 1157.
E. California Code, Business and Professions Code § 805, 805.01.
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F. California a Code, Business and Professions Code § 2113 or 2168.
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B. Credentialing Standards

7. Assessment of Organizational Providers

**APPLIES TO**

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

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

**POLICY:**

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

B. 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.

C. 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.

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

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

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

**PURPOSE:**

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

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

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

D. Delegated Providers that subcontract with Ancillary and organizational Providers are responsible for ensuring that their subcontracted Providers meet IEHP’s requirements as stated herein and in Policy 05A7, “Credentialing Standards - Assessment of Organizational Providers”. IEHP audits Delegate’s compliance with IEHP requirements on an annual basis, using the IEHP Delegation Oversight Audit Tool beginning with a pre-contractual assessment, in accordance with Policy 25A2, “Delegation Oversight – Audit.” Delegated IPAs are subject to corrective action as defined in Policy 25D3, “Quality Management - 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 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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7. Assessment of Organizational Providers

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 Provider's regulatory status is not acceptable.

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

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

2. 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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- 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.

REFERENCES:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 7.
B. Medicare Managed Care Manual, Chapter 6 § 70.
C. Medi-Cal Law, Welfare and Institutions Code (W&I Code), § 14043.6 and 14123.
D. DHCS All Plan Letter (APL) 19-004 supersedes APL 17-019, “Provider Credentialing/Recredentialing and Screening/Enrollment”.
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022 supersedes 16-017 and APL 15-017, “Provision of Certified Midwife and Alternative Birth Center Facility Services.”
F. Knox-Keene Act of Title 28.
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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 subdelegates 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. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered subdelegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for subdelegation 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
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8. Delegation of Credentialing

the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

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

PROCEDURES:

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

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

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

3. Delegate must determine the method of reporting and the content of the reports, but the agreement specifies:
   a. The reporting is at least 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.
   b. What information is reported by the delegate about delegated activities.
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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 subdelegates, even NCQA-Accredited or NCQA Certified delegates.

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

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

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

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

1. Delegates may use an accredited Health Plan audit as the pre-delegation evaluation.
   a. If Delegate uses a health plan audit, there must be evidence that the health plan audit was reviewed, e.g. Committee minutes, email approval or other methods indicating acceptance of review.
   b. If Delegate changes Management Services Organizations (MSOs), the Delegate must evaluate the new MSO prior to contracting.

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

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

4. The Delegate must have a systematic method for conducting this evaluation, especially if more than one (1) delegation agreement is in effect. The following list are examples:
   a. Site Visit.
   b. Written review of the subdelegate’s understanding of the standards and the delegated tasks.
   c. Staffing capabilities.
   d. Performance records (e.g. Audit).
   e. Exchange of documents and review.
   f. Pre-delegation/Committee meetings.
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   g. Telephone consultation.
   h. Virtual review.

C. For delegation arrangements in effect for twelve (12) months or longer the Delegate must:

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

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a. Assess the Quality or Credentialing Committee Minutes.

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

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

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

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

5. 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.

a. 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.

b. 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.

REFERENCES:

A. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 1, 2, 3, 4, 5, 6, 7, and 8.


C. Medicare Managed Care Manual, Chapter 11 § 110.2.
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 subdelegation, and the organization would be considered a subdelegate. The Delegate will be responsible for subdelegation 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.

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;
B. Credentialing Standards

9. Identification of HIV/AIDS Specialists

3. For Physician Assistants, continuing medical education units approved by the American 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
B. Credentialing Standards  

9. Identification of HIV/AIDS Specialists

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

B. Delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS Specialist on 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 prior’s years annual screening.

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

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.
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   9. Identification of HIV/AIDS Specialists

REFERENCES:

A. California Health & Safety Code § 1374.16.
B. DMHC TAG (QM – 004).
C. DHCS MMCD All-Plan Letter 02001, “Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program”.

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25. DELEGATION AND OVERSIGHT

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 IEHPs criterion as specified in Policy 25B1, “Credentialing Standards – Credentialing Policies.”

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

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

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

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

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

PURPOSE:

A. IEHP must receive reports from its Delegates at least semiannually. At a minimum, Delegates must report its progress in conducting credentialing and recredentialing activities, and on performance-improvement activities, if applicable. Findings from the Delegates pre-delegation evaluation, annual evaluation, file audit or ongoing reports can be sources to identify areas of improvement for reporting. Areas could be related to NCQA credentialing standards or to IEHPs expectations.
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B. In addition to IEHP’s quality oversight, Delegated 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 Delegated 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 subdelegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for subdelegation 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 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 your email with a confirmation that you are credentialing files were located.

      • Upon receipt of credentialing files into the Delegates SFTP ‘Credentialing’ folder, IEHP will begin the credentialing process. Submitted files will be forwarded to IEHP Credentialing for processing.
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- For all Primary Care Physicians (PCPs), Obstetrics/Gynecology (OB/GYNs) and Urgent Care’s, once all credentialing information is received, IEHP’s Credentialing Department will request for a facility site review with IEHPs Quality Management (QM) Department, in accordance to Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring.”

- If a Practitioner’s submission packet is incomplete and/or missing supporting documentation, the Delegate is notified via email with the reason why that the process was terminated for the Practitioner. The Delegate must resubmit all documents again, to include missing information to IEHP for review and reconsideration.

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

2. The Delegate must submit the following for review and consideration:

   a. Contract (1st and signature pages)
      1) To include any applicable addendums to show the Practitioner’s relationship or affiliation with that contract.

   b. W-9 for all Tax Identification Numbers (TINs) used by the Practitioner.

   c. Delegation of Services Agreement & Supervising Physician Form (applicable to Physician Assistants (PAs) only).

   d. Standardized Procedures (applicable to Nurse Practitioners (NPs) and Nurse Midwives (NMs) only).

   e. 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.

   f. Practitioner Profile or spreadsheet that includes all the elements listed below, otherwise, it will be rejected back to the Delegate with the reason for review and resubmission.
## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

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<thead>
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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

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<tr>
<th>PROVIDER PROFILE ELEMENT(S)</th>
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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

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

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

   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 Delegated 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 Delegated 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 Delegated 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) Delegated IPA to another, identified as a “pend change,” the new Delegated IPA must submit the Providers documentation (as noted in Procedure A above) within sixty (60) calendar days of the effective date of the change.

1. Failure to meet this timeframe will result in “freezing” the Provider to auto-assignment of Member or possible termination.
   a. Delegated 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 and/or employed 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:

   REREDENTIALING ACTIVITIES:

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25. **DELEGATION AND OVERSIGHT**

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

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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. Mid-Levels (PAs, NMs, and NPs) relocating or changing supervising Physicians, Delegates must provide a current copy of the following documents to ensure compliance with IEHP guidelines (See Policy 6F, “Non-Physician Practitioner Requirements”).

   a. Physician Assistants (PAs) may act as an agent of the supervising Physician in which they have an agreement. A Delegation of Services Agreement may authorize a PA to provide or perform the following activities as long as there is documentation
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

- evidencing the activity was actually 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.

b. Nurse Practitioners (NPs) and Nurse Midwives (NMs) may perform the following procedures if a standardized procedure is in place:

1) To diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissue of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions.

2) Standardized Procedures must be on-site site specific and
   - Reference textbooks and other written sources to meet the requirements of Title 16, CCR § 1474 (3), must include:
     - Book (specify edition) or article title, page numbers and sections.
   - NP and/or NM must be practicing at a site assigned to their supervising physician; and
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   10. Credentialing Quality Oversight of Delegates

- 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).

- 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.

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.

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, Delegated IPA credentialing committee dates and, for obstetricians only the Hospitals where they deliver. Delegates are required to verify and update the following information:

1. Delegated 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
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
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are required.

d. “Provider Term Date” – provided to indicate the Practitioner is no longer part of the Delegated 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 Delegated 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 being made available in IEHP’s secure portal.

F. Delegated 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 Provider Services Analyst emails all Delegates on the 15th of each month for verification of all Admitters to ensure accurate information is obtained.

2. Delegated IPAs are responsible for the following:

a. Ensuring all providers listed with the correct Admitting Provider.

1) Any changes from the Delegated IPAs must be submitted by the 25th of every month, via Secure File Transfer Protocol (SFTP) server.

   • The Delegated 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 Delegated 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 Delegated IPA confirms admitting privileges to the Hospitals they are admitting to, are in place and in good standing.

1) The Delegated IPA is responsible for providing a replacement. If not, the Provider will be terminated from the Delegated IPA’s network for not having Hospital admitting arrangements, and;
25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
   10. Credentialing Quality Oversight of Delegates

   d. The Delegated 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 Delegated IPA network as the referring Physician.

   e. Ensuring all Providers on the report are still active with the Delegated IPA.

On the last day of the month all network Hospitals are emailed the final Admitter list for that month. It includes Admitters name, phone number and fax number for each Provider who utilizes a Hospital Admitter. If Hospitals find discrepancies, they are emailed back to the Credentialing Specialist, who verifies with the Delegated IPA’s credentialing contact.

REFERENCES:

A. Title 16, California Code of Regulations § 1474.
B. California Code, Business and Professions Code § 1399.540.
C. NCQA, 2019 HP Standards and Guidelines, Credentialing and Recredentialing (CR) 8.
D. Title 16, Division 13.8, Article 4, section 1399.540
E. Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474.
F. Medical Board of California, Title 16, CCR Section 1379.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
   1. IEHP Monitoring and Oversight

APPLIES TO:

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

POLICY:

A. IEHP delegates care management (CM) activities to IPAs that meet standards set by the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare & Medicaid Services (CMS), and IEHP. Delegated responsibilities are outlined in Policy 25C2, “Care Management Requirements – Delegated IPA Responsibilities”.

B. IEHP monitors the IPAs’ care management activities monthly, quarterly, annually, and as frequently as necessary.

PROCEDURES:

A. IEHP Delegation Oversight staff monitors and supports the IPAs’ care management activities through:
   1. Review of the IPAs’ care management report logs and cases monthly, annually and as needed; and
   2. Completion of monthly file audits of care management and California Children’s Services (CCS), Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and Early Start cases to ensure regulatory compliance.

B. As described in Policy 25C2, “Care Management Requirements – Delegated IPA Responsibilities,” IEHP staff provides monthly and quarterly monitoring and oversight of the IPAs’ care management activities through file reviews for elements which may include, but not limited to the following:
   1. Care Management/Care Coordination
      a. IEHP does not delegate Complex Case Management (CCM) to the IPAs. IEHP will however review cases that potentially qualify and assess for appropriate referral. Cases that do not qualify for CCM level program enrollment with IEHP but are identified as needing care coordination and/or care management assistance are sent to the IPA for assessment and enrollment into the IPA’s CM program.
      b. Seniors and Persons with Disabilities (SPD) – All SPD Members are required to have a Health Risk Assessment (HRA) reviewed in order to be assigned to the appropriate level of care management. IEHP uploads monthly SPD HRAs to the Secure File Transfer Protocol (SFTP). The IPA is required to review the assessment and develop an individual care plan (ICP) if the Member is stratified as High risk or if the Member demonstrates the need for an ICP. The IPA will also offer all high-risk SPD Members an Interdisciplinary Care Team (ICT) when a need is demonstrated and accommodate
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
   1. IEHP Monitoring and Oversight

   those who request one.

c. Long-Term Services and Supports (LTSS) – IEHP provides Delegated IPAs a list of
   their Members who are receiving LTSS Services. Delegated IPAs are to also identify
   Members for LTSS services through various activities such as the IPAs Utilization
   Management (UM) review process, Care Management activities such as discharge
   planning process, concurrent review or upon referral from PCPs, Specialist, Member
   and other services. The following information is provided through the secure provider
   portal.

   1) For Members receiving Multipurpose Senior Services Program (MSSP) services, IEHP will provide if available their MSSP Care Plan and Health
      Assessment summary

   2) For Members receiving Community-Based Adult Services (CBAS), IEHP will
      provide if available the Individual Plan of Care from the CBAS Center, CBAS
      Eligibility Determination Tool and Discharge Summary.

   3) For Members receiving In-Home Supportive Services (IHSS, IEHP will provide
      if available the approved IHSS services hours and the County Social Worker’s
      contact information.

d. Medi-Cal HIV/AIDS Home and Community Based Waiver Program – IEHP
   Delegated IPAs are to assist in coordinating care and for Members who are identified
   by a Contracted (PCP) or Specialists as a candidate potentially eligible for the
   Acquired Immune Deficiency Syndrome (AIDS) Waiver Program. This includes the
   following activities:

   1) Assistance with eligibility questions and completion of referral;
   2) Provision of telephonic monitoring of potential high-risk Members;
   3) Maintenance of continuity of care through coordination with AIDS Project Staff;
   4) Timely reporting to IEHP of Members being considered for placement in the
      AIDS Medi-Cal Waiver Program’
   5) Coordination with the PCP to ensure that all medically necessary health services
      are provided to the Member except for services covered directly under the AIDS
      Medi-Cal Waiver Program; and
   6) Maintenance of continuous and unimpeded flow of medical information
      between providers and specialists.

e. Waiver Programs- Delegated IPAs must have procedures in place to identify
   Members who may benefit from the HCBS Waiver programs and refer Members to
   the agency administering the waiver program. These waiver programs include, but
   are not limited to, the nursing facility/acute hospital waiver and all HCBS waivers.
25. **DELEGATION AND OVERSIGHT**

C. **Care Management Requirements**

1. **IEHP Monitoring and Oversight**

   - The Delegated IPA shall continue comprehensive case management if the Member is placed into the program, if the Member does not meet criteria or if placement is not available.

   - IEHP will select and review, at a minimum, five (5) targeted cases each month for monitoring and oversight.

2. **California Children’s Services (CCS), Early Start and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Cases** – IEHP will upload monthly CCS reports to the SFTP. IPAs ensure coordination of care and services and joint case management between its Primary Care Physicians (PCPs), CCS specialty providers, and the local CCS program. 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 Attachment, “Delegated IPA Reporting Requirements Schedule - Medi-Cal” in Section 25).

C. **Delegated Care Management Services – Utilizing Delegated IPA Care Management Review Tools** (See Attachment, “Delegated 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. Delegated IPA pre-contractual audits;
   2. IEHP and Delegated 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;
   7. Follow-up on care management needs for Members who were recently discharged from the hospital; and
   8. Monthly CCS Referral Log (See Attachment, “Monthly CCS Referral Log” in Section 25) and CCS file reviews (See Attachment, “Monthly CCS Review Tool” in Section 25[MO1] for review criteria[LN2]).

D. The IPA CM staff is responsible to provide care coordination and/or care management services for all Members demonstrating a need.

E. IEHP provides education and training on care coordination at scheduled Joint Operations Meetings and as needed.

F. As described in MC_25D3, “Quality Management - Corrective Action Plan Requirements”,

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all IPAs that score less than 90% may be required to submit a CAP to remedy any deficiencies noted on the audit tool. Upon request, the IPA must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies noted.

REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-012, Supersedes APL 14-010, “Care Coordination Requirements for Managed Long-Term Services and Supports”.

B. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-013, Supersedes APL 14-005, “Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities”.


D. Department of Health Care Services (DHCS) All Plan Letter (APL) 02-001, Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program.
C. Care Management Requirements
   2. IPA Responsibilities

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

POLICY:
A. IEHP delegates the responsibility of primary care management (CM) of assigned Members to IPAs. IPA care management responsibilities include, but are not limited to: identifying cases appropriate for care management program enrollment, care coordination, continuity of care, referral for services, and development of an individualized care plan (ICP) in collaboration with an Interdisciplinary Care Team (ICT) (for Seniors and Persons with Disabilities [SPD] Members) that is assembled to meet the needs of the Member.1,2
B. The assigned 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. IEHP and its IPAs maintain procedures for monitoring the coordination of Members’ care, including but not limited to all medically necessary services delivered both within and outside the IPA’s Provider Network.3
D. IEHP and its 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), California Children’s Services (CCS), and Inland Regional Center (IRC).4
E. IPAs are responsible for reporting care management activities to IEHP via IEHP’s Secure File Transfer Protocol (SFTP) for delegation oversight purposes.

PROCEDURES:
Care Management Program Description
A. IEHP and its IPAs will develop a care management program that includes:
   1. Evidence used to develop the program;

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2 DHCS All Plan Letter (APL) 17-013, Supersedes Policy Letter (PL) 14-005 “Requirements for Health Risk Assessment for Medi-Cal Seniors and Persons with Disabilities”.
4 DHCS APL 17-012, Supersedes APL 14-010 “All Medi-Cal Managed Care Health Plans Operating in Coordinated Care Initiative Counties”.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements

2. IPA Responsibilities

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;
5. Defined program goals;
6. How the IPA will evaluate the effectiveness of their care management program; and
7. A process to evaluate Member satisfaction with the IPA’s care management program.

Care Management Identification

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

1. At least monthly, IEHP and its IPAs analyze internal data such as claims, encounters, utilization, pharmacy, Member, Provider and Health Plan referrals against the identification criteria described in IEHP or the IPA’s care management program description.

2. IEHP and IPAs analyze data that is made available to them by IEHP. This data includes the Health Risk Assessment (HRA) for SPD Members, LTSS data, CCS and Early Start Services information as well as Member referrals.⁵
   a. IEHP provides IPAs a list of their Members who are receiving LTSS services. The following information will be provided through the secure Provider portal.
      1) For Members receiving MSSP services, IEHP will provide, if available, their MSSP care plan and health assessment summary.
      2) For Members receiving CBAS, IEHP will provide, if available, the Individual Plan of Care from the CBAS center, CBAS Eligibility Determination Tool, and Discharge Summary.
      3) For Members receiving IHSS, IEHP will provide, if available, the approved IHSS services hours and the County Social Worker’s contact information.
   b. IEHP will provide the IPAs monthly reports that identify new CCS Members, whose Primary Care Physicians (PCPs) and parents/guardians will need to be informed of their status. These Members may require additional support and possible care management services.
   c. IEHP will provide a monthly report that identifies Members who are turning 21 years of age that will be transitioning out of CCS and may require additional support. IPAs

⁵ DHCS APL 17-012.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements

2. IPA Responsibilities

assist in the transition of Members and to the extent possible, ensure the continuity of Members’ care.

d. IEHP will provide a monthly roster of children who are currently receiving services through Inland Regional Center’s Early Start Program. These Members may require additional support and possible care management services. IPAs ensure the coordination of care and services and joint case management between their PCPs and the Early Start Program.

3. The IPA will utilize a care management assessment tool that includes, but is not limited to:
   a. Member’s current health status (medical and behavioral);
   b. Clinical history;
   c. Medication;
   d. Assessment of activities of daily living, cognitive function, psychosocial issues, health behaviors and life planning activities;
   e. Evaluation of cultural and linguistic needs, visual and hearing needs, preferences or limitations;
   f. Evaluation of caregiver resources and involvement; and
   g. Evaluation of community resources.

Care Management Steps for Seniors and Persons with Disabilities (SPD)

A. The IPA will review the uploaded SPD HRAs on the Provider portal and/or the SFTP daily. The SPD HRA includes basic assessment questions needed to identify and determine what level of care management would be most appropriate for the Member.\(^6\)

1. The IPA must have a process to enroll Members into an appropriate care management program for their risk level.

2. Assessment of risk 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.

3. 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.

\(^6\) DHCS APL 17-013.
B. If IEHP 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. Outreach attempts must be documented (See Attachment, “Monthly Care Management Log” in Section 25).

1. Contact attempts must be made within thirty (30) calendar days of HRA status notification.
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.

IPA Program Requirements

A. **Care Coordination:** 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.

B. **Program Referral:** For Members that meet criteria for IEHP’s Complex Case Management program, the IPA should send a referral to IEHP that includes information supporting the complex need (see below for referral details). For Members that do not meet criteria for IEHP managed programs and belong to a IPA, the IPA will be responsible for coordinating care under their own care management program.

**Referring Members to IEHP Complex Case Management Program**

A. IEHP does not delegate Complex Case Management (CCM). Members meeting complex criteria are referred to IEHP CM. The IPA must notify the IEHP CM team with Member information when a review for CCM is requested. Members needing CCM typically have (a) health condition(s) status that is severe in nature and without intensive assistance the Member would likely decline or use acute services more frequently. Members needing CCM level of assistance often requires numerous or extensive resource coordination in order to improve their health or circumstances. IEHP accepts referrals to care management for Members needing CCM (See Attachment, “IEHP Care Management Referral Form – Medi-Cal” in Section 25). Referrals for CCM will be reviewed and assessed for the IEHP Complex Care Management Program.7

B. The following CCM Program Trigger List was developed as a general guide for those who refer Members for CCM (i.e. Providers, IPAs) and should be used in combination with considering the following questions:

1. Is the Member’s current situation severe?

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7 DHCS Final Rule Contract Amendment, Exhibit A, Attachment 11.
2. Is the level of assistance needed intense and likely to require numerous/extensive resource coordination?

Triggers for CCM include but are not limited to:

**Diagnosis Triggers**

1. Advanced Liver Disease
2. Metastatic Cancer
3. Pediatric Cancer
4. Decompensating Neurological Conditions
5. New Cerebral Neurological Conditions
6. New Cerebral Vascular Accident
7. Complex Pain Management Control Issues
8. Trauma (current)
9. Multiple Chronic Illnesses – uncontrolled

**AND/OR**

**Utilization Triggers**

1. Six (6) or more ER visits in the past twelve (12) months
2. Four (4) or more inpatient stays in the past twelve (12) months
3. Two (2) or more readmissions to acute setting
4. On multiple medications for multiple chronic conditions
5. Projected cost of care within a 12-month period anticipated to be > $100,000 (including high cost medications and/or DME)

**AND/OR**

**Psychosocial/Frailty Triggers**

1. Malnutrition and/or Catabolic illness
2. Dementia
3. Severe Vision Impairment
4. Decubitus Ulcer
5. Major Problems of Urine Retention or Control
6. Loss of Weight
7. Absence of Fecal Control
25. **DELEGATION AND OVERSIGHT**

C. **Care Management Requirements**

2. **IPA Responsibilities**

8. Social Support Needs (Lack of Housing, inadequate Housing, inadequate material resources)

9. Difficulty Walking

10. Fall (fall on stairs or steps, fall from wheelchair)

11. Suspected or reported abuse of Member

C. IEHP will provide a monthly IPA CCM Report by IPAs, located on the STFP. This report will include the following:

1. IPA Members active in CCM
   a. A list of assigned Members by IPA that are in active CCM with IEHP (as of report run date).

2. IPA Members closed from CCM
   a. A list of assigned Members by IPA that were closed from CCM with IEHP in the previous month with CCM Closure Reason included.

3. IPA Members referred but not opened to CCM
   a. A list of assigned Members by IPA that were referred to IEHP for CCM but were not opened to CCM (as of report run date) because Members did not meet criteria.
   b. IPAs are responsible to review cases and evaluate Members who did not meet CCM criteria and perform Member outreach and assess for care coordination into other programs.

**Interdisciplinary Care Team**

A. All high-risk SPD Members identified and enrolled into a care management program who request an ICT or demonstrate a need should be offered the opportunity to have an ICT. This is 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.8

1. At a minimum, the ICT consists of 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, Health Plan staff and other individuals that are actively involved in the Member’s care.

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8 DHCS APL 17-012.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements

2. IPA Responsibilities

2. At times, it will be necessary to schedule a case conference for Members that require face-to-face interactions with their ICT. IEHP has case conferences on a regular basis and can support the IPA if a face-to-face case and/or teleconference is needed. The IPA may contact IEHP Provider Services if it needs assistance with coordination of the ICT case conference by calling (909) 890-2054. IEHP recommends that the IPA holds 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.

Individualized Care Plan

A. IEHP and its IPA are required to develop an ICP for high risk SPD Members and other Members that demonstrate a need for an ICP, or when it’s requested by the Member, Provider or Health Plan or as described in the IPA’s care management program description/policies and procedures.⁹

1. The IPA is required to develop an ICP within thirty (30) business days from the date the HRA was completed. The ICP must be developed based on the specific health care needs of the Member, and must consider input from the Member, data obtained from the HRA, and input from the ICT if appropriate. The Member’s HRA completion date is found in the IEHP’s secure Provider portal within the “Health Risk Assessment Survey” PDF document.

2. If IEHP is unable to contact the Member to complete their HRA, the HRA status under the “Assigned Roster” will display as “Incomplete.” The IPA shall continue to outreach to the Member for assessment [LN1][MO2] and ICP completion. If the Member is successfully contacted, the ICP must be developed with the Member’s participation. [AE3][DS4][AE5]

B. The ICP includes prioritized goals that are agreed upon by the Member.

C. The ICP identifies barriers to meeting the goals.

D. The ICP includes development of a schedule for follow-up that adheres to the risk stratification and program description/policies of the IPA.

E. The ICP includes an 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:

   A change in the Member’s health condition, including but not limited to a change in the level of care;

   1. A new problem has been identified with the Member;

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

C. Care Management Requirements

2. IPA Responsibilities

2. A goal has changed priority, has been met or is no longer applicable; and
3. ICP is closed or completed.

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

H. 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.

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

Care Management Interventions

A. 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.

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10 DHCS APL 17-012.
11 Ibid.
12 Ibid.
C. Care Management Requirements

2. IPA Responsibilities

California Children’s Services

A. IEHP will provide the IPA monthly CM CCS reports of Members who are newly enrolled into CCS and of Members who will be turning 21 years of age within six (6) months. The monthly CM CCS reports will be uploaded to the IEHP SFTP.

1. IPA is required to ensure the coordination of care and services for newly enrolled CCS Members. This includes PCP notification that CCS Services are starting, coordination between PCP and Specialist on an as needed basis. IPA also notifies parents of newly eligible CCS Members to advise of CCS services, provide education of service coverage and assess for any care coordination needs.

2. IPA is also required to 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 Member turning 21 years of age, communication between IPA and Member to ensure care is established with an adult PCP and County CCS collaboration as needed. IPA will have the responsibility 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 by requests for assistance from PCPs or Specialist. 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 supportive medical documentation along with the potential CCS referral. IPA will continually provide any care coordination needs are met while Member pending CCS eligibility. Please see Policy 12B, “California Children’s Services,” for more information.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

A. EPSDT care management services may be provided by IEHP, the IPA, Inland Regional Center Child Protective Services or the Department of Mental Health as needed. When EPSDT services come to an end, IPA is to ensure PCP and Member notification. Care coordination is to be provided to assist with the transition of any services such as EPSDT shift nursing. This includes coordination with County CCS Social Worker as needed. Please see Policy 12D, “Early and Periodic Screening, Diagnosis and Treatment,” for more information.

Early Start Services

A. IEHP will send 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 is required to notify the PCP and Member to advise of Early Start Services ending. Care coordination support is to be provided to assist the transition of services such as Local Education Agency (LEA), supplemental therapy, and

other necessary treatments. This includes assisting with coordination between Member and PCP to obtain referrals as s. Please see Policy 12C, “Early Start Services and Referrals,” for more information.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements

3. Reporting Requirements

APPLIES TO:

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

POLICY:

A. All Delegated IPAs must report care management information to IEHP as described below on a monthly basis.

B. 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 (by the 15th of the following month) and in the correct format, via IEHP’s Secure File Transfer Protocol (SFTP). Files not submitted in the correct format will be rejected, and Delegated IPA will be required to resubmit in the required format.

C. Persistent failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), freezing of new Member enrollment or termination or non-renewal of the IEHP Agreement.

PROCEDURES:

A. 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) within the timeframes specified in the Medi-Cal Delegated IPA Reporting Requirements Schedule regardless if it falls on a holiday or weekend (See Attachment, “Delegated 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. The care management log includes:
   a. Member Name;
   b. IEHP Member ID Number;
   c. Date of Birth;
   d. Referral Source;
   e. Referral Reason;
   f. Case Status (open or closed);
   g. Case Level (general or complex);
   h. Case Open Date (or Ref to waiver, CCS) community-based services or BH;
   i. Individualized Care Plan Documented;
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements

3. Reporting Requirements

j. Diagnosis (ICD Codes/Description);
k. Problems/Issues Identified;
l. Goals Identified;
m. Interventions Documented; (ex. Monthly follow up, transition in care);
n. Care Plan sent to PCP Documented;
o. Case notes;
p. Communication with Member Documented;
q. Case Closure Date; and
r. Reason for Closure/Case outcome documented.

Members who remain in care management will have a minimum of a 30-day review or an intervention as Member needs require. Each Delegated IPA must submit the information noted in the Monthly Care Management Log (See Attachment, “Monthly Care Management Log” in Section 25).

2. CCS Logs – Delegated IPAs must submit a log that identifies referred newly identified CCS Members. The report should include the following:

a. Member name;
b. ID number;
c. CCS approved diagnosis;
d. County;
e. Date of referral to the County;
f. State file number (CCS);
g. PCP and/or Specialist; and
h. the CCS status (e.g., pending, approved, or denied).

Each Delegated IPA must submit the information noted in the Monthly CCS Report Log (See Attachment, “Monthly CCS Report Log” in Section 25).

B. As described in 25D3, “Quality Management - Corrective Action Plan Requirements”, Persistent failure to submit required reports may result in the request of a CAP. Upon request, the Delegated IPA must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies noted. The CAP must be submitted to IEHP within thirty (30) calendar days of written notification by IEHP.
25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
   3. Reporting Requirements

REFERENCE:

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

<table>
<thead>
<tr>
<th>INLAND EMPIRE HEALTH PLAN</th>
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<tbody>
<tr>
<td>Chief Approval: Signature on file</td>
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<tr>
<td>Chief Title: Chief Medical Officer</td>
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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. All Delegates must report Quality Management (QM) and Quality Improvement (QI) information to IEHP as described below.
B. Persistent failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), freezing of new Member enrollment, or termination or non-renewal of the IEHP Agreement.

DEFINITION:
A. Delegate – For this purpose of this policy, this is defined as a medical group, Health Plan, Delegated 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 include the following:
         1) Quality of Clinical Care;
         2) Quality of Service;
         3) Safety of Clinical Care;
         4) Member Experience;
         5) Program Scope;
         6) Yearly Objectives;
         7) Yearly Planned Activities;
         8) Timeframe within which each activity is to be achieved;
         9) Staff member(s) responsible for each activity;
         10) Monitoring of previously identified issues; and
         11) Evaluation of the QM/QI program.
   2. QM Semi-Annual Reports must be submitted to IEHP via IEHP’s Secure File Transfer
25. DELEGATION AND OVERSIGHT

D. Quality Management
   1. Quality Management Reporting Requirements

Protocol (SFTP) by these due dates, regardless of whether these dates fall on a weekend or holiday:
   a. 1st Semi-Annual: August 15th; and
   b. 2nd Semi-Annual: February 15th.

3. The reporting periods for each report are as follows:
   a. 1st Semi-Annual: January 1st through June 30th of the reporting year; and
   b. 2nd Semi-Annual: July 1st through December 31st of the reporting year.

B. Annual Reporting Requirements: The following reports must be submitted annually to IEHP via IEHP’s SFTP by no later than the 15th of February each calendar year regardless of whether this date falls on a weekend or holiday:

1. Quality Management
   a. Quality Management Program Description: Reassessment of the QM Program Description must be done on an annual basis by the QM Committee and reported to IEHP. The following must be included with the submission to IEHP:
      1) Any changes made to the QM Program Description during the past year or intended changes identified during the annual evaluation; and
      2) Signature page noting date of committee approval.
   b. Quality Management Work Plan: Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include planned audits, follow-up activities and interventions related to identified problem areas.
   c. Quality Management Program Annual Evaluation: The evaluation should include a description, trending, barrier analysis and evaluation of the overall effectiveness of the QM Program.

C. IEHP’s Quality Management Department monitoring and oversight duties include:
   1. Review 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 those listed above.
   2. Review and approve the semi-annual and annual reports submitted by the Delegates (e.g., QM Program Description and Work Plan).
   3. Review all grievances received by IEHP for Delegates. The review includes assessment of grievance rates and response timeliness, examination for trends, significant changes in volume or amount of grievances received, quality issues, or other significant findings. Any trends or discrepancies in reported information are addressed with the Delegates in
25. DELEGATION AND OVERSIGHT

D. Quality Management
   1. Quality Management Reporting Requirements


REFERENCES:

A. Title 28, California Code of Regulations §1300.70(b)(G)(3).
B. DHCS Technical Assistance Guide, Category 5, Quality Improvement.
E. NCQA, 2019 HP Standards and Guidelines, Quality Management and Improvement (QI) 7.
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Delegated IPA Quality Management Program Structure Requirements

APPLIES TO:

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

POLICY:

A. IEHP is responsible for conducting the Health Plan Quality Management (QM) Program. IEHP and its Delegates are required to have certain QM structural components as noted below:

1. All Delegates must have a written QM Program Description, QM Work Plan, Annual Evaluation and related QM Policies and Procedures.

2. The Delegate’s QM Program Description outlines the structure and content of the Delegate’s QM Program, including the QM Committee and related activities.

3. All Delegates’ QM Program activities must meet Department of Health Care Services (DHCS), National Committee for Quality Assurance (NCQA) and IEHP standards.

4. The Delegate’s QM Committee is responsible for oversight and annual approval of the Delegate’s QM Program Description, Work Plan and Annual Evaluation.

5. The Delegates’ QM Committees are responsible for monitoring, measuring, and evaluating the quality, effectiveness, safety, coordination and appropriateness of the care provided by Practitioners to Members for the purpose of continued quality improvement.

6. The Delegates must have adequate QM staffing to support QM Program and related activities.

7. QM Programs must be accountable to the Delegates’ QM Committees.

B. IEHP monitors Delegates’ QM Program Structure and implementation of quality management activities as outlined in their Delegation Agreements through the Delegates’ semi-annual reports and the annual Delegation Oversight Audit (DOA). The DOA audit tool is based upon current NCQA, DHCS, and IEHP standards.

DEFINITION:

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

PROCEDURES:
25. **DELEGATION AND OVERSIGHT**

D. **Quality Management**

2. **Delegated IPA Quality Management Program Structure Requirements**

A. **Responsibilities** – IEHP has adopted a health care delivery structure that includes QM Program activities required of contracted Delegates. Details are noted in both the Agreement between IEHP and Providers and the IEHP Provider Policy and Procedure Manual. Activities related to medical services include:

1. **Quality Management:**
   
   a. **Quality Structure** – IEHP is responsible for conducting the Health Plan QM Program. Delegates are also required to have a structure in place that monitors quality activities, including a formal Committee structure and sufficient personnel in place to perform quality management activities.
   
   b. **Quality Studies** – IEHP is responsible for performing quality studies to maintain compliance with DHCS and NCQA requirements. In addition, 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 Physicians (PCPs) and IEHP Members upon request. IEHP has the right to mandate the type of access study required if the Plan has identified quality or access issues.
   
   c. **Peer Review** – 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. In addition, the 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 is responsible for providing 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
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Delegated IPA Quality Management Program Structure Requirements

management activities. Refer to Section 14, “Utilization Management,” for more information.

3. Credentialing/Recredentialing - Delegates may be delegated the responsibility for credentialing and recredentialing of participating Practitioners, as identified in Section 25, “Delegation and Oversight.” This includes a signed attestation by the Delegate’s Medical Director that states all Practitioner-required reviews were conducted. IEHP’s Chief Medical Officer and/or Medical Director designee review all Practitioners (PCPs and Specialists) individually for quality-related issues prior to assignment of Members. The IEHP Peer Review Subcommittee performs peer review for Practitioners on 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) – Delegates have been delegated care management responsibilities for Members including case finding, assessment of needs and care coordination, referral to outside agencies, and all other necessary care management activities. Refer to Policy 25C2, “Care Management Requirements – Delegated IPA Responsibilities,” for more information.

5. Practitioner Education – 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. IEHP provides network-wide training on a variety of subjects including pediatric and adult preventive services, perinatal standards, IEHP policies and procedures, case management, 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 actively works to improve the health and welfare of Members. Those Members with chronic conditions are identified through pharmacy data, referral information, and other reporting measures. IEHP notifies the 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
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Delegated IPA Quality Management Program Structure Requirements

with health education brochures, materials, forms and a Provider Resource Directory. Refer to Section 15, “Health Education” for more information.

7. Medical Records Maintenance – IEHP is responsible for establishing and distributing medical record standards to Providers and Practitioners. Delegates are required to monitor Physician offices for compliance. Practitioners are required to maintain policies and procedures consistent with IEHP requirements. These requirements are outlined in Policy 7A, “Provider and Delegated IPA Medical Records Requirements.”

8. Preventive Care and Non-Preventive Care Guidelines – Practice guidelines are developed by IEHP using current published literature, current practice standards, and expert opinions. They are based upon specific medical issues commonly found within IEHP’s Membership. Delegates are expected to monitor Practitioner’s care related to clinical guidelines as applicable. IEHP measures its performance against at least four (4) of its standards on an annual basis, two (2) of which relates to Behavioral Health. Standards are reviewed and updated by IEHP at least every two (2) years, or earlier, if necessary.

9. Access Standards – Delegates are required to adhere to IEHP standards for availability and accessibility of services. Refer to Section 9, “Access Standards” for more information. IEHP ensures the standards for appointment availability, after-hours access, Practitioner wait time, Physician site hours, emergency service availability, medical triage both during and after hours, proximity of Specialists and Hospitals, and follow-up care through studies and audits. The Delegate is required to perform access studies on their Practitioners to ensure they meet IEHP requirements.

B. Assessment and Monitoring: To ensure that Delegates have the capacity and capability to perform required functions, IEHP has a rigorous pre-contractual and ongoing assessment and monitoring system.

1. Pre-Delegation Audit – IEHP performs pre-delegation audits to newly Delegated IPAs to evaluate the Delegate’s capacity to meet regulatory requirements within twelve (12) months prior to implementing delegation using an audit tool that reflects current NCQA, DHCS, and IEHP standards.


C. Delegate QM Reporting Requirements: Delegates are required to report the following information on a periodic basis. Policy 25D1, “Quality Management - Quality Management Reporting Requirements,” specifies the reporting requirements.

1. QM Program Description - copy of the annual, updated program description;
25. DELEGATION AND OVERSIGHT

D. Quality Management

2. Delegated IPA Quality Management Program Structure Requirements

2. QM Work Plan - copy of the annual work plan, that includes responsible person and anticipated completion date for activities;

3. QM Semi-Annual Reports of quality improvement activities;

4. Quality Studies performed by the Delegate; and

5. QM Program Annual Evaluation - annual assessment of Delegate’s QM Program and related activities.

D. Annual Quality Management Program Description

1. Contracted Delegates must have a written Annual QM Program Description that describes the structure of the Delegate’s Quality Program. This program must include the following:

   a. QM Program goals, objectives, and structure;
   
   b. Accountability to the Delegate’s Governing Body;
   
   c. Designated Physician involvement in the QM Program;
   
   d. Patient Safety;
   
   e. Member Experience;
   
   f. Description of behavioral health care activities, as applicable;
   
   g. Description of behavioral health care Practitioner involvement in behavioral health care aspects of the program; as applicable;
   
   h. Description of QM Committee oversight of quality management functions;
   
   i. Role, structure and function of the QM Committee and related Sub-committees including meeting frequency;
   
   j. An annual work plan;
   
   k. Description of the resources that devote time to meeting the objectives of the QM Program;
   
   l. Objectives for serving a culturally and linguistically diverse membership; and
   
   m. Objectives for serving Members with complex health needs and Seniors and Persons with Disabilities (SPD).

2. The Delegate’s Annual QM Program Description must be evaluated annually and updated as necessary by the Delegate’s QM Committee. The Annual QM Program Evaluation must include a description, trending, analysis, and evaluation of the overall effectiveness of the Delegate’s QM Program. The Annual QM Program Evaluation
D. Quality Management

2. Delegated IPA Quality Management Program Structure Requirements

must be submitted to IEHP via IEHP’s Secure File Transfer Protocol (SFTP) no later than February for each calendar year.

3. The Delegate must have a written description for the staff dedicated to perform the activities defined in the QM Program.

4. The Delegate must document all resources devoted to the QM Program, not merely the QM Program staff, but also the planned number and type of quality management activities. There must be documentation of the resources regularly devoted to specific quality management activities and if the Delegate is completing quality management activities in a competent and timely manner. These resources include but are not limited to the following:
   a. Employees;
   b. Consultants;
   c. Data sources; and
   d. Analytic resources such as statistical persons and/or programs.

5. The Delegate must have access to, and the ability to manage, the data supporting measurement of quality management activities documented in the QM Work Plan.

6. The Delegate’s Board of Directors is responsible for the QM Program Structure. There must be documentation of this responsibility in the Annual QM Program Description.

7. There must be evidence of the Board of Directors’ review and approval of the Annual QM Program Description on an annual basis.

8. The Delegate’s Annual QM Program Description must be submitted to IEHP via IEHP’s SFTP for final approval from the QM Department. This submission must be received by IEHP no later than the February for each calendar year.

9. The Delegate’s Annual QM Program Description must outline their approach to address the cultural and linguistic needs of its membership.

10. The Delegate’s Annual QM Program Description must outline their approach to address Members with complex needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions, and severe mental illness.

E. Quality Management Committee

1. The QM Committee is an interdisciplinary committee with participation from the Delegate’s appointed Practitioners who represent network Physicians. The QM Committee is responsible for developing, implementing, monitoring and overseeing the activities in the QM Program.
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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 how the following actions are performed:
   a. Recommending policy decisions;
   b. Analyzing and evaluating QM Activity findings;
   c. Ensuring Practitioners’ participation in the QM Program through planning, design and implementation or review;
   d. Implementing needed actions;
   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.

6. The Delegate’s QM Committee is responsible for monitoring, measuring, and evaluating the effectiveness of care provided to its Members.

F. Quality Management Work Plan

1. The QM Work Plan must be a separate document included in the Annual 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:
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   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.

2. The Work Plan must be submitted to IEHP via IEHP’s SFTP by no later than the February for each calendar year.

G. **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.

2. The QM Semi-Annual Reports assist the Delegate in its development of the QM annual assessment.

3. The QM Semi-Annual Report must include:
   a. Component/Activity;
      1) Clinical Improvement;
      2) Continuity and Coordination of Care;
         - General Medical Care
         - General Medical and Behavioral Health
      3) Access;
      4) Satisfaction Improvement;
      5) Patient Safety; and
      6) Other QI Activities.
   b. Each Component must include:
      1) Objectives;
      2) Activities planned;
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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.

4. QM Semi-Annual Reports must be submitted via IEHP’s SFTP to IEHP on the following dates:
   a. 1st Semi-Annual report covers period from January 1st to June 30th and must be reported to IEHP by August 15th.
   b. 2nd Semi-Annual report covers period from July 1st to December 31st and must be reported to IEHP by February 15th.

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

1. The QM Annual Evaluation may be included on the QM Work Plan or in a separate document. The Annual Evaluation must evaluate the 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.

I. **Continuity and Coordination of Care:** IEHP delegates care management and coordination of care activities to contracted Delegates. CM requirements are delineated in Section 12, “Coordination of Care.”

J. **Confidentiality:** Providers are required to restrict Member medical records access to those Practitioners and associated staff with a legitimate reason to view the files. Records must be maintained in a protective and confidential manner and not be readily accessible to
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unauthorized persons or visible to the general public. Providers and Practitioners must maintain procedures to ensure appropriate records processing to prevent breach of confidentiality.

1. **Medical Records Release** – Medical records contain confidential information that must not be released to any party other than the PCP without the expressed written consent of the Member or legal representative. The PCP must maintain procedures for obtaining such written consent prior to release of records copies. Refer to Policy 7B, “Information Disclosure and Confidentiality of Medical Records,” for more information.

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

3. **Education of PCP Staff Regarding Confidentiality Issues** – Providers must educate Physicians and associated staff regarding confidentiality issues. Signed confidentiality statements are required for participation in the IEHP Practitioner network and monitored as part of the facility review process. Referral or access to sensitive services requires the maintenance of high standards of confidentiality. Members requiring family planning services, treatment for sexually transmitted diseases, abortion information and/or treatment, and Human Immunodeficiency Virus (HIV) testing or are requesting assistance with highly sensitive issues, must be treated with respect and consideration for confidentiality.

4. **Conflict of Interest** – Delegates are required to perform Peer Review within their organization. Should a significant practitioner problem or quality issue arise that cannot be resolved at this level; Delegates’ QM Committees may refer the issue to the IEHP Peer Review Subcommittee for resolution. Should an issue arise involving care provided by a Physician member of the QM Committee or any Subcommittee, that Physician is replaced by a substitute until the issue is resolved. The Member involved in the issue has all rights normally given to anyone with a case presented to the Committee or Subcommittee. IEHP Committee members are required to sign a confidentiality and conflict of interest statement.

5. **Confidentiality Policy** – IEHP retains oversight for Provider confidentiality procedures through the IEHP QM Committee and Peer Review Subcommittee. As a condition of participation in the IEHP network, all contracted and subcontracted Providers retain
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signed confidentiality forms for all staff and provide education regarding policies and procedures for maintaining the confidentiality of IEHP Members.

6. **Provider Confidentiality Procedures** – Delegates must have policies and procedures for maintaining the confidentiality of Members.


K. Provider Participation:

1. **Provider Information** – Delegates are required to inform network Practitioners of guidelines, policy and procedure changes, and other important information. Delegates’ methods of Practitioner education or notification are evaluated annually during Delegation Oversight Audits performed by IEHP Health Services staff. Practitioners are informed through the IEHP Provider Newsletter, letters, memorandums, distribution of updates to the Provider Manual, and training sessions. Delegates are notified through letters, memorandums, Provider Manual updates, training sessions for specific issues, Joint Operations Meetings, and by attending IEHP University, when available.

2. **Provider Cooperation**: IEHP requires that Delegates and Hospitals cooperate with IEHP QM Program studies, audits, monitoring, and quality related activities. Requirements for cooperation are included in Hospital and Delegate Provider contract language that describes contractual agreements for access to information.

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

1. 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
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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.

d. Hospital shall cooperate with IEHP’s QM Program and, upon reasonable request, provide IEHP with summaries of or access to records maintained by Hospital and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.

M. Auditing and Monitoring Activities: IEHP performs a series of activities to monitor Delegate functions including the following:

1. Delegation Oversight Audit – IEHP performs an annual Delegation Oversight Audit of all contracted Delegates using an audit tool that is based upon current 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.
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2. **Joint Operations Meetings (JOMs)** - JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities that the Delegates are required to perform. JOMs may address specific UM, QM, QI, CM, grievance, study results, or any other pertinent quality issues. They are held with Delegates. These meetings are designed to address issues from an operational level.

3. **Member or Practitioner Grievance Review**: IEHP performs review, tracking, and trending of Member or Practitioner grievances and appeals. IEHP reviews individual grievances and their resolutions for Delegate policies or procedures, actions, or behaviors that could potentially negatively impact health care delivery or Member health status.

4. **Specified Audits**: IEHP performs specific audits of Delegates and PCPs to assess compliance with IEHP standards. These audits include facility reviews, claims audits, CM audits, and health education audits.

5. **Focused Audits**: IEHP performs focused audits of Delegates or Practitioners as indicated whenever a quality or clinical issue is identified.

6. **Review of Referral Universes**: All Delegates are required to submit monthly referral universes to IEHP listing all approvals, denials and partial approvals (modifications) of referrals or services from the previous month. In addition, Delegates are required to submit copies of all denial letters sent to Members. All denials are reviewed for appropriateness and trends or patterns of concern. Refer to Policy 25E1, “Utilization Management – Delegation and Monitoring” for more information.

7. **Review of CM Logs**: 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 25C1, “Care Management Requirements – IEHP Monitoring and Oversight” for more information.

8. **Delegated Reporting Requirements Review**: IEHP performs review of scheduled submitted reports as defined in the Delegated IPA Reporting Requirements Schedule (See attachment, “Delegated IPA Reporting Requirements Schedule – Medi-Cal” in Section 25), and delegated activities as defined in the Delegation Agreement 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
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10. Member and Physician Satisfaction Surveys: IEHP performs Member and Physician satisfaction surveys to assess their satisfaction with IEHP, their Delegate and managed care.

N. Delegates that are significantly out of compliance with QM requirements receive letters requesting a Corrective Action Plan (CAP). Persistent non-compliance, or failure to adequately address or explain discrepancies identified through oversight activities, may result in freezing of new Member enrollment, termination or non-renewal of the Agreement with IEHP.

REFERENCES:

A. Title 28, California Code of Regulations §1300.70(b)(2).
C. DHCS Technical Assistance Guide, Category 5, Quality Improvement.
D. NCQA 2019 HP Standards and Guidelines, Quality Management and Improvement.
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APPLIES TO:

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

POLICY:

A. IEHP’s Quality Management (QM) Department is responsible for the oversight, monitoring and tracking of all assessments and Corrective Action Plans (CAPs), including but not limited to: Facility Site Review (FSR) and Medical Record Review (MRR) Surveys, Focused Audits, or as determined by the Delegation Oversight Committee.

B. Provider Services is responsible for oversight of required Delegates reporting, Clinical Audits and the Annual Delegation Oversight Audits (DOAs), or as determined by the Delegation Oversight Committee.

C. IEHP monitors Primary Care Physician (PCP) compliance against pertinent IEHP, Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) requirements through FSR and Medical MRR Surveys.

D. IEHP may choose whether to delegate site review responsibilities to another Health Plan.

E. Each collaborating Health Plan determines whether to accept the IPA’s site review findings.

F. The CAP process addresses deficiencies found during the FSR and/or MRR and provides guidance for PCPs to bring their site into full compliance with regulatory standards.

G. All PCPs are responsible for developing and submitting their CAPs directly to IEHP.

H. IEHP monitors the Delegates and IEHP Health Plans Quality Management (QM), Utilization Management (UM), Care Management (CM), Compliance, and Credentialing program structure and implementation of policies through the annual Delegation Oversight Audits. These audits are performed using current NCQA, DHCS, and IEHP standards. IEHP also monitors these areas through the Delegates’ monthly, quarterly, semi-annual and annual report submissions which are presented to the Delegation Oversight Committee.

I. CAPs are also required to remediate deficiencies identified during monthly review of required reporting and file reviews, focused and/or clinical audits, and the annual Delegation Oversight Audits (DOA).

DEFINITION:

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

PROCEDURES:

Facility Site Review and Medical Record Review Survey CAP
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A. Deficiencies that are identified through the combined FSR and MRR Survey resulting in an audit score below 90% or above 90% with deficiencies in the nine (9) critical elements, pharmacy, and/or infection control sections require a CAP. MRR Surveys scoring below 90%, or above 90% with one (1) or more individual sections scoring below 80%, also require a CAP. A CAP may also be required at the discretion of the Certified Site Reviewer (CSR), Designated Plan Trainer (DPT), or Master Trainer (MT). See Policy 6A, “Facility Site Review and Medical Record Review Survey Requirements and Monitoring.”

B. The CAP is a standardized, pre-formatted document developed to assist the PCP in meeting Medi-Cal Managed Care Division (MMCD) and IEHP requirements. This CAP includes deficiencies noted during the PCP FSR and MRR Surveys, specified corrective actions, their evidence of corrections, date corrections were implemented, Physician or designee responsible for corrective actions, and the name and title of the CSR. In addition, there is a section for IEHP’s verification of corrections. The CAP contains three (3) separate sections: Facility Site Review Survey; Critical Elements Survey; and Medical Record Review Survey.

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

C. CAP Process

1. The entire CAP process must be completed within one hundred twenty (120) calendar days from the date of the audit and CAP notification, as follows:
   a. Provider has forty-five (45) days to resubmit a corrective action plan to IEHP.
   b. IEHP has forty-five (45) days to review and accept the CAP and/or complete a verification site visit.
   c. If the site continues to have deficiencies, an additional thirty (30) days may be given for the PCP to address all issues and IEHP to review and accept the CAP or perform a verification site visit.

2. CSRs perform focused audits within six (6) months on any PCP with persistent issues. If the deficiencies are not corrected at the time of the focused audit, the CAP process begins again. The site is also placed on annual review requiring a full survey which includes both the FSR and MRR.

3. The IEHP CSR evaluates the FSR and MRR findings and documents deficiencies on the review tool and CAP. IEHP provides a survey findings report and a formal written request for corrections of all (i.e. critical and/or non-critical) deficiencies to Providers.
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4. Upon completion of the review, the IEHP CSR discusses the findings and the required corrective actions with the PCP or designee as follows:
   a. The PCP must submit a CAP that includes implementation dates and evidence of corrections to IEHP within forty-five (45) calendar days from the date of the survey;
   b. The critical element deficiencies must be addressed with CAP submitted to IEHP within ten (10) business days of the survey date with evidence of correction(s) approved by IEHP. If evidence does not support the corrective action(s) taken, IEHP will verify corrections within thirty (30) calendar days;
   c. The survey findings and CAP information are shared with collaborative Health Plans, if applicable; and
   d. The CSR explains that the PCP/designee signature acknowledges receipt of the CAP and agreement to comply with designated timeframes.

5. The PCP should note corrections on the CAP as follows:
   a. Document the corrective actions taken in the “Corrective Action Taken” column;
   b. Document the date the correction was implemented. PCP may document additional steps taken in this column;
   c. Initial the appropriate column on the CAP (by person responsible for corrective actions); and
   d. Attach evidence of correction(s) (e.g. in-service sign-in sheet and agenda, invoices, forms, used, etc.).

6. FSR CAPs: CAP verification may be accomplished by PCP submission of appropriate evidence of corrections (e.g. invoices for receipt of safety needles). CAP verification may require an onsite visit within forty-five (45) calendar days from receipt of the CAP if evidence of corrections is insufficient or deficiency cannot be verified in writing.

7. MRR Survey CAPs: Follow-up action is scheduled at the discretion of IEHP and may include the following within forty-five (45) days of receipt of the CAP:
   a. Score < 80%: Onsite visit to verify processes have been implemented;
   b. Score 80-89%: Accept documented CAP and/or a CAP verification visit or follow-up record review may be requested at the discretion of IEHP; or
   c. Score 90-100%: Exempted Pass without CAP required; however, CAP and CAP Verification may be requested at the discretion of IEHP for any individual section that scores below 80% on the Medical Record Review.
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8. Critical Element CAPs: At the time of the survey, CSRs notify PCPs of critical element deficiencies, or other deficiencies determined by IEHP to require immediate corrective action, and the CAP requirements for these deficiencies. Within ten (10) business days of the survey date, PCPs must submit to IEHP a completed CAP with verification for all critical elements and/or other survey deficiencies requiring immediate correction.

9. Any site unable to complete actions required for a CAP for the original survey, or any PCP that scores less than 80% on the FSR and/or MRR is placed on a twelve (12) month monitoring at which time a full resurvey, including FSR and MRR, is performed.

10. New Members are not assigned to PCPs that score below 80%. If the corrections are appropriately made and the CAP is closed, the PCP remains in the network and new Member assignments resumes.

11. Communication to Participating Health Plans: IEHP monitors the CAP until completion. Information regarding PCPs showing no improvement and/or non-compliance to the CAP within the defined Medi-Cal Managed Care Division (MMCD) timeframes is communicated to the collaborative Health Plans.

12. IEHP notifies all Medi-Cal Managed Care Health Plan collaborative partners of PCP scores below 80% within three (3) business days from the audit.

D. Pre-contractual PCP Surveys and CAPs

1. New sites that are noted to have deficiencies in Critical Elements, regardless of the overall score, are not eligible to receive Membership until the Critical Element CAPs are submitted and accepted by IEHP.

2. New sites scoring below 80% are not accepted into the PCP network, but may request reconsideration of this decision by the IEHP Chief Medical Officer or designee.

   a. PCPs wishing to request reconsideration of the results of an FSR and/or MRR Survey must do so in writing to the IEHP Chief Medical Officer within fourteen (14) working days of the date of the notification letter.

   b. After receiving a written appeal, the IEHP Chief Medical Officer or designee responds to the appealing PCP in writing noting the status of the request within thirty (30) calendar days.

   c. If the request reconsideration is approved by IEHP, the PCP has thirty (30) days to submit a CAP addressing all deficiencies noted in the FSR and MRR Survey.

   d. If the CAP is approved by IEHP, a re-assessment is scheduled within thirty (30) days. If upon re-assessment the site and/or medical record review score is less than 80%, it is considered a “failed site” and is not approved as a participating site with IEHP.

3. Providers who do not pass the initial FSR may correct deficiencies, reapply to IEHP and be re-surveyed after twelve (12) months.
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4. Any PCP whose site review reveals significant quality of care issues is not eligible for initial participation in the IEHP network, pending the outcome of a review by the IEHP Chief Medical Officer or designee, and possible further review by the IEHP Peer Review Subcommittee.

E. PCP Non-compliance for CAP Completion

1. If a PCP submits a CAP but continues to be non-compliant with the CAP process after 120 calendar days, the PCP is frozen to auto assignment until such time as the corrections are verified and the CAP is closed.

   a. Delayed CAP submission process:

      1) If the CAP for the critical element was not completed and submitted within ten (10) business days from the date of the review, a reminder phone call is made to the PCP. Failure to submit required documentation within seventy-two (72) hours of the reminder call results in the freezing of Member assignment.

      2) CAP deficiencies other than critical elements should be received within forty-five (45) calendar days from the date of the request.

         a) If a CAP is not received within forty-five (45) calendar days of the request, a concerted effort of communication is made to the PCP. If the CAP is not received within five (5) business days, IEHP notifies the collaborative Health Plans. Each Health Plan follows internal escalation procedures.

         b) Providers who do not correct survey deficiencies within established CAP timelines are not assigned new Members until such time as corrections are verified and the CAP is closed. Any network Provider who does not come into compliance with survey criteria within one hundred and twenty (120) calendar days is administratively removed from the network.

         c) Provider sites scoring below 80% in either the FSR or MRR for two (2) consecutive reviews will receive a non-compliance notification letter and must score a minimum of 80% in the next site review in both the FSR and MRR or will be administratively terminated from the IEHP Network. IEHP shall notify affected Members thirty (30) calendar days prior to the non-compliant Provider termination from the network. Plan Members shall be appropriately reassigned to other network Providers.

         d) IEHP tracks the CAP process and may contact its collaborative partners with a mutual contract to meet with the PCP to review deficiencies and to make joint efforts to bring the PCP into compliance with MMCD requirements.
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e) PCP failure to submit a CAP within the established CAP timelines requires IEHP to notify its collaborative partners for submission to their appropriate committee for review and action.

f) Providers who do not correct survey deficiencies within established CAP timelines are not assigned new Members until such time as corrections are verified and the CAP is closed.

g) Provider sites that score below 80% in either the FSR and/or MRR for two (2) consecutive reviews must score a minimum of 80% in the next site review in both the FSR and/or MRR. Sites that continually score under 80% in both the FSR and/or MRR may be removed from the network. Providers that receive two (2) consecutive non-passing scores (under 80%) will be sent a non-compliance notification letter and are at risk for administrative termination from the IEHP Provider Network. IEHP shall notify affected Members thirty (30) calendar days prior to the non-compliant Provider termination from the Network. Plan Members are appropriately reassigned to other network Providers.

F. Providers administratively terminated from the IEHP network shall have the right to appeal the decision with the health plan. IEHP has a formal and fair process to resolve grievances and complaints submitted by Providers of medical services. If verified evidence of corrections is accepted by IEHP and the decision is reversed, IEHP shall repeat the full scope survey or accept the current survey and CAP as completed and place the PCP site on intensive review for twelve (12) months and shall re-survey the site at the end of twelve (12) months from the last survey. The Provider must receive 80% on both surveys. If the appeal decision is not reversed by IEHP, the Provider may re-apply through the application process.

G. IEHP monitors all sites for subsequent deficiencies through review of grievances, information from quality improvement activities, and through internal and external sources such as public health.

Delegated IPA Delegation Oversight Audit

A. IEHP monitors Delegate compliance with IEHP, DHCS and NCQA requirements through its annual Delegation Oversight Audits, which includes oversight for QM, UM, Credentialing, Compliance, and Care Management. See Policy 25A2, “Delegation Oversight – Audit.” These audits are performed using current NCQA, IEHP, and DHCS (when appropriate) standards.

B. IEHP uses the IEHP Delegation Oversight Audit Tool, which is based on current standards, to sufficiently document information from the examined policies and procedures, committee minutes, files and other documents to meet standards, as well as to support the conclusions reached.
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C. The Delegates receives an exit interview with IEHP auditors at the completion of the Delegation Oversight Audit. This interview identifies areas found to be deficient, allowing the Delegates an opportunity to provide additional information within two (2) business days, to clear the deficiency, and highlighting opportunities for improvements that need to be addressed through the CAP process.

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

E. Scoring categories for each section of the Delegation Oversight Audit are as follows:
   1. Full Compliance  90-100%
   2. Partial Compliance  80-89%
   3. Non-compliance  <79%

F. All Delegates that score 90% or greater pass that section of the audit. However, 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:
      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 Delegation Oversight Audit 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.
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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 Delegation Oversight Audit score received for each section;
   b. A list of the deficiencies identified by IEHP;
   c. CAPs must identify the root cause analysis for the deficiency;
   d. CAPs must specifically state how the deficiency is corrected and must include 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 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 enrollment until a CAP is received and approved.
   c. The Delegates are required to resubmit a second CAP within fifteen (15) calendar days to IEHP.

9. 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 enrollment.
   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.

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

H. After receiving a written appeal, the IEHP Provider Delegation Manager 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
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appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.

I. IEHP monitors for subsequent Delegate deficiencies through review of grievances, assessment of reports, and results of activities related to each area addressed by the Delegation Oversight Audits.

Other Oversight Activities or Focused and/or Clinical Audits

A. Other QM monitoring activities that could result in CAPs include but are not limited to:
   1. 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
   13. Follow up audits.

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

C. Within thirty (30) calendar days of the audit or study, the Delegates receive written notification of the results including any required CAPs or sanctions. The written notification includes a cover letter and a completed audit tool (when applicable) noting any deficiencies found during the audit. Identified deficiencies will include requests for standard Corrective Action Plans (CAP) and/or Immediate Corrective Action Plans (ICAP). 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.

   2. A CAP is considered complete only if all deficiencies from each section are present and submitted together. These sections are as follows:
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a. QM;
b. UM;
c. Grievance and Appeals;
d. Compliance; and
e. Care Management.

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

4. 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.

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

6. 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 Corrective Action Plan 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 and must include supporting documentation, including policies and procedures, training agenda, training materials, and sign in sheets when applicable;
e. Completion dates for each of the corrective actions;
f. Identification and signature of the person responsible for completing the corrective action; and
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. For Immediate Corrective Action Plans, 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.

8. 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 enrollment until a CAP is received and approved.

c. For standard Corrective Action Plan findings, the Delegates are required to resubmit a second CAP response within fifteen (15) calendar days to IEHP. For Immediate Corrective Action Plan findings, the Delegate is required to submit a second CAP response within (72) hours to IEHP.

9. Upon receipt of the second CAP by IEHP:

a. If the second CAP response is approved, the CAP process is closed. If applicable, the Delegates are then re-opened to new Member enrollment.

b. If the second CAP response is denied, the Delegates may be placed in a contract cure process that gives the Delegates thirty (30) calendar days to adequately correct the deficiencies.

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

E. After receiving a written appeal, the IEHP Provider Delegation Manager 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.

F. 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 enrollment;

2. Request for cure under contract compliance;

3. Requirement to subcontract out the deficient activities within Management Services Organization (MSO) or Delegates;

4. De-delegation of specified functions;

5. Contract non-renewal; or


REFERENCES:

A. Department of Health Care Services (DHCS) Policy Letter (PL) 14-004 Supersedes PL 02-002, “Site Reviews: Facility Site Review and Medical Record Review”.

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E. Utilization Management
   1. Delegation and Monitoring

APPLIES TO:

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

POLICY:

A. IEHP is responsible for the development, implementation, and distribution of standards for Utilization Management (UM) processes and activities to contracted entities delegated to perform UM activities.¹
   1. IEHP and its Delegates are responsible for meeting IEHP UM standards.
   2. IEHP and its Delegates are responsible for implementing a process to track open and unused referrals as stipulated in their contract.

B. IEHP is responsible for maintaining a monitoring system for UM Program oversight.

C. IEHP, through its delegation oversight process, is responsible for performing an evaluation of UM Program objectives and progress on an annual basis with modifications, as directed by the Delegation Oversight Committee and IEHP Governing Board.

D. IEHP delegates all or partial UM activities to Delegates that meet IEHP UM standards except for referrals for foster children in the Open Access program, vision services, and referrals for behavioral health.

E. IEHP and its Delegates must have a UM Work Plan, policies and procedures, and perform UM activities in a manner that meets IEHP, National Committee for Quality Assurance (NCQA), Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC) standards.

F. IEHP and its Delegates who make utilization-related decisions are responsible for identifying barriers to care and instances of under/over utilization of services and assisting with appropriate use of services.

G. Members are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, medical history, claims history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source payment. Please see Policy 9H3, “Cultural and Linguistic Services – Non-Discrimination” for more information.

H. Provider or Member appeals of UM decisions are handled through the IEHP Provider or Member grievance and appeals process. Please refer to Section 16, “Grievance Resolution System” for more information on Provider and Member grievances.

¹ Department of Health Care Services (DHCS)-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
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I. IEHP’s UM staff and physicians are available to respond to Provider inquiries regarding authorization requests, status and clinical decisions and processes, Monday through Friday, from the hours 8:00 AM to 5:00 PM.

PURPOSE:

A. To ensure that IEHP and all Delegates perform utilization management activities that meet IEHP, NCQA, DHCS and DMHC standards.

DEFINITION:

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

PROCEDURES:

A. UM Standards: IEHP is responsible for defining overall standards for UM activities performed by its Delegates. These standards must be performed in accordance with California Health and Safety Code Section 1367.01 and represent the minimum performance level acceptable to IEHP for its Delegates; however, Delegates can choose to exceed any specific standard.²

B. Criteria:³ Delegates must use nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when making decisions related to medical care. 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, DHCS Medi-Cal Provider Manual, and IEHP UM Subcommittee Approved Authorization Guidelines. 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.⁴⁵ The criteria or guidelines must be consistent with sound clinical principles and processes and must be evaluated at least annually and updated if necessary.

   2. Application: IEHP and its Delegates are required to apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual

² California Health and Safety Code (Health & Safe. Code) § 1367.01
³ NCQA, 2020 HP Standards and Guidelines, UM 2, Element A
⁴ DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
⁵ NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 4
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Members. When applying criteria, individual factors such as age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable, are taken into consideration. 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 the issues of whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual Member’s care plan. The organization also considers characteristics of the local delivery system available for specific Members, such as:

a. Availability of skilled nursing facilities, subacute care facilities or home care in the organization’s service area to support the Member after hospital discharge;

b. Coverage of benefits for skilled nursing facilities, subacute care facilities, home care where needed, Community Bases 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.

IEHP and its Delegates must ensure consistent application of UM criteria by following this specific order as IEHP or Delegate is licensed to use:

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

b. Department of Health Care Services (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. Criteria are presented to the UM Subcommittee for adoption and implementation. After approval by UM Subcommittee it is sent to QM Committee for reference.

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6 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 2
7 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factor 3
4. **Annual Review and Adoption of Criteria:** Members of the UM Subcommittee and Practitioners in the appropriate specialty, review clinical criteria annually and update as necessary. New criteria that become available prior to the annual evaluation are reviewed by IEHP’s Chief Medical Officer (CMO) and the Medical Directors and are presented to the IEHP UM Subcommittee for discussion, research, and refinement. Once IEHP’s UM Subcommittee has approved the criteria and updates, the information is disseminated to Providers via letter, website, or email.

5. **Process for Obtaining Criteria:** IEHP and its Delegates must disclose to network 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.

IEHP and its 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) Letter must state the address, toll free phone number and/or TTY/TDD number for obtaining the utilization criteria or benefits provision used in the decision. The following notice must accompany every disclosure of information: “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). IEHP and its Delegates must maintain a log of all requests for criteria (See Attachment, “Request for UM Criteria Log” in Section 25). UM staff must be available during normal business hours, Monday through Friday, 8:00 AM to 5:00 PM to answer any UM issues.

6. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** IEHP and its Delegates are responsible for evaluating, at least annually, the consistency with which all appropriate Practitioners included in utilization review apply appropriate criteria for decision-making. The sample assessed must be statistically valid, or IEHP or its Delegates may use one (1) of the following three (3) auditing methods:

a. Five percent (5%) or fifty (50) of its UM determination files, whichever is less;

b. NCQA’s 8/30 methodology; or

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8 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
9 NCQA, 2020 HP Standards and Guidelines, UM 2, Element A, Factors 4 and 5
10 NCQA, 2020 HP Standards and Guidelines, UM 2, Element B, Factors 1 and 2
11 NCQA, 2020 HP Standards and Guidelines, UM 2, Element C, Factors 1 and 2
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   c. Ten (10) hypothetical cases.

7. Behavioral Health Triage and Referral:¹² Medi-Cal Members will be “screened” for specialty mental health by the Behavioral Health (BH) Department. Members who meet the County Tier III Specialty Mental Health criteria will be referred to the County Behavioral/Mental Health Agency of their respective county of residence for specialty mental health services. Members who are mild/moderate will be referred to an in-network IEHP BH Provider. IEHP is responsible for mild to moderate behavioral health services. IEHP’s BH Department can assist Members that self-refer and/or those accessing behavioral health services, as needed. IEHP’s BH Department is responsible for ensuring triage and referral decisions are made according to protocols that define the level of urgency and appropriate setting of care. Triage and referral protocols utilized must be based on sound clinical evidence and currently accepted practices for behavioral health care service delivery. Please refer to Policy 12K1, “Behavioral Health Services,” for more information.

   a. The protocols address the urgency of the Member’s clinical circumstances and define the appropriate care settings and treatment resources that are to be used for behavioral health and substance use cases.

   b. Triage and referral staff members must utilize protocols and guidelines that are up-to-date and the staff must be provided appropriate education and training regarding their use.

   c. Protocols used by staff are reviewed and/or revised annually.

In accordance with the parity in mental health and substance use disorder requirements in Title 22 of the Code of Federal Regulations, Section 438.900 et. seq, IEHP does not impose Quantitative Treatment Limitations or Non-Quantitative Treatment Limitations to its timelines and processes more stringently on plan-covered mental health and substance use disorder services than are imposed on medical/surgical services.¹³

C. Delegate UM Structure:

1. IEHP and its Delegates must have the following UM structure and processes in place:¹⁴

   a. UM Program Description, policies, procedures, and UM activities that meet IEHP, DHCS, DMHC and NCQA standards. These policies and procedures must ensure that decisions based on the medical necessity of proposed health care services are consistent with sound clinical principles and processes. These policies and procedures must address the Delegate’s responsibility for continuity and coordination of care for Members with medical and/or behavioral health needs. The

¹² NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 2
¹³ Title 22 Code of Regulations, Section § 438.900
¹⁴ NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 1
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   UM Program must be evaluated, and updated if necessary, at least annually.15-16
   b. Authorization processes for specialty referral, specified diagnostic or therapeutic
      services, home health, elective surgeries, etc;
   c. Coordination of care and discharge planning with IEHP UM for inpatient Members,
      as applicable;
   d. Management of out-of-network emergency for Members;
   e. Availability of UM staff, at least eight (8) hours a day during normal business days,
      to respond to Providers regarding UM issues; and
   f. Process to track open and unused referrals.

2. IEHP and Delegate UM Medical Director17 - There must be a designated physician who
   holds an unrestricted license in the state of California, responsible for reviewing and
   monitoring the UM processes, including at a minimum, the following activities:
   a. Review and final decision-making on referrals denied or partially approved
      (modified) for medical necessity to assure consistent processes and decision-making;
   b. Review of requests for out-of-network services must be based on medical necessity;
   c. Review of physician-specific UM data to assess for potential over and
      underutilization of services;
   d. Sign-off on all internal policies and procedures related to UM; and
   e. Chairing the UM Committee or designating a Chair.

3. IEHP and Delegate UM Committee- 18 Committee membership must include a
   minimum of three (3) practicing Physicians from its network, representing the appropriate
   specialties pertinent to IEHP Membership including Obstetrics and Gynecology
   (OB/GYN), Pediatrics, Family Practice and other Specialists, as needed. The UM
   Committee must meet at least quarterly and perform, at a minimum, the following
   activities:
   a. Concurrent review of complex referrals requiring multiple physician input;
   b. Retrospective review of approved, denied and partially approved (modified) referrals
      to assess consistency of processes and decisions;
   c. Review of physician-specific UM data to assess for potential under and over
      utilization; and

15 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization
Management Program.
16 NCQA, 2020 HP Standards and Guidelines, UM 1, Element B
17 NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 3
18 Ibid.
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   d. Review of appeals or grievances related to UM decisions, as needed, with referral to QM or Peer Review Committee as appropriate.

4. IEHP and Delegate UM Program Description must include:
   a. Mission statement, goals, and objectives;
   b. Designated standards used for determination of medical necessity that meet IEHP requirements;
   c. Authorization process, in detail, including staffing and Compliance mandated turnaround timeframes;
   d. Evidence of full range of UM activities;
   e. UM Committee meeting frequency;
   f. UM Committee chairperson and membership including a rotation policy;
   g. Documentation of ability to collect and report all required UM data;
   h. Delineation of timeframes for approval or denial of referrals that meet IEHP and regulatory standards;
   i. Denial process that includes letters to Members and Practitioners;
   j. Procedures for informing Providers of referral process;
   k. Submission of plan reporting requirements; and
   l. Dissemination of summary UM data to Providers.

5. Network Practitioner Responsibilities: Network Practitioners are required to follow established UM procedures for authorization that include:
   a. Providing sufficient information for decision-making; and
   b. Following IEHP or its Delegate’s directions for initiating the UM process.

D. 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 has adopted standards for personnel making review decisions and reviewing denials. The following types of personnel can perform the functions listed:

   1. For medical decisions:
      a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with Provider office to obtain any needed non-medical information and approval of authorizations as determined appropriate.
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   authorizations). Delegates should be able to provide a list of all services approvable by the UM Technician/Coordinator.

   b. Registered Nurse (RN)/Licensed Vocational Nurse (LVN) – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information, as needed, from the Provider’s office, and approval of criteria-based referrals.

   c. A physician must supervise review processes and decisions.

   d. A designated, California-licensed physician must review all denials and partial approvals for medical necessity and obtain additional medical information from treating physician, as needed within the required timeframes. A designated Board-Certified physician in the appropriate specialty must be consulted to review all applicable denied referrals and approve complex referrals, as needed.\textsuperscript{21,22,23}

   e. Compensation arrangements for individuals who provide utilization review services must not contain incentives, direct or indirect, to make inappropriate review decisions. If incentives are used, IEHP or its Delegate must demonstrate that there is a mechanism in place to ensure that all decisions are based on sound clinical judgment.\textsuperscript{24}

   f. IEHP and its Delegates that utilize referral decision-making and hospital length of stay information for economic profiling must provide documentation to their PCPs and IEHP, if requested.

   2. Use of Board-Certified Physicians for UM Decisions:\textsuperscript{25} IEHP and its Delegates use designated physicians with current unrestricted license for UM decisions. 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.

      a. IEHP and its Delegates are required to have a written policy and procedure in place that addresses the process for the use of Board-certified Specialists for UM decisions.

      b. IEHP and its Delegates are required to either maintain lists of Specialists to be utilized for UM decisions or consult with an organization contracted to perform such review. The interaction can be completed by a telephone call to a network Specialist,

\textsuperscript{21} DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorization and Review Procedures
\textsuperscript{22} CA Health & Saf. Code § 1367.01(e)
\textsuperscript{23} NCQA, 2020 HP Standards and Guidelines, UM 4, Element A, Factor 1
\textsuperscript{24} DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
\textsuperscript{25} NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 3

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   a written request for review, or use of a contracted vendor that provides Board
   Specialist review.26

   c. The primary physician reviewer determines the type of specialty required for
   consultation.

   d. IEHP maintains a contract with one (1) or more external review companies, for
   specialty consultation.

E. Authorization, Inpatient Review, and Notification Standards: There must be written
policies and procedures regarding the process to review, 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.27
Mandated timeframes for decisions including approval, denial or partial approval
(modification) of a request and subsequent notification to the Member and Provider are
outlined below.28,29 For further details regarding pharmaceutical pre-authorization guidelines,
see Policy 11B, “Prior Authorization for Non-Formulary Medications.”

1. 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. This includes the following:

   a. IEHP and its Delegate UM staff are available at least eight (8) hours a day during
   normal business hours for inbound collect or toll-free calls regarding UM issues;30

   b. Outbound communication from staff regarding inquiries about UM during normal
   business hours;

   c. Staff identify themselves by name, title, and organization when initiating or returning
   calls regarding UM issues;31

   d. Staff can receive inbound communication regarding UM issues after normal business
   hours;

   e. Staff are accessible to callers who have questions about the UM process; and

   f. IEHP and its Delegates are responsible for assuring TDD/TTY services for the deaf,
hard-of-hearing, or speech-impaired, and language assistance are available to all

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26 NCQA, 2020 HP Standards and Guidelines, UM 4, Element F, Factor 1
27 CA Health & Saf. Code § 1363.5(a)
28 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior
   Authorizations and Review Procedures
29 Health and Safety Code § 1367.01(d)
30 NCQA, 2020 HP Standards and Guidelines, UM 3, Element A, Factor 1
31 NCQA, 2020 HP Standards and Guidelines, UM 3, Element A, Factor 3
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IEHP Members. IEHP will audit to assure that all policies and procedures state that IEHP and its Delegates have these services in place.\(^{32}\)

2. **Authorization and Notification for Referrals or Services:**\(^{33}\) Authorization and notification of decision for proposed services, referrals, or hospitalizations at the Provider level involves utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting Provider in the review determination. 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.\(^{34}\) Prior authorization for all outpatient services and elective admissions should take place at an IEHP network facility.

When an outpatient or inpatient service requested appears to be unavailable within the IEHP network 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 the 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 a possible delay of 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 then modify or deny as appropriate.

a. **Prior Authorization**\(^{35-36}\)
   1) 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 except for emergent services.

   Providers have two (2) working days from the determination that a referral is necessary, to submit the referral and all supporting documentation. 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.

   2) The timeframes for completion and adjudication of the referral are as follows:\(^{37}\)

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\(^{32}\) NCQA, 2020 HP Standards and Guidelines, UM 3, Element A, Factor 4

\(^{33}\) NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 5,6

\(^{34}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 16, Out-of-Network Providers

\(^{35}\) NCQA, 2020 HP Standards and Guidelines, UM 1, Element A, Factor 5 and 6

\(^{36}\) NCQA, 2020 HP Standards and Guidelines, UM 3, Element A, Factor 4

\(^{37}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes of Medical Authorization
For urgent concurrent decisions, IEHP and its Delegates must give electronic/written notification to the Provider and Member within seventy-two (72) hours of receipt of the request. The notification may be made orally but must be followed by a written notification within three (3) calendar days after providing oral notification. The Delegate must have a written policy/job aid that outlines the mailroom process to ensure timely Member written notification. Examples of cases that should be classified as urgent concurrent: Continued Home Health, Physical Therapy (PT), Speech Therapy (ST), and Occupational Therapy (OT) requests, only when initial preservice request for service did not expire.

- For urgent preservice decisions, IEHP and its Delegates must give electronic/written notification to the Provider and Member of the decision within seventy-two (72) hours of receipt of the request (includes holidays and weekends).

- For non-urgent preservice decisions, IEHP and its Delegates must render decisions within five (5) business days of receipt of the request. The initial notification of the decision to the Provider must occur within twenty-four (24) hours from the decision date. The written notification to the Provider and Member needs to be sent within two (2) business days of the decision.

- Initial notification of all adverse decisions to the Provider must include the decision, the decision reason and a phone number through which the reviewer who made the decision can be contacted.

- IEHP or its 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 needed.

- Delegates will identify upon intake any prior authorization request for which the Health Plan is responsible to authorize and forward the request for review to the Health Plan via fax to (909) 890-5751 within twenty-four (24) hours of receipt. 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.
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b. Prior Authorization for Emergent/Urgent or Urgent Concurrent Pre-Service Decisions:38
   1) Prior authorization is not required for emergent services. Please see Policy 14C, “Emergency Services” for more information.
   2) Prior authorization is not required for services necessary to treat and stabilize an emergency medical condition.
   3) Providers must submit urgent preservice and urgent concurrent referrals the same day of the determination that the referral is necessary.
   4) IEHP and its Delegates have forty-eight (48) hours after receipt of an urgent preservice or urgent concurrent request to determine if it is non-urgent. 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. Examples of requests that may not be downgraded from urgent preservice or urgent concurrent to non-urgent are Hematology/Oncology and Total Fracture Care.
      - IEHP or its Delegate RN/LVN reviewer or physician reviewer must communicate the change to non-urgent status by phone or fax.
      - 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.
      - Faxed communication to the Provider should state that the request did not meet the definition of urgent pre-service:
         - Delay could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function, based on a prudent layperson’s judgment; or
         - 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.
   5) IEHP or its Delegate must notify both the Practitioner 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.org39

38 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes of Medical Authorization
39 DHCS, All Plan Letter (APL) 17-006, Supersedes APL 04-006 and 05-005; and Policy Letter (PL) 09-006, “Grievance and Appeal Requirements and Revised Notice Templates and ‘Your Rights’ Attachments”
25. DELEGATION AND OVERSIGHT

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   c. Post-Service Decisions (Retrospective Review):
      1) 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.
      
      2) Relevant clinical information must be obtained and reviewed for medical necessity based on approved clinical criteria and applicable state and federal regulations. If medical necessity is not met, denial determinations must be made by the IEHP or Delegate Medical Director.
      
      3) Retrospective review decisions and written notification to the Providers must be made within thirty (30) calendar days from receipt of the request.
      
      4) Members do not need written notification of the decision in the following situations:
         - Retrospective review is only to determine payment level; or
         - The Member is not at financial risk.
         [For example, a retrospective billing adjustment of an Emergency Department visit does not require Member notification because the services have already been rendered, the Member is not financially impacted by the decision, and payment must be made for the medical screening exam (MSE).]

   d. Experimental and Investigational Determinations:
      1) The determination for all experimental and investigational services is the responsibility of IEHP. The Delegate must send to IEHP all authorization requests for experimental/investigational services as soon as possible after receipt of the request. This must be sent by facsimile to IEHP, attention Medical Director at fax number (909) 890-5751, 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 codes) 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 delineate a request is considered experimental/investigational. These requests must be reviewed utilizing the next criteria set in the hierarchy. If there is no other criteria to review, the Delegate must forward the request to IEHP as outlined above.
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   e. Denial Notices: Medical necessity denials of a requested health care service, in whole or in part, must be reviewed and approved by the IEHP or Delegate UM Medical Director, physician designee, or UM Committee. Members must receive an approved Notice of Action (NOA) letter including all “Your Rights” and required attachments for any requested referral that is denied, partially approved (modified), or terminated, as appropriate. IEHP and its Delegates are responsible for notifying Members of the reason for denial and citing the criteria or benefit coverage information used to render the decision. Any denial notices regarding experimental and investigational therapy are the responsibility of IEHP, as stated above.

   f. Denial letters must include the following (IEHP approved notification templates are available online at: www.iehp.org). The Delegate is responsible for ensuring the most recent version of the template is being utilized:

   1) Required Department of Managed Health Care (DMHC) language (in bold within sample);

   2) Required Department of Health Care Services (DHCS) language and in a manner, format, and language that can be easily understood;

   3) Be made available in English & Spanish (IEHP Threshold Languages), upon requests;

   4) 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;

   5) Any written communication to a Physician or other health care Provider of a denial, or modification of a request, include the name and telephone number of the health care professional responsible;

   6) The right to appeal the decision, file a grievance, ask for an Independent Medical Review (IMR), refer to “Your Rights”;

   7) 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) that excludes that coverage (i.e. the IEHP Member

40 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 8, Denial, Deferral or Modification of Prior Authorization Requests
41 NCQA, 2020 HP Standards and Guidelines, UM 7, Element C
25. DELEGATION AND OVERSIGHT

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Handbook) or State or Federal regulations, including the section. Non-benefit 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;
- Member-specific denial language should be at a readability level of 6th grade and should not include CPT Codes; and

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

g. 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. Such communication must offer the requesting Provider the opportunity to discuss any issues or concerns regarding the decision within seventy-two (72) hours of the initial notification of the denial or partial approval (modification). This written notification of denial or partial approval (modification) must include language informing the Provider that they can appeal the decision to the Delegate Medical Director, IEHP Chief Medical Officer or the IEHP Medical Director. If the Provider chooses to appeal the denial or partial approval (modification) to the Delegate and the Delegate upholds the original decision, the subsequent letter must inform the Provider of their right to submit a formal appeal to the IEHP Grievance and Appeals Department. If the Delegate upholds the denial or partial approval (modification) of an urgent referral, the Delegate must send all information to IEHP’s Medical Director for review, no later than one (1) business day following the decision to uphold the denial or partial approval (modification).42

h. On a monthly basis for monitoring purposes as outlined in Policy 25E2, “Utilization Management Reporting Requirements” the Delegate must send IEHP all documentation for each denial including the following:

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;

42 NCQA, 2020 HP Standards and Guidelines, UM 7, Element A
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   - Decision Date and Time;
   - RN/LVN or physician reviewer note from medical management system; and
   - Proof of date and time letter was mailed to the Member

7) Criteria used for the determination
8) Initial notification including opportunity to discuss; and
9) Audit trail to include all changes and dates made to the case.

i. IEHP and its Delegates shall retain information on decisions, e.g., authorizations, denials, appeals, grievances, or partial approvals (modifications) for a minimum period of ten (10) years.

j. Exceptions: Prior authorization is not required for the following services:
   1) Family Planning;
   2) Abortion Services;
   3) Sexually transmitted infection (STI) treatment;
   4) Sensitive and Confidential Services;
   5) HIV testing and counseling at the Local Health Department;
   6) Immunizations at the Local Health Department;
   7) Routine OB/GYN services, including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IEHP network;
   8) Out of area renal dialysis;

43 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
44 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Specialty Arrangements
45 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
46 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Specialty Arrangements
47 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
48 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Specialty Arrangements
49 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
50 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Specialty Arrangements
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9) Urgent Care; and
10) Preventive services.

3. Emergency Services: Prior authorization is not required for the medical screening exam (COBRA exam) performed at an Emergency Department or for services necessary to treat and stabilize a life-threatening emergency.\(^{51}\) All emergency care costs are covered.\(^{52}\) Please see Policy 14C, “Emergency Services” for more information.

4. Standing Referrals: IEHP and its Delegates are required to have 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 for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist.\(^{53-54}\) IEHP and its Delegates must have a system in place to track open, unused, and standing referrals. Please see Policy 14A3, “Standing Referral and Extended Access to Specialty Care” for more information.

5. Behavioral Health: Behavioral Health benefits are a shared risk between IEHP and the respective County Behavioral Health Services program. Please refer to Policy 12K1, “Behavioral Health Services” for more information.

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

7. Pharmacy Services: IEHP does not delegate the responsibility for utilization management associated with pharmacy services. Please refer to Section 11, “Pharmacy,” for further details.

F. IEHP and Delegated UM Requirements – Delegates must meet the following requirements for utilization management processes:

1. Services Requiring Prior Authorization: IEHP and its Delegates must maintain a list of services that require prior authorization or have a list of services that do not require prior authorization.

2. Medical Necessity Determination: IEHP and its Delegates must determine medical necessity for a specific requested service as follows:
   a. Utilize a definition for medical necessity which includes all health care services necessary for the diagnosis and/or treatment of a medical condition causing

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\(^{51}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
\(^{52}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization.
\(^{53}\) CA Health & Saf. Code § 1374.16(a)
\(^{54}\) DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 6, Standing Referrals
25. DELEGATION AND OVERSIGHT

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   significant pain, negative impact on the health status of the Member, potential
disability or is potentially life threatening;

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;

c. Employ IEHP approved UM standards including Milliman Care Guidelines,
InterQual, Apollo Managed Care Guidelines/Medical Review Criteria, and IEHP
UM Subcommittee Approved Authorized Guidelines;

d. 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

e. 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.

3. Denials because the requested service or procedure is not a covered benefit: IEHP
Evidence of Coverage (EOC) Member Handbook and Medi-Cal Provider Manual must
be utilized to determine if a requested service or procedure is a covered benefit.

4. Denial due to lack of documentation: IEHP and its Delegates must include in the denial
letter to the Member and Provider the specific clinical criteria necessary to meet the
requirements (e.g. diagnosis, labs, premiums, treatments, etc.).

5. Referral Requests: The PCP provides general medical care for Members. Referral to
Specialists, or authorization for procedures, services, or hospital admissions, should be
initiated through the Member’s Delegated IPA. Specialists caring for Members can
request referrals directly from the Delegated IPA.

G. Documentation of Medical Information and Review Decisions: IEHP and its Delegates
must base review decisions on documented evidence of medical necessity provided by the
attending physician. Regardless of criteria, the Member’s condition must always be
considered in the review decision.

   1. Physician Documentation: Attending Physicians must maintain adequate medical
record information to assist the decision-making process. The requesting Provider must
document the medical necessity for requested services, procedures, or referrals and
submit all supporting documentation with the request.

   2. Reviewer Documentation: IEHP and 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.
25. DELEGATION AND OVERSIGHT

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   1. Delegation and Monitoring

Decisions must be based on clinical information and sound medical judgment with consideration of local standards of care.

3. Documentation: IEHP and its 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. IEHP and 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. IEHP and Delegate documentation must also include a written assessment of medical necessity, appropriateness of level of care, and decision. Any denial of a proposed service or referral must be signed by IEHP or Delegate’s UM Committee, Medical Director, or physician designee. Written notifications to a Provider of a denial must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial.\textsuperscript{55}

4. Affirmative Statement Regarding Incentives: UM decisions for Members must be based only on appropriateness of care and existence of coverage. IEHP and its Delegates do not provide compensation for Practitioners or other individuals conducting utilization review for issuing denials of coverage or service. IEHP and its Delegates ensure that contracts with physicians do not encourage or contain financial incentives for denial of coverage or service that result in underutilization. The Affirmative Statement about incentives is distributed annually to all Practitioners, Providers, employees, and Members.

5. Prohibition of Penalties for Requesting or Authorizing Appropriate Medical Care: Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care.

6. Inpatient Stay: The utilization management process must include:
   a. Determining medical necessity;
   b. Determining appropriate level of care;
   c. Coordinating with hospital Case Manager’s discharge plan.

7. Discharge Planning:\textsuperscript{56} The UM process must include coordination of care with IEHP and facilities the following activities related to discharge planning:
   a. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc.); and

\textsuperscript{55} NCQA, 2020 HP Standards and Guidelines, UM 4, Element C
\textsuperscript{56} DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 2, Discharge Planning and Care Coordination
25. DELEGATION AND OVERSIGHT

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   b. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office.

8. Out-of-Network Management: IEHP and its Delegates must assist with the transfer of Members, as medically appropriate, back into the IEHP network during an inpatient stay, as applicable.

9. Review of UM Data: IEHP and its Delegates must collect, report, and analyze UM data related to Members for potential over or under utilization.
   a. UM data reported includes, at a minimum, the following:
      1) Enrollment;
      2) Re-admits within thirty (30) days of discharge;
      3) Total number of prior authorization requests;
      4) Total number of denials;
      5) Denial percentage; and
      6) Emergency encounters.
   b. Presentation of above data in summary form to IEHP or Delegate’s UM Committee for review and analysis at least quarterly upon receipt of necessary information;
   c. Presentation of selected data from above to the Delegates, PCPs, Specialists, and/or Hospitals as a group, e.g., Joint Operations Meetings (JOMs), or individually, as appropriate; and
   d. Evidence of review of data above by the Delegate’s UM Committee for trends by physicians for both over-utilization and under-utilization.

H. Appeals and Grievance Non-Urgent Process: 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. IEHP acknowledges and resolves UM-related grievances and appeals in accordance with state and federal regulatory guidelines. The Member may file an appeal or grievance by phone, by mail, fax, website, or in person. IEHP resolves Member appeals and grievances within industry standard timeframes. Please refer to Section 16, “Grievance and Appeal Resolution System.”

I. Second Opinions: 57,58 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

57 CA Health & Saf. Code Code § 1383.1(a)
58 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
25. DELEGATION AND OVERSIGHT

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   a second opinion outside of the network, if services are not available within the network.59 . Refer to Policy 14B, “Second Opinions,” for more information.

J. New Technology: The IEHP UM Subcommittee is responsible for reviewing new medical technologies and new applications of existing technologies for potential addition as a medical benefit for Members. IEHP’s Chief Medical Officer or physician designee will identify and research new technology and new applications of existing technologies, including medical procedures, treatment, and devices. Research and investigation includes review of scientific information, such as ECRI’s Health Technology Information Services, and review of regulatory body publications from such agencies as the Food and Drug Administration (FDA). Information is then presented to the UM Subcommittee regarding the technology/product, its scope and limitations. The UM Subcommittee obtains an opinion from an appropriate Specialist physician whenever necessary to assist in the decision regarding coverage of a new technology as a covered benefit for Members. Once approved by the UM Subcommittee, IEHP Chief Medical Officer or physician designee presents the new benefit/service, including scope and limitations, to the IEHP QM Committee for reference.

K. Satisfaction with the UM Process: At least annually, IEHP performs Member and Physician Satisfaction Surveys as a method for determining barriers to care and/or satisfaction with IEHP processes including UM.

L. Delegated UM Responsibilities: IEHP delegates all aspects of UM activities related to medical services for assigned Members to Delegates. All medical services are arranged for or provided by professional personnel and at physical facilities according to professionally recognized standards of medical practice and healthcare management. Delegate medical services must be rendered by qualified medical Practitioners, unhindered by fiscal and administrative management. All Delegates must further agree to provide or arrange for referrals to Specialists and facilities as are necessary, appropriate, and in accordance with generally accepted managed care industry standards of medical practice, in compliance with the standards developed by IEHP and NCQA.

M. Non-delegated UM Responsibilities: IEHP retains responsibility for select UM activities for non-covered benefits, authorizations for vision services, pharmacy services, foster children in the Open Access program, and behavioral health authorizations. A medical management system is maintained to accommodate authorizations by IEHP for services that are not covered under the Medi-Cal Managed Care contract but are authorized by the IEHP Chief Medical Officer or Medical Director. Examples include special lenses, abortions under special circumstances, or special referrals/ treatment out-of-network.

59 NCQA 2020 HP Standards and Guidelines, MED 1, Element C
25. DELEGATION AND OVERSIGHT

E. Utilization Management

1. Delegation and Monitoring

N. Monitoring Activities and Oversight: 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. Delegate and Hospital Contracts – The IEHP Agreements contain language that designates compliance requirements for participation in an ongoing utilization management program to promote efficient use of resources.

2. Delegation Oversight Audits (DOA) – IEHP performs a Delegation Oversight Audit of the Health Plan and its Delegates. IEHP reviews the Health Plan’s and Delegates’ UM policies, procedures, and activities. 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.

3. 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).

4. Review of Approvals and Denials – IEHP and its Delegates are required to submit a monthly Referral Universe (See Attachment, “Referral Universe” in Section 25). From the IPA Authorization Tracking Log, IEHP will select thirty (30) pre-service/retrospective denial files including partial approvals (modifications) and ten (10) approved pre-service/retrospective requests for review. Delegates are required to submit copies of all denial letters sent to Members and to Providers. If the Provider appeals a denial to the Delegate, and the Delegate upholds the decision, the notification letter sent to the Provider, regarding the upheld decision, must be submitted to IEHP with the monthly submission of denials. All denials are reviewed for appropriateness and adherence to timeliness requirements by IEHP through the delegation oversight process.

5. 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.

6. Member or Provider Grievance Review: IEHP performs review, tracking, and trending of Member or Provider grievances and appeals related to UM. IEHP reviews Delegate grievances and recommended resolutions for policies, procedures, actions, or behaviors that could potentially negatively impact Member health care.

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60 DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities.
61 NCQA, 2020 HP Standards and Guidelines, UM 13, Element A, Factor 4
25. DELEGATION AND OVERSIGHT

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7. **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.\(^{62}\)

O. **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.

P. **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.

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**INLAND EMPIRE HEALTH PLAN**

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<th>Chief Approval:</th>
<th>Signature on file</th>
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\(^{62}\) NCQA, 2020 HP Standards and Guidelines, UM 13, Element D
25. DELEGATION AND OVERSIGHT

E. Utilization Management

2. Reporting Requirements

APPLIES TO:

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

POLICY:

A. All Delegates must report utilization management (UM) information to IEHP as described below on a monthly, semi-annual, and annual basis.

B. Delegate reports must be received by IEHP electronically using a Secure File Transfer Protocol (SFTP) server.

C. Reports are due on or before the due dates regardless if the due date is a weekend or a holiday.

D. Persistent failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), freezing of new Member enrollment, termination or non-renewal of the IEHP Agreement.

DEFINITION:

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

PROCEDURES:

A. Monthly Reporting Requirements:

1. Reporting requirements include a monthly assessment of utilization data and denial activity. Monthly reports are due to IEHP by the 15th of the month following the month in which services were approved, denied or partially approved, 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 standard denial rate will be 5% overall, which may include non-benefit, out-of-network, etc., and 3% for medical necessity denials.
25. DELEGATION AND OVERSIGHT

E. Utilization Management

2. Reporting Requirements

1) Reasons for Denials and Partial Approvals:
   - **Not Medically Necessary** – Does not meet approved nationally recognized criteria or IEHP UM Subcommittee Approved Authorization Guidelines. Please see Policy 25E1, “Utilization Management Delegation and Monitoring” for a list of these criteria.
   - **Out-of-Network** – Requested provider is a non-contracted Provider. Out-of-Network requests must be reviewed by a physician and must be considered as a medical necessity decision.
   - **CCS** – Services requested are carved-out to California Children’s Services. Member must have an open, active case 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. UM Semi-Annual Reports must be submitted to IEHP by February 15th and August 15th. The reports should include, at a minimum the Delegated IPA’s 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 planned activities for the year, timelines, responsible person(s) and committee(s).
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2. Reporting Requirements

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 by the last day of February of each calendar year:

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.

E. Any discrepancies in reported information are addressed with the Delegated IPA in accordance with monitoring activities outlined in Policy 25E1, “Utilization Management Delegation and Monitoring.”

REFERENCES:

A. Health and Safety Code §1367.01(a) & (b).
B. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, “Subcontractual Relationships and Delegation”.
C. NCQA, 2019 HP Standards and Guidelines, Utilization Management (UM) 12.
25. DELEGATION AND OVERSIGHT

E. Utilization Management
   3. Referral and Denial Audits

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

POLICY:
A. Per IEHP Policy 25E1, “Utilization Management Delegation and Monitoring,” utilization management activities are delegated to contracted entities that meet IEHP UM standards.
B. IEHP performs monthly retrospective audit of approved, denied and partially approved (modified) referrals submitted monthly by the Delegate.
C. IEHP performs a Delegation Oversight Audit (DOA) of all Delegates to review the utilization management process for approving, denying or partially approving (modifying) referrals as outlined under Policy 25E1, “Utilization Management Delegation and Monitoring.” Focused approved referral and denial audits are also performed when issues are identified.
D. Persistent non-compliance may result in the termination of the Delegate’s contract.

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, “Delegated IPA Denial Log Review Tool” in Section 25).
B. IEHP uses the Referral Universe for the monthly retrospective denial audits to evaluate referral timeliness and document the examined referral results (See Attachment, “Referral Universe” in Section 25).
C. In order to pass the monthly audit, the Delegates must achieve a:
   1. Score of 90% or greater on:
      a. Overall Denial Review;
      b. Critical Element #1: Timeliness of Member Notification;
      c. Critical Element #2: Member Language;
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   d. Critical Element #3: Decision Timeliness
   e. Critical Element #4: Timeliness of Provider Notification
   f. Critical Element #5: Appropriate Clinical Decision
   g. Critical Element #6: Provider Outreach
   h. Critical Element #7: Appropriate use of Criteria; and
   i. Critical Element #8: Correct Template.

2. Score of 5% or lesser on:
   a. Denial and Partial Approval (Modification) Rate
      1) Appropriateness and volume of denials and partial approvals
         (modifications) would be taken into consideration.

D. If the Delegate fails to achieve a Substantial 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.

E. Persistent non-compliance may result in the termination of the Delegate’s contract.

F. Delegates who disagree with the audit score can appeal in writing to the IEHP Deputy Chief Medical Officer (CMO) 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 that month.

B. IEHP may request for more approved referral files in addition to the ten (10) referral files submitted monthly by the Delegate.
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3. Referral and Denial Audits

C. IEHP uses the Referral Universe for the monthly retrospective approval audits to evaluate referral timeliness and document the examined referral results (See Attachment, “Referral Universe” in Section 25).

D. In order to pass the monthly audit, the Delegates must achieve a score of 90% or greater on the Overall Approval File Review (See Attachment, “Approved Referral Audit Tool” in Section 25).

E. If the Delegate fails to achieve a Substantial Compliance score of 90% for two (2) consecutive months, a Corrective Action Plan (CAP) will be issued. At its discretion, IEHP may also enforce one (1) or more of the following:
   1. Concurrent approval review for a percentage of total approvals may be initiated at which time the Delegate may receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
   2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
   3. A focused meeting with the Delegate’s administration and IEHP’s leadership; and
   4. Other action as recommended by the Delegation Oversight Committee.

F. Persistent 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 Deputy CMO within thirty (30) calendar days after the release of the final audit results.

Delegation Oversight Audit (DOA)

A. IEHP performs an onsite Delegation Oversight Audit DOA of all Delegates to review the UM process. Please refer to Delegation Oversight Audit Preparation Instructions (See Attachment, “Delegation Oversight Audit Preparation Instructions – Medi-Cal” in Section 25).

B. IEHP staff notifies the Delegate in writing at least thirty (30) days in advance of the scheduled annual audit. IEHP reserves the right to give as little as twenty-four (24) hours verbal notice for focused audits that occur between DOAs.

C. Audit staff from IEHP includes, at a minimum, the Delegation Oversight Nurse. In addition, the Provider Delegation Manager, UM Operations Manager, Senior Director of Medical Management, or other IEHP staff may participate.

D. 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.
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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.

E. IEHP audit staff conducts a verbal exit conference with Delegate staff at the end of an audit.

F. Within thirty (30) days of the audit, a final score and cover letter are sent to the Delegate.

G. Delegates pass the UM Referral and Denial audit sections of the DOA if the Delegate achieves a score of 90% on the file review.

H. 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 Deputy CMO within thirty (30) calendar days after the release of the final audit results.

I. Delegates that score 90% may still be required to submit a CAP to address any deficiencies.

J. Audit results are included in the overall annual assessment of Delegates.

Focused Audits

A. Focused audits are conducted under the following circumstances:
   1. Follow-up audit for deficiencies noted on the DOA;
   2. Review of approvals and denials demonstrate that decisions being made are inconsistent, do not appear to be medically appropriate, or are not based on professionally recognized standards of care.
   3. Deficiencies identified through the monthly file review process;
   4. Number of Corrective Action Responses (CARs) issued to Delegate as a result of IEHP routine monitoring;
   5. Deficiencies identified through prior audits;
   6. Delegate self-reported compliance issues;
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7. Potential risk areas identified by IEHP (i.e., Member and Provider grievances, appeals);

8. Number of months IEHP has placed Delegate on concurrent review for specific delegated UM functions;

9. Significant increase in volume of IEHP assigned Members in the applicable LOB;

10. 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

11. Any other circumstance that in the judgment of the IEHP Chief Medical Officer 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 standards to determine any areas of non-compliance and/or systemic problems within the Delegate’s utilization management process.

E. IEHP will also select five (5) cancelled referrals from the submitted universe to review for appropriateness. The cancelled referrals will not be provided to the Delegate prior to the audit webinar.

F. If IEHP identifies a potential issue during the case file review, additional detail will be required to determine:

1. If the issue is systemic;
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2. The root cause of the issue; and

3. How many Members were impacted.

If the issue resulted in negatively impacting the Member, 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 an identified systemic deficiency 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 an identified systemic deficiency 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;
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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.
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REFERENCES:

A. Health and Safety Code §1367.01(a) & (b).
C. NCQA, 2019 HP Standards and Guidelines, Utilization Management (UM) 12.
## 25. DELEGATION AND OVERSIGHT

### Attachments

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>POLICY CROSS REFERENCE</th>
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<tbody>
<tr>
<td>Approved Referral Audit Tool</td>
<td>25E1</td>
</tr>
<tr>
<td>Credentialing DOA Audit Tool</td>
<td>5A8, 25B8</td>
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<tr>
<td>Credentialing and Recredentialing Report</td>
<td>25B10</td>
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<tr>
<td>IEHP Care Management Referral Form – Medi-Cal</td>
<td>25C2</td>
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<tr>
<td>IPA Biographical Information Sheet</td>
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<td>Delegated IPA Care Management Review Tool</td>
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<td>Delegated IPA Delegation Agreement – Medi-Cal</td>
<td>25A1</td>
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<tr>
<td>Delegated IPA Reporting Requirements Schedule – Medi-Cal</td>
<td>25C1, 25C3, 25D2</td>
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<tr>
<td>Delegated IPA Denial Log Review Tool</td>
<td>25E3</td>
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<tr>
<td>Delegated IPA Performance Evaluation Tool</td>
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<tr>
<td>Delegation Oversight Audit Preparation Instructions – Medi-Cal</td>
<td>5A8, 25A2, 25E3</td>
</tr>
<tr>
<td>Delegation Oversight Audit Preparation Instructions – Medi-Cal (NCQA Certified)</td>
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<td>Monthly Care Management Log</td>
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<td>Monthly CCS Report Log</td>
<td>25C1, 25C3</td>
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<tr>
<td>QI UM CM DOA Audit Tool</td>
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<td>Request for UM Criteria Log</td>
<td>25E1</td>
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<tr>
<td>Response to Request for UM Criteria</td>
<td>25E1</td>
</tr>
<tr>
<td>Second Opinion Tracking Log</td>
<td>14E, 25E2</td>
</tr>
<tr>
<td>Subcontracted Facility Services and Delegated Functions</td>
<td>25A2</td>
</tr>
</tbody>
</table>
IPA Approval Review Tool

All LOB’s

IPA:

Service Month:

Review Date:

Reviewer:

Instructions: IEHP randomly 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.

<table>
<thead>
<tr>
<th>(a) Approval Tracking #</th>
<th>(b) File Type requested</th>
<th>(c) Auto Authorization</th>
<th>(d) Referral Request Date</th>
<th>(e) Referral Received Date</th>
<th>(f) Decision Date</th>
<th>(g) Written Physician Notification Date</th>
<th>(h) Decision Time</th>
<th>(i) Member Written Notification</th>
<th>(j) Physician Written Notification</th>
<th>(k) Member Language</th>
<th>(l) Practitioner Language</th>
<th>(m) Clinical Information</th>
<th>(n) Referral Form</th>
<th>(o) Correct Template</th>
<th>(p) Points Received</th>
<th>(q) Points Possible</th>
<th>(r) Individual Score</th>
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Selected Individual Scores:

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<thead>
<tr>
<th>Data Dictionary</th>
<th>Policy and/or Regulation</th>
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</thead>
<tbody>
<tr>
<td>a Approval Tracking #</td>
<td>Provided from the delegate file submission</td>
</tr>
<tr>
<td>b File Type Requested</td>
<td>CMS UM Timeliness, IEHP Provider Policy and Procedure Medi-Cal 01/20 MC_25E1 Procedures - Authorization and Notification for Referrals or Services</td>
</tr>
<tr>
<td>c Auto Authorization</td>
<td>Approvals that are instantly approved.</td>
</tr>
<tr>
<td>d Referral Request</td>
<td>CMS UM Timeliness, IEHP Provider Policy and Procedure Medi-Cal 01/20 MC_25E1 Procedures - Authorization and Notification for Referrals or Services</td>
</tr>
<tr>
<td>e Referral Received</td>
<td>Date the referral was received by the Delegate for a decision.</td>
</tr>
<tr>
<td>f Decision</td>
<td>Date the Delegate decision was made by the Delegate to Approve, Modify or Deny the case.</td>
</tr>
<tr>
<td>g Written Physician</td>
<td>Date of the physician written notification.</td>
</tr>
<tr>
<td>h Decision Time</td>
<td>Delegates decision to approve, modify, deny a referral request in a timely manner according to regulations.</td>
</tr>
<tr>
<td>i Member Written</td>
<td>Written Notification to the Member of the requested referral decision by the Delegate.</td>
</tr>
<tr>
<td>j Physician Written</td>
<td>Written Notification to the physician of the requested referral decision by the Delegate.</td>
</tr>
<tr>
<td>k Member Language</td>
<td>The approval letter Reason is clear &amp; concise.</td>
</tr>
<tr>
<td>l Practitioner Language</td>
<td>The approval letter reason is clear &amp; concise.</td>
</tr>
<tr>
<td>m Clinical Information</td>
<td>Clinical information supporting the request. Not applicable if auto auth</td>
</tr>
<tr>
<td>n Referral Form</td>
<td>Form submitted by Provider that includes requested services, CPT and ICD codes</td>
</tr>
<tr>
<td>o Correct Template</td>
<td>Use of IEHP provided CMS Template</td>
</tr>
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<td>p Points Received</td>
<td>Total points earned from letters (g)-(r) above.</td>
</tr>
<tr>
<td>q Points Possible</td>
<td>Total points possible from letters (g)-(r) above, excluding non applicable elements.</td>
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<tr>
<td>r Individual Score</td>
<td>Total points earned from letters (g)-(r) above divided by total points possible from letters (g)-(r) above, excluding non applicable elements for each file.</td>
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</table>

Total Score: 0 80 %
| IPA NAME | INITIAL DATE | CRED DATE | LICENSE TYPE | LAST NAME | FIRST NAME | M.I. | DEGREE | SPECIALTY(1) | SPECIALTY(2) | BOARD CERTIFICATION (1) | EXPRES | BOARD CERTIFICATION (2) | EXPRES | BOARD CERTIFICATION (3) | EXPRES | BOARD CERTIFICATION (4) | EXPRES | BOARD CERTIFICATION (5) | EXPRES |
Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

The IPA documents have a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. The IPA has a rigorous process to select and evaluate practitioners.

### Element A: Practitioner Credentialing Guidelines

<table>
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<th>The organization specifies:</th>
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<tbody>
<tr>
<td>1. The types of practitioners to credential and recredential</td>
<td>*</td>
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<tr>
<td>2. The verification sources used</td>
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</table>

The policy must describe the sources used to verify credentialing information of each of the following criterion: (If one verification source is missing, than this factor is non-compliant)

- State License to Practice
- DEA Registration
- Education and Training
- Board Certification
- Work History
- Malpractice Claims History
- Current Malpractice Insurance Coverage
- Hospital Admitting Privileges
- State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice
- Medicare/Medicaid Sanctions

**Total Factors**: 0

<table>
<thead>
<tr>
<th>The criteria for credentialing and recredentialing</th>
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<tbody>
<tr>
<td>The policies must define the criteria required to reach a credentialing decision and must be designed to assess the providers ability to deliver care (examples below)</td>
<td>*</td>
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</tbody>
</table>

- A current and valid, unencumbered license to practice medicine in his/her state of practice
- Appropriate malpractice claims history
- Must not have engaged in any unprofessional conduct or unacceptable business practice
- Absence of sanctions or restrictions on licensure
- Current and valid DEA to practice in CA
- Absence of use of illegal drugs
- Absence of criminal history
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Credentialing and Recredentialing

Delegate:  
Reviewed By:  
Review Date:  

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<tr>
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<tbody>
<tr>
<td>4</td>
<td></td>
<td>The process for making credentialing and recredentialing decisions</td>
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<tr>
<td>Policies must define the process used and the criteria required to reach credentialing decisions that are designed to assess the practitioners ability to deliver care</td>
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<tr>
<td>At a minimum, the Credentialing Committee must receive and review the credentials of practitioners who do not meet the IPA’s established criteria</td>
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<td>Policy must identify what is considered acceptable to be determined as a clean file, if the IPA utilized a clean file process</td>
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<tr>
<td>The process for managing credentialing files that meet the IPA’s established criteria</td>
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<tr>
<td>The IPA’s policies and procedures must describe the process used to determine and approve clean files. They must identify the Medical Director or equally qualified practitioner as the individual with the authority to determine that a file is “clean” and to sign off on it as a complete, clean and approved. If the IPA identifies an equally qualified practitioner to review the clean files, the practitioner must be responsible for the oversight of the credentialing process</td>
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<tr>
<td>If the Medical Director or equally qualified practitioner signs off on clean files, the sign-off date is the Committee date</td>
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<tr>
<td>If the IPA decides not to use the Medical Director or equally qualified practitioner, the IPA can continue to send “clean” files to the Credentials Committee</td>
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Total Factors 0
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Credentialing and Recredentialing

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<tbody>
<tr>
<td>6</td>
<td>The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner.</td>
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<tr>
<td>Policies <strong>must</strong> 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 <strong>and</strong> describes the steps for monitoring and preventing discriminatory practices during the credentialing/recredentialing processes.</td>
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<tr>
<td>The IPA's procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to; periodic audits of practitioner complaints to determine if there are complaints alleging discrimination; maintaining a heterogeneous Credentialing Committee membership and requiring those responsible for credentialing decisions to sign an affirmative statement to make decisions in a non-discriminatory manner.</td>
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<tr>
<td>Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes</td>
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<tr>
<td>Examples for <strong>monitoring</strong> for discriminatory practices:</td>
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<td>Having a process for performing periodic audits of credentialing files (in process, denied and approved files)</td>
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<tr>
<td>Having a process for performing periodic audits of practitioner complaints about possible discrimination. (Can be reviewed and discussed during quarterly or semi-annual review of complaints)</td>
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<td>Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes</td>
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<tr>
<td>Examples for <strong>preventing</strong> discriminatory practices:</td>
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<td>Maintaining a heterogeneous credentialing committee and requiring those responsible for credentialing decisions to sign a statement affirming that they do not discriminate</td>
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<tr>
<td>The above information is intended to provide examples of how to ensure the nondiscriminatory process. The auditor will be looking for a description in the credentialing policies and procedures of how the IPA ensures.</td>
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<td>Policy must indicate that monitoring must be conducted at least annually.</td>
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<td>Timeframe for prevention: None. Only review policy, committee members can attest annually or at each meeting</td>
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<tr>
<td>Monitoring</td>
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<td>Prevention</td>
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<tr>
<td>Total Factors</td>
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</table>

7 The process for notifying a practitioner about any information obtained during the organization's credentialing process that varies substantially from the information provided to the IPA's practitioner. | * | | | | |
# Delegation Oversight Annual Audit Tool 2020 Documentation

## Credentialing and Recredentialing

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<tr>
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<th>COMMENTS</th>
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<tbody>
<tr>
<td>Policies must describe the process for notifying practitioners. A statement that practitioners are notified of discrepancies does not meet the requirement</td>
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<tr>
<td>The process to ensure that practitioners are notified of the credentialing or recredentialing decision within 60 calendar days of the committee’s decision</td>
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<tr>
<td>The IPA is not required to notify practitioners regarding recredentialing approvals, but must have a process for notifying practitioners of initial credentialing decisions (approvals/denials) and recredentialing denials</td>
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<tr>
<td>The medical director or other designated physician’s direct responsibility and participation in the credentialing program</td>
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<tr>
<td>The process used to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law</td>
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<tr>
<td>The IPA’s credentialing policies and procedures must clearly state that the information obtained in the credentialing process is confidential</td>
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<td>The organization must also describe the mechanisms in effect to ensure confidentiality of information collected</td>
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<tr>
<td>The organization meets 8-10 factors</td>
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<td>The organization meets 5-7 factors</td>
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<tr>
<td>The organization meets 3-4 factors</td>
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<tr>
<td>The organization meets 0-2 factors</td>
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The organization meets 0-2 factors.
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Credentialing and Recredentialing

Delegate: ____________________________
Reviewed By: ____________________________ Review Date: ____________________________

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<tbody>
<tr>
<td>CR 1: Credentialing Policies (continued)</td>
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</table>

The IPA’s policies and procedures include the following practitioner rights:
This standard does not require the IPA to allow a practitioner to review references or recommendations, or other information that is peer-review protected.
The types of information about which an IPA would alert practitioners, if there are substantial variations from the practitioner’s information, include:
- Actions on a license
- Malpractice claims history
- Board-certification decisions

Element B: Practitioner Rights

The organization notifies practitioners about their right to:

<table>
<thead>
<tr>
<th>The time frame for changes</th>
<th>Score</th>
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<tbody>
<tr>
<td>Policy must clearly state:</td>
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<tr>
<td>The format for submitting corrections</td>
<td></td>
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<tr>
<td>Where corrections must be submitted</td>
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<tr>
<td>How practitioners are notified of their right to correct erroneous information</td>
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</table>

Total factors 0

<table>
<thead>
<tr>
<th>1 Receive the status of their credentialing or recredentialing application, upon request</th>
<th>Score</th>
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Total 0

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<td>The organization meets all 3 factors</td>
<td>The organization meets 2 factors</td>
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<tr>
<td>No scoring option</td>
<td>The organization meets 1 factor</td>
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<tr>
<td>The organization meets no factors</td>
<td>The organization meets no factors</td>
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</table>

The organization meets all 3 factors

The organization meets 2 factors

No scoring option

The organization meets 1 factor

The organization meets no factors
### Delegation Oversight Annual Audit Tool 2020 Documentation
#### Credentialing and Recredentialing

**Delegate:**

**Reviewed By:**

**Review Date:**

### CREDENTIALING AND REcredentialing documentation Tool

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<tr>
<td><strong>CR 1: Credentialing Policies (continued)</strong></td>
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<tr>
<td>The IPA makes timely recredentialing decisions and incorporates information from quality improvement activities and members complaints in its recredentialing decision-making process</td>
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<tr>
<td><strong>Element C: Performance Monitoring for Recredentialing - CMS/DHCS</strong></td>
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<tr>
<td>The IPA uses practitioner performance information when it makes recredentialing decisions</td>
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<tr>
<td>1 The IPA recredentialing policies and procedures requires information from quality improvement activities and member complaints in the credentialing decision-making process.</td>
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<tr>
<td><strong>CR 1: Credentialing Policies (continued)</strong></td>
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<tr>
<td>The IPA does not employ or contract with physicians who have opted out of participation in the Medicare Program.</td>
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<tr>
<td><strong>Element D: Contracts - Opt-Out Provisions - CMS</strong></td>
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<tr>
<td>Opt Out physicians are not employed or contracted by the IPA</td>
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<tr>
<td>1 The IPA has policies and procedures to ensure that it only contracts with physicians who have not opted out and includes the verification source for Medicare Opt-Out</td>
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<tr>
<td>The IPA does not employ or contract with physicians who have opted out of participation in the Medicare Program.</td>
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<tr>
<td>Element E: Medicare-Exclusions/Sanctions - CMS</td>
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<tr>
<td>1 The IPA 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</td>
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<td>CR 2: Credentialing Committee</td>
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<tr>
<td>The IPA designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing decisions. The IPA obtains meaningful advice and expertise from participating practitioners in making credentialing decisions.</td>
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<tr>
<td>Element A: Credentialing Committee</td>
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<tr>
<td>The Credentialing Committee</td>
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<tr>
<td>1 Uses participating practitioners to provide advice and expertise for credentialing decisions. Delegate will be reviewed for documented process and committee minutes for evidence that the requirements are met.</td>
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<tr>
<td>Policies</td>
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<tr>
<td>The policy states that Credentialing Committee is comprised of a range of participating practitioners</td>
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<tr>
<td>If a IPA's Credentialing Committee is comprised of PCP's only, the IPA must have the following order to be compliant</td>
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<td>Evidence</td>
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<tr>
<td>Representation includes a range of participating practitioners in the IPA's network</td>
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<td>There is evidence through their committee minutes that a specialist was conducted, when applicable</td>
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<tr>
<td>There is a listing that indicates that specialists are used, if appropriate</td>
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<tr>
<td>Meetings should include a quorum of practitioners for each meeting, as established in the IPA's policy. If a quorum was not met, educate and do not score down</td>
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<td>Total Factors</td>
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<tr>
<td>2 Reviews credentials for practitioners who do not meet established thresholds. The committee must give thoughtful consideration of the credentialing information. The committee's discussion must be documented within its meeting minutes</td>
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<tr>
<td>Policies</td>
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</tr>
<tr>
<td>The credentialing committee must receive and review the credentials of practitioners who do not meet the IPA's established criteria. The credentialing committee must give thoughtful consideration of the credentialing information</td>
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<tr>
<td>Evidence</td>
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<tr>
<td>There is evidence that the Credentialing Committee reviewed credentials for practitioners who do not meet established thresholds</td>
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<tr>
<td>The committee's discussion must me documented within its meeting minutes</td>
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Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

Delegate:  
Reviewed By:  
Review Date:  

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<td>3</td>
<td></td>
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<tr>
<td>Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician</td>
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**SCORING**

<table>
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<tbody>
<tr>
<td>The organization meets all 3 factors</td>
<td>The organization meets 2 factors</td>
<td>No scoring option</td>
<td>The organization meets 1 factor</td>
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**CR 3: Credentialing Verification**

The IPA verifies credentialing information through primary sources, unless otherwise indicated. The IPA conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.

**NOTE:**

- CR 3 is gathered from Credentialing File Audit Tool. Information must be available for review at the time of the audit. Review 5% or 50 files, whichever is less, with a minimum of 10 credentialing files. Complete the Credentialing File Worksheet.
- The IPA may use oral, written, and Health Plan approved Internet website data to verify information. Oral and Internet website verification requires a note in the credentialing file that includes the date and is either signed or initialed by the IPA staff who verified each credential. It should also contain the name/title of the person providing the verification, if applicable.

Refer to the Credentialing/Recredentialing Elements and Policies and Procedures for complete details. All document location will be Credentialing Files. Only additional sources will be noted.
## Delegation Oversight Annual Audit Tool 2020 Documentation
### Credentialing and Recredentialing

### Credentialing File Review Results

<table>
<thead>
<tr>
<th>Assessment of the following File Review Elements</th>
<th>Ratio</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>A.1 Licensure</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>A.2 DEA or CDS</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>A.2 DEA or CDS (Medicare)</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>A.3 Education, training</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>A.4 Board Certification</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>A.5 Work History</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>A.6 Malpractice claim history</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
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### Sanction Information

<table>
<thead>
<tr>
<th>Sanction Information</th>
<th>Ratio</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>B.1 State sanctions, restrictions on licensure and/or limitations on scope of practice</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>B.2 Sanction Activity by Medicare and Medicaid</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>B.3 Sanction Activity by Medicare and Medicaid (CMS)</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>B.4 Medi-Cal Suspended and Ineligible List (DHCS)</td>
<td>8 out of 8</td>
<td>100%</td>
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### Credentialing Application

<table>
<thead>
<tr>
<th>Credentialing Application</th>
<th>Ratio</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>C.1 Reasons for any inability to perform the essential functions of the position, with or without accommodation</td>
<td>8 out of 8</td>
<td>100%</td>
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<tr>
<td>C.2 Lack of present illegal drug use</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>C.3 History of loss of license and felony convictions</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>C.4 History of loss or limitation of privileges or disciplinary actions</td>
<td>8 out of 8</td>
<td>100%</td>
</tr>
<tr>
<td>C.5 Current malpractice insurance coverage</td>
<td>8 out of 8</td>
<td>100%</td>
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<tr>
<td>C.6 Current and signed attestation confirming the correctness and completeness of the application</td>
<td>8 out of 8</td>
<td>100%</td>
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### Sanction Information

<table>
<thead>
<tr>
<th>Sanction Information</th>
<th>Ratio</th>
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<tr>
<td>D Hospital Admitting Privileges (CMS/DMHC/DHCS)</td>
<td>8 out of 8</td>
<td>100%</td>
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<tr>
<td>E Medicare Opt-Out Verification (CMS)</td>
<td>8 out of 8</td>
<td>100%</td>
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Credentialing and Recredentialing

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<tr>
<td>Element A: Verification of Credentials</td>
<td></td>
<td></td>
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<tr>
<td>The IPA verifies that the following are within the prescribed time limits:</td>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. A current and valid license to practice is present and within the prescribed time limits.</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. A valid DEA or CDS certificate, if applicable</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Education and training</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Board certification</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Work history</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner</td>
<td>100%</td>
<td></td>
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<tbody>
<tr>
<td>High (90-100%, on file review for all six factors)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>High (90-100%) on file review for 4 or 5 factors and medium (60-89%) on file review for remaining 1-2 factors</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>At least medium (60-89%) on file review for all 6 factors</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Low (0-59%) on file review for 1-3 factors</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Low (0-59%) on file review for 4 or more factors</td>
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</table>

CR 3: Credentialing Verification
Element A: Verification of Credentials
The IPA verifies that the following are within the prescribed time limits:

<table>
<thead>
<tr>
<th>Score</th>
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<tbody>
<tr>
<td>2 A valid DEA or CDS certificate, if applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SCORING</th>
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<th>80%</th>
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<tbody>
<tr>
<td>Met</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No scoring option</td>
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<td>No scoring option</td>
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</tr>
<tr>
<td>Not Met</td>
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Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

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**Element B: Sanction Information**

In a review of credentialing files, two factors are present and within 180 calendar day time limit.

Scoring for this element is based on a review of a sample of credentialing files.

<table>
<thead>
<tr>
<th>Element B: Sanction Information (OIG) CMS</th>
<th>Score</th>
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<tbody>
<tr>
<td>1 The IPA reviewed the OIG, within Verification Time limit of 180 calendar days</td>
<td>100%</td>
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<th>20%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (90-100%) on file review for both factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High (90-100%) on file review for 1 factor and medium (60-89%) on file review for 1 factor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium (60-89%) on file review for both factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High (90-100%) or medium (60-89%) on file review for 1 factor and low (0-59%) on file review for 1 factor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low (0-59%) on file review for both factors</td>
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</table>

<table>
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</thead>
<tbody>
<tr>
<td>Met</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
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#### Credentialing and Recredentialing

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<tbody>
<tr>
<td>Element B: Sanction Information ( Medi-Cal Suspended and Ineligible Report (DHCS)</td>
<td>Score</td>
<td></td>
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</tr>
<tr>
<td>1 The IPA reviewed evidence of the Medi-Cal Suspended and Ineligible Report</td>
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<tbody>
<tr>
<td></td>
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<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
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The IPA reviewed evidence of the Medi-Cal Suspended and Ineligible Report.
### Delegation Oversight Annual Audit Tool 2020 Documentation
#### Credentialing and Recredentialing

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**Review Date:**

#### CREDENTIALING AND RECREREDENTIALING DOCUMENTATION TOOL

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<td>Element C: Credentialing Application</td>
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<tr>
<td>The application includes a current and signed attestation and addresses: To count any elements as present, the practitioner must sign and date the application and any relevant addenda. It may not be older than 180 calendar days at the time of the credentialing decision. Receipt of the attestation is not required before the IPA conducts other credentialing verification and queries. If the attestation exceeds 180 calendar days and the IPA updates it, the practitioner must attest only that the information on the application remains correct and complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Reasons for any inability to perform the essential functions of the position, with or without accommodation</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Lack of present illegal drug use</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 History of loss of license and felony convictions</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 History of loss or limitation of privileges or disciplinary actions</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A history of all past and present issues regarding loss or limitations of clinical privileges at all facilities or organizations with which the practitioner has had privileges</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Current malpractice insurance coverage</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A copy of the insurance face sheet that includes the dates and amount of current malpractice coverage</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Current and signed attestation confirming the correctness and completeness of the application</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An attestation indicates that the applicant personally attests to the correctness and completeness of the application at the time he/she applied to the IPA.</td>
<td>100%</td>
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#### SCORING

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<tbody>
<tr>
<td>High (90-100%) on file for all 6 factors</td>
<td>High (90-100%) on file review for 4 or 5 factors and medium (60-89%) on file review for remaining 1-2 factors</td>
<td>High (90-100%) or medium (60-89%) on file review for 5 factors and low (0-59%) on no more than 1 factor</td>
<td>High (90-100%) or medium (60-89%) on file review for 4 factor and low (0-59%) on no more than 2 factors</td>
<td>Low (0-59%) on file review for 3 or more factors</td>
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Credentialing and Recredentialing

Delegate: 

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<tr>
<td>Element D: Hospital Admitting Privileges - CMS/DHMC/DHCS</td>
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</tr>
<tr>
<td>1 Practitioner must have clinical privileges in good standing. Physicians must indicate their current hospital affiliation or admitting privileges at participating hospitals.</td>
<td>100% Score</td>
<td></td>
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<tbody>
<tr>
<td></td>
<td>High (90-100%) on file review</td>
<td>No scoring option</td>
<td>Medium (60-89%) on file review</td>
<td>No scoring option</td>
<td>Low (0-59%) on file review</td>
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</tr>
<tr>
<td>Element E: Sanction Information (Monitoring Physicians Who Have Opted Out) - CMS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 The IPA monitors its credentialing files to ensure that it only contracts with physicians who have not opted out</td>
<td>Met (90-100%) on file review</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>Not Met (0-89%) file review</td>
</tr>
<tr>
<td>Score</td>
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</thead>
<tbody>
<tr>
<td>Met (90-100%) on file review</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>Not Met (0-89%) file review</td>
</tr>
</tbody>
</table>

---

**CR R3: Recredentialing Verification**

The IPA verifies recredentialing information through primary sources, unless otherwise indicated. The IPA conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.

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**Review Date:**

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<th>Page(s)</th>
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<tr>
<td><strong>Recredentialing File Review Results</strong></td>
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<tr>
<td><strong>Assessment of the following File Review Elements</strong></td>
<td><strong>Ratio</strong></td>
<td><strong>Percentage</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A.1 Licensure</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.2 DEA or CDS</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.3 DEA or CDS (Medicare)</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.3 Board Certification</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Score is combined with Education/Training)</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.4 Malpractice claim history</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.1 Sanction Activity by Medicare and Medicaid</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.2 Sanction Activity by Medicare and Medicaid (CMS)</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.4 Medi-Cal Suspended and Ineligible List (DHCS)</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
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<tr>
<td>C.1 Reasons for any inability to perform the essential functions of the position, with or without accommodation</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>C.2 Lack of present illegal drug use</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.3 History of loss of license and felony convictions</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.4 History of loss or limitation of privileges or disciplinary actions</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.5 Current malpractice insurance coverage</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
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<tr>
<td>C.6 Current and signed attestation confirming the correctness and completeness of the application</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Hospital Privileges or Alternate Admitting Agreement, as applicable</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sanction Information</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D State sanctions, restrictions on licensure and/or limitations on scope of practice</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Assessment of the following File Review Elements (CMS of DHCS)</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>E Medicare Opt-Out Verification (CMS)</td>
<td>8 out of 8</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>F Review of Performance Information (CMS &amp; DHCS)</td>
<td>8 out of 8</td>
<td>100%</td>
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Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

Delegate: ________________________________________________
Reviewed By: ___________________________________________
Review Date: ____________________

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<tr>
<td>CR R3: Credentialing Verification</td>
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</tr>
<tr>
<td>Element A: Verification of Credentials</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The IPA verifies that the following are within the prescribed time limits:</td>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 A current and valid license to practice</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 A valid DEA or CDS Certificate, if applicable</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Board Certification, as applicable</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner</td>
<td>100%</td>
<td></td>
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### SCORING

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<thead>
<tr>
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<th>80%</th>
<th>50%</th>
<th>20%</th>
<th>0%</th>
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</thead>
<tbody>
<tr>
<td>High (90-100%) on file review for all 4 factors</td>
<td>High (90-100%) on the file review for 2-3 factors and medium (60-89%) on file review for the remaining 1 factor</td>
<td>At least medium (60-89%) on file review for all 6 factors</td>
<td>Low (0-59%) on file review for 1-3 factors</td>
<td>Low (0-59%) on file review for 4 or more factors</td>
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### Element A: Verification of Credentials

The IPA verifies that the following are within the prescribed time limits:

<table>
<thead>
<tr>
<th>Score</th>
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<tbody>
<tr>
<td>100%</td>
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</tbody>
</table>

- 2 A valid DEA or CDS certificate, if applicable
- Medicare - Verification time limit - 180 days
- Not Met (0-89%) file review
Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

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Reviewed By: 
Review Date: 

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<thead>
<tr>
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<tr>
<td>CR R3: Credentialing Verification (continued)</td>
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</tr>
<tr>
<td>Element B: Sanction Information</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>In a review of credentialing files, two factors are present and within 180 calendar day time limit. Scoring for this element is based on a review of a sample of credentialing files.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 State sanctions, restrictions on licensure and/or limitations on scope of practice</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Medicare and Medicaid sanctions</td>
<td>100%</td>
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**SCORING**

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</thead>
<tbody>
<tr>
<td>High (90-100%) on file review for both factors</td>
<td>High (90-100%) on file review for 1 factor and medium (60-89%) on the file review for 1 factor</td>
<td>Medium (60-89%) on file review for both factors</td>
<td>High (90-100%) or medium (60-89%) on file review for 1 factor and low (0-59%) on file review for 1 factor</td>
<td>Low (0-59%) on file review for both factors</td>
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**Element B: Sanction Information (OIG) CMS**

<table>
<thead>
<tr>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The IPA reviewed the OIG, within Verification Time limit of 180 calendar days</td>
</tr>
</tbody>
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**SCORING**

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<tr>
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<th>80%</th>
<th>50%</th>
<th>20%</th>
<th>0%</th>
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</thead>
<tbody>
<tr>
<td>Met (90-100%) on file review</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No Met (0-89%) file review</td>
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</tbody>
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## Delegation Oversight Annual Audit Tool 2020 Documentation
### Credentialing and Recredentialing

### Delegate:

### Reviewed By:

### Review Date:

### CREDENTIALING AND RECREDECNTIALING DOCUMENTATION TOOL

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<tbody>
<tr>
<td>Element B: Sanction Information (Medi-Cal Suspended and Ineligible Report) DHCS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The IPA reviewed evidence of the Medi-Cal Suspended and Ineligible Report</td>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
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### SCORING

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<th>80%</th>
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<tbody>
<tr>
<td>Met (90-100%) on file review</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>Not Met (0-89%) file review</td>
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</table>
Delegation Oversight Annual Audit Tool 2020 Documentation
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Delegate: ____________________________  Reviewed By: ____________________________  Review Date: __________________

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<td>CR R3: Credentialing Verification (continued)</td>
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<tr>
<td>Element C: Recredentialing Application</td>
<td></td>
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</table>

The application includes a current and signed attestation and addresses:
To count any elements as present, the practitioner must sign and date the application and any relevant addenda. It may not be older than 180 calendar days at the time of the credentialing decision. Receipt of the attestation is not required before the IPA conducts other credentialing verification and queries. If the attestation exceeds 180 calendar days and the IPA updates it, the practitioner must attest only that the information on the application remains correct and complete.

<table>
<thead>
<tr>
<th>Score</th>
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<tbody>
<tr>
<td>100%</td>
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<th>Element</th>
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<tr>
<td>1</td>
<td>Reasons for any inability to perform the essential functions of the position, with or without accommodation</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>Lack of present illegal drug use</td>
<td>100%</td>
</tr>
<tr>
<td>3</td>
<td>History of loss of license and felony convictions</td>
<td>100%</td>
</tr>
<tr>
<td>4</td>
<td>History of loss or limitation of privileges or disciplinary actions</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>A history of all past and present issues regarding loss or limitations of clinical privileges at all facilities or organizations with which the practitioner has had privileges</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Current malpractice insurance coverage</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>A copy of the insurance face sheet that includes the dates and amount of current malpractice coverage</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Current and signed attestation confirming the correctness and completeness of the application</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>An attestation indicates that the applicant personally attests to the correctness and completeness of the application at the time he/she applied to the IPA.</td>
<td></td>
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**TOTAL** 6

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<tr>
<td>Element</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>High (90-100%) on file for all 6 factors</td>
<td>High (90-100%) on file review for 4 or 5 factor and medium (60-89%) on file review for remaining 1-2 factors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>High (90-100%) or medium (60-89%) on file review for 5 factors and low (0-59%) on no more than 1 factor</td>
<td>High (90-100%) or medium (60-89%) on file review for 4 factor and low (0-59%) on no more than 2 factors</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Low (0-59%) on file review for 3 or more factors</td>
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Credentialing and Recredentialing

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<tbody>
<tr>
<td>Element D: Hospital Admitting Privileges - CMS/DHMC/DHCS</td>
<td>100%</td>
<td>80%</td>
<td>50%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Practitioner must have clinical privileges in good standing. Physicians must indicate their current hospital affiliation or admitting privileges at participating hospitals.</td>
<td>100%</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>Low (0-59%) on file review</td>
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</tbody>
</table>

SCORING

<table>
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<tr>
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<tbody>
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<tr>
<td>50%</td>
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<tr>
<td>20%</td>
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Credentialing and Recredentialing

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Review Date: ____________________________________________

<table>
<thead>
<tr>
<th>CR 4: Recredentialing Cycle Length</th>
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<tr>
<td>The IPA formally recredits its practitioners at least every 36 months through information verified from primary sources, unless otherwise indicated. The IPA identifies any changes that may have occurred since the last credentialing process that may affect the care provided to members</td>
<td>100%</td>
</tr>
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<table>
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<tr>
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<th>0%</th>
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</thead>
<tbody>
<tr>
<td>Met (90-100%) on file review</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>Not Met (0-89%) on file review</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Element F: Review of Performance information - CMS/DHCS</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>The IPA includes information from quality improvement activities and member complaints in the recredentialing decision-making process for all practitioners. Performance indicators include:</td>
<td>100%</td>
</tr>
</tbody>
</table>

1. Quality Improvement Activities (e.g. utilization management system, enrollee satisfaction surveys, other activities from the organization)
2. Grievance/complaints

<table>
<thead>
<tr>
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<th>50%</th>
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<tr>
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<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>Not Met (0-89%) on file review</td>
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</table>

<table>
<thead>
<tr>
<th>Element E: Sanction Information (Monitoring Physicians Who Have Opted Out) CMS</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>The IPA monitors its credentialing files to ensure that it only contracts with physicians who have not opted out</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Met (90-100%) on file review</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>Not Met (0-89%) on file review</td>
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<table>
<thead>
<tr>
<th>Element A: Recredentialing Cycle Length</th>
<th>Score</th>
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<tbody>
<tr>
<td>The length of the recredentialing cycle is within the required 36-month time frame</td>
<td>100%</td>
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<th>50%</th>
<th>20%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met (90-100%) on file review</td>
<td>No scoring option</td>
<td>Medium (60-89%) on file review</td>
<td>No scoring option</td>
<td>Low (0-59%) on file review</td>
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Credentialing and Recredentialing

<table>
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Review Date: January 0, 1900
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Reviewed By: 
Review Date: 

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<tbody>
<tr>
<td>CR 5: Practitioner Office Site Quality</td>
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<tr>
<td>The IPA has a process to assess the quality, safety and accessibility of the office sites where care is delivered</td>
<td></td>
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</tr>
<tr>
<td>Element A: Performance Standards and Thresholds</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>The organization sets site performance standards and thresholds for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Physical Accessibility</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td>IPA is not delegated for this element</td>
</tr>
<tr>
<td>2 Physical Appearance</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td>IPA is not delegated for this element</td>
</tr>
<tr>
<td>3 Network Adequacy of waiting and examining room space</td>
<td></td>
<td>N/A</td>
<td></td>
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<tr>
<td>4 Adequacy of medical/treatment record keeping</td>
<td></td>
<td>N/A</td>
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Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

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Reviewed By: __________________________ Review Date: ______________

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<td>Element B: Site Visits and Ongoing Monitoring</td>
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<tr>
<td>The organization implements appropriate interventions by:</td>
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<td></td>
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<tr>
<td>1 Continually monitoring member complaints for all practitioner sites</td>
<td>N/A</td>
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<td>2 Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met</td>
<td>N/A</td>
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<tr>
<td>3 Instituting actions to improve offices that do not meet thresholds in Element A</td>
<td>N/A</td>
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<td>IPA is not delegated for this element</td>
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<tr>
<td>4 Evaluating the effectiveness of the actions at least every six months, until deficient offices meet site standards and thresholds in Element A</td>
<td>N/A</td>
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<td>IPA is not delegated for this element</td>
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<tr>
<td>5 Documenting follow-up visits for offices that had subsequent deficiencies</td>
<td>N/A</td>
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Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

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<tr>
<td>CR 6: Ongoing Monitoring</td>
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</table>

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

**Element A: Ongoing Monitoring and Interventions**

The IPA implements ongoing monitoring and takes appropriate interventions by:
To assess implementation, documentation of how the IPA reviews data sources, investigates complaints and considers the finding in its evaluation of practitioners will be reviewed. Documentation may include a checklist, a log or an initialed dated report.

<table>
<thead>
<tr>
<th>1</th>
<th>Collecting and reviewing Medicare and Medicaid sanctions</th>
<th>Score</th>
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<tbody>
<tr>
<td>2</td>
<td>Collecting and reviewing sanctions or limitations on licensure</td>
<td>*</td>
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<tr>
<td>3</td>
<td>Collecting and reviewing complaints</td>
<td>*</td>
</tr>
<tr>
<td>4</td>
<td>Collecting and reviewing information from identified adverse events</td>
<td>*</td>
</tr>
<tr>
<td>5</td>
<td>The IPA implements appropriate interventions when it identifies instances of poor quality related to 1-4</td>
<td>*</td>
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| TOTAL | 0 |

**SCORING**

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<td>The organization meets 0-1 factor</td>
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## CR 6: Ongoing Monitoring (Continued)

### Element B: Monitoring Medicare Opt-Out Report - CMS

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The IPA maintains a documented process for monitoring whether physician network physicians have opted out of participating in the Medicare Program.
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Credentialing and Recredentialing

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## CREDENTIALING AND REcredentialing DOCUMENTATION TOOL

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<tr>
<td>Element C: Monitoring Medi-Cal Suspended and Ineligible Provider Reports - DHCS</td>
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<tr>
<td>1 The IPA will verify that their contracted providers have not been terminated as a Medi-Cal providers or have not been placed on the Suspend and Ineligible Provider List</td>
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</table>

| CR 6: Ongoing Monitoring (Continued) | | | | | |
| Element D: Preclusions List - CMS | | | | | |
| 1 The IPA will verify that their contracted providers are not precluded from receiving payment for Medicare Advantage (MA) Items and services Part D Drugs furnished or prescribed to Medicare Beneficiaries. | Score | | | | |

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| CR 7: Notification to Authorities and Practitioner Appeal Rights | | | | | |
| | | | | | |
| Element A: Actions Against Practitioners | | | | | |

When an IPA has taken action against a practitioner for quality reasons, it offers the practitioner a formal appeal process and reports the action to the appropriate authorities. The IPA uses objective evidence and patient care considerations to decide on the means of altering a practitioner’s relationship with the IPA if that practitioner does not meet the IPA’s quality standards.
The IPA has written policies and procedures for:
Policies and procedures state how the IPA reviews participation of practitioners whose conduct could adversely affect member’s health or welfare. Must at a minimum, meet the requirements of the Health Care Quality Improvement Act of 1986

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<tr>
<td>1.The range of actions available to the IPA</td>
<td></td>
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<tr>
<td>Policies must specify the range of actions that may be taken to improve the practitioner performance before termination (e.g. Profiling, Corrective Actions, Monitoring, Medical Record Audit)</td>
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## Credentialing and Recredentialing Documentation Tool

### Delegation Oversight Annual Audit Tool 2020 Documentation

**Credentialing and Recredentialing**

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<tr>
<td>2</td>
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<tr>
<td>Procedures for reporting to authorities</td>
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<tr>
<td>The IPA must have clear policies that describe:</td>
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<tr>
<td>Specific reportable incidences including suspensions, terminations, restrictions and revocations</td>
<td></td>
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</tr>
<tr>
<td>Entities that will be reported to and how reports will be made e.g. (Appropriate Licensing Board, NPDB) Policies are not required to specify all the details of the 805 and 805.01 reporting requirements</td>
<td></td>
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<tr>
<td>Must specify their time frames for reporting:</td>
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<tr>
<td>Medical Board of California 805 and 805.01 reports or the appropriate licensing boards (15 days after a recommendation or final determination)</td>
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<tr>
<td>National Practitioner Data Bank (NPDB) (30 days after the final determination)</td>
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</tr>
<tr>
<td>What is expected of staff and outline accountabilities</td>
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<tr>
<td>Policy should at a minimum identify the department or person responsible for filing or reporting to the appropriate authorities</td>
<td></td>
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</tr>
<tr>
<td>Note not all licensing boards require 805 and 805.01 Reporting. Required practitioner types are: Medical Doctors (MD), Dentists (DDS), Osteopaths (DO), Podiatrists (DPM), Marriage Family Therapists (MFT), Licensed Clinical Social Workers (LCSW), Psychologists (Psy.D., PhD) and Physician Assistants (PA)</td>
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<tr>
<td>Total Factors</td>
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<tr>
<td>3</td>
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</tr>
<tr>
<td>A well-defined appeal process</td>
<td></td>
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<tr>
<td>The IPA's policies and procedures must give practitioners the right to appeal and must include the following steps within the appeal process: Provide written notification when a professional review action has been brought against a practitioner, reasons for the action and a summary of the appeal rights and process</td>
<td></td>
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</tr>
<tr>
<td>Allow practitioners to request a hearing and the specific time period for submitting the request</td>
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<tr>
<td>Allow at least 30 calendar days after the notification for practitioners to request a hearing</td>
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<tr>
<td>Allowing practitioners to be represented by an attorney or another person of their choice</td>
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</tr>
<tr>
<td>A practitioner has a right to an attorney</td>
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<td></td>
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<tr>
<td>A policy cannot state that it is at the discretion of the chairperson for attorney representation</td>
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<tr>
<td>Policy must state that the PO cannot have an attorney, if the practitioner does not have attorney representation</td>
<td></td>
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<tr>
<td>Appoint a hearing officer or a panel of individuals to review the appeal</td>
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<tr>
<td>Provide written notification of the appeal decision that contains the specific reasons for the decision</td>
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<tr>
<td>Total Factors</td>
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Note: This table represents a portion of the Delegation Oversight Annual Audit Tool 2020 Documentation for Credentialing and Recredentialing. The entire document includes detailed standards, policies, and documentation requirements for the audit process. The table above captures a subset of these requirements to illustrate the format and content. For a comprehensive review, please refer to the full document.
Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

| Delegate: | | | | |
| Reviewed By: | | | | Review Date: | | |

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<td>4 Making the appeal process known to practitioners</td>
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<td>The policy must specify or address how the appeal process is made known to the practitioner</td>
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<td>Can use an attachment or addendum or policy or contract or manual</td>
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The organization meets all 4 factors.

Scoring:
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<tr>
<td>Element B: Reporting to the Appropriate Authorities</td>
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<tr>
<td>The organization reports practitioner suspension or termination to the appropriate authorities, when applicable</td>
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<tr>
<td>1 There is documentation that the IPA reports practitioner suspension or termination to the appropriate authorities</td>
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<tr>
<td>Applicable to physicians an non physicians</td>
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<td>If the IPA states that there is a reportable deficiency the IPA must report it to the appropriate agency (e.g. MBC, NPDB). In other words, if the IPA takes action altering the participation of a practitioner suspension, termination, restriction or revocation based on quality of care of service, the IPA must report it to the appropriate agency</td>
<td></td>
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</tr>
<tr>
<td>Within 15 days of a recommendation or final decision, the IPA must report to the Medical Board 805 and/or 805.01</td>
<td>^</td>
<td>-</td>
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<tr>
<td>Within 30 days of the final decision, the IPA must report to the NPDB</td>
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<td>Documentation may be de-identified for confidentiality purposes</td>
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<td>This element is N/A in the following circumstances</td>
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<td>If there is no instances of suspension, termination, restriction or revocation to report for quality reasons</td>
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<td>For automatic administrative terminations based on the practitioner not meeting specific contractual obligations for participation in the network</td>
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**Total Factors** 0

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**Delegate:**

**Reviewed By:**

**Review Date:**

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<tbody>
<tr>
<td>CR 7: Notification to Authorities and Practitioner Appeal Rights (continued)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Element C: Practitioner Appeals Process</td>
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</tr>
</tbody>
</table>

**Appeal process/actions to be taken:**
The IPA has an appeal process for instances in which it chooses to alter the conditions of a practitioner’s participation based on issues of quality of care and/or service. The IPA informs practitioners of the appeal process.

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Provide written notification indicating that a professional review action has been brought against the practitioner, reasons for the action and a summary of the appeal rights and process.</td>
<td>▲</td>
</tr>
<tr>
<td>2</td>
<td>Allow practitioners to request a hearing and a specific time period for submitting request</td>
<td>▲</td>
</tr>
<tr>
<td>3</td>
<td>Allow at least 30 days after notification for practitioner to request hearing</td>
<td>▲</td>
</tr>
<tr>
<td>4</td>
<td>Allow practitioner to be represented by an attorney or another person of the practitioner’s choice</td>
<td>▲</td>
</tr>
<tr>
<td>5</td>
<td>Appoint hearing officer or panel of individuals appointed by organization to review appeal</td>
<td>▲</td>
</tr>
<tr>
<td>6</td>
<td>Provide written notification of appeal decision that contains specific reasons for decision</td>
<td>▲</td>
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**TOTAL**

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<tr>
<td>The organization meets all 6 factors</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>The organization meets 0-5 factors</td>
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Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

Delegate:  
Reviewed By:  
Review Date:  

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<tr>
<td>Appeals Process for Termination/Suspension - CMS</td>
<td></td>
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<tr>
<td>On suspension or termination of a contract with a participating physician, the IPA gives the affected physician written notice of the appeal process and the reasons for the suspension or termination. The IPA ensures that the majority of the appeal hearing panel members are peers of the affected physician. The organization notifies physicians in writing of the initial adverse decision.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Element D: Appeals Process for Termination/Suspension Policies and Procedures - CMS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The IPA’s policies and procedures regarding suspension or termination of a participating physician require the organization to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Ensure that the majority of the hearing panels are peers of the affected physician</td>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A peer is an appropriately trained and licensed physician in a practice similar to that of the affected physician. Panel members do not have to possess identical specialty training.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policies and procedures do not always have to state the word “majority”, but at least 51% of the members must be peers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tbody>
<tr>
<td>Met</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>Not Met</td>
<td></td>
</tr>
</tbody>
</table>

CR 8: Assessment of Organizational Providers

The delegate has written policies and procedures for the initial and ongoing assessment of providers with which it contracts. The delegate has written policies and procedures for the initial and ongoing assessment of organizational providers with which it contracts. Providers include laboratories, home health agencies, outpatient rehabilitations and free-standing surgical centers. Also included are behavioral health facilities providing mental health or substance abuse services to inpatient, residential or ambulatory settings.

Element A: Review and Approval of Provider

The IPA’s policy for assessing health care delivery providers specifies that before it contracts with a provider, and for at least every three years thereafter, it:

1. Confirms that the provider is in good standing with state and federal regulatory bodies
2. Policies must specify the sources used

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<th>Score</th>
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Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

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<th>Page(s)</th>
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<tbody>
<tr>
<td>2</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policies must state which accrediting bodies it accepts for each type of provider</td>
<td>^</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A IPA that contracts only with accredited facilities must have a written policy stating that it does not contract with unaccredited facilities. In this case the IPA meets this factor</td>
<td>^</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conducts an onsite quality assessment if the provider is not accredited</td>
<td>^</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policies must state that if the provider has not been accredited an onsite quality assessment must be conducted. The IPA must develop a selection process and assessment criteria for each type of non-accredited provider with which it contracts which includes a process for ensuring the provider credentials its practitioners</td>
<td>^</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A CMS or state review may be used in lieu of a site visit and may not be greater than 3 years old at the time of verification/approval</td>
<td>^</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A IPA that contracts with only accredited facilities that must have a written policy stating that it does not contract with unaccredited facilities. In this case the IPA meets this factor</td>
<td>^</td>
<td></td>
<td></td>
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<tr>
<td>Total Factors</td>
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<tr>
<td>The organization meets all 3 factors</td>
<td>The organization meets 2 factors</td>
<td>The organization meets 1 factor</td>
<td>No scoring option</td>
<td>No written policy exists</td>
<td></td>
</tr>
</tbody>
</table>

**CR 8: Assessment of Organizational Providers (continued)**

**Element B: Medical Providers**

The IPA includes at least the following medical providers:
The IPA must have policies and procedures that specifically address the assessment of hospitals, home health agencies, skilled nursing facilities, nursing homes and free standing surgical centers with which it contracts, regardless of the number of members treated at the facilities

| 1 | Hospitals | * | |
| 2 | Home Health Agencies | * | |
| 3 | Skilled Nursing Facilities | * | |

Score
Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

Delegate: 
Reviewed By: 
Review Date: 

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<tbody>
<tr>
<td>4. Free Standing Surgical Centers (includes stand-alone abortion clinics and multi-specialty outpatient surgical centers)</td>
<td>*</td>
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<tr>
<td>The organization meets all 4 factors</td>
<td>The organization meets 3 factors, including factor 1</td>
<td>The organization meets 3 factors, including factor 1</td>
<td>The organization meets 2 factor</td>
<td>No written policy exists</td>
<td></td>
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</tbody>
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### Delegation Oversight Annual Audit Tool 2020 Documentation

**Credentialing and Recredentialing**

#### Attachment 25 - Credentialing DOA Audit Tool

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#### CREDENTIALING AND REcredentialing DOCUMENTATION TOOL

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<tr>
<td>CR 8: Assessment of Organizational Providers (continued)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Element B: Medical Providers - CMS Providers and Suppliers</td>
<td></td>
<td></td>
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</table>

The IPA includes at least the following medical providers:

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities
- Free Standing Surgical Centers
- Hospices
- Clinical Laboratories
- Comprehensive Outpatient Rehabilitation Facilities
- Outpatient Physical Therapy Providers
- Speech Pathology Providers
- End-Stage Renal Services Providers
- Outpatient Diabetics Self-Management Training Providers
- Portable X-Ray Suppliers
- Rural Health Clinics
- Federally Qualified Health Centers

IPAs that contract with these type of providers and do not provide a documented process will be scored 0%

If the policies and procedures address all types of providers the IPA will be considered compliant and will not need to specify which types they do not contract with

| 1 Hospitals | | | | | |
| 2 Home Health Agencies | | | | | |
| 3 Skilled Nursing Facilities | | | | | |
| 4 Free Standing Surgical Centers (includes stand-alone abortion clinics and multi-specialty outpatient surgical centers) | | | | | |
| 5 Hospices | | | | | |
| 6 Clinical Laboratories | | | | | |
| 7 Comprehensive Outpatient Rehabilitation Facilities | | | | | |
| 8 Outpatient Physical Therapy Providers | | | | | |
| 9 Speech Pathology Providers | | | | | |
| 10 End-Stage Renal Services Providers | | | | | |
| 11 Outpatient Diabetics Self-Management Training Providers | | | | | |
| 12 Portable X-Ray Suppliers | | | | | |
| 13 Rural Health Clinics | | | | | |
| 14 Federally Qualified Health Centers | | | | | |

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<tr>
<td>Met</td>
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<td>No scoring option</td>
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Reviewed By: 

Review Date: 

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<tbody>
<tr>
<td>CR 8: Assessment of Organizational Providers (continued)</td>
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<td></td>
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<tr>
<td>Element C: Behavioral Healthcare Providers</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>The IPA includes behavioral healthcare facilities providing mental health or substance abuse services in the following settings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Inpatient</td>
<td>N/A</td>
<td>IPA is not delegated for this element</td>
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<tr>
<td>2 Residential</td>
<td>N/A</td>
<td>IPA is not delegated for this element</td>
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<td></td>
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</tr>
<tr>
<td>3 Ambulatory</td>
<td>N/A</td>
<td>IPA is not delegated for this element</td>
<td></td>
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</tr>
<tr>
<td>TOTAL</td>
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<tr>
<td>N/A</td>
<td>The organization meets all 3 factors</td>
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# Delegation Oversight Annual Audit Tool 2020 Documentation
## Credentialing and Recredentialing

### Attachment 25 - Credentialing DOA Audit Tool

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<tr>
<td>CR 8: Assessment of Organizational Providers (continued)</td>
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<td></td>
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<tr>
<td>Element D: Assessing Medical Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The delegate has documentation of assessment of contracted medical health care providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of the tracking mechanism that the IPA uses to ensure that it has met these requirements. Must maintain a checklist, spreadsheet or other records of assessing providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score</td>
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<tr>
<td>No documentation is present that the organization completed an assessment of contracted medical providers</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No documentation is present of a completed assessment</td>
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</table>

| CR 8: Credentialing Verification | |
|-------------------------------| |
Delegation Oversight Annual Audit Tool 2020 Documentation  
Credentialing and Recredentialing

Delegate: ____________________________________________________________________  
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Review Date: ____________________________________________________________________  

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</tbody>
</table>

The IPA verifies credentialing information through primary sources, unless otherwise indicated. The IPA conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.

**NOTE:**  
- **CR 8** is gathered from [HDO File Audit Tool](#). Information must be available for review at the time of the audit. Review 5% or 50 files, whichever is less, with a minimum of 10 credentialing files. Complete the Credentialing File Worksheet.
- The IPA may use oral, written, and Health Plan approved Internet website data to verify information. Oral and Internet website verification requires a note in the credentialing file that includes the date and is either signed or initialed by the IPA staff who verified each credential. It should also contain the name/title of the person providing the verification, if applicable.

Refer to the Credentialing/Recredentialing Elements and Policies and Procedures for complete details. All document location will be Credentialing Files. Only additional sources will be noted.
Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

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<td>File Review Results</td>
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<td>Organizational Provider File Review Results</td>
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<td>Assessment of the following File Review Elements</td>
<td>Ratio</td>
<td>Percentage</td>
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<tr>
<td>Element D: Review and Approval of Medical Providers</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A.1 Confirms that the provider is in good standing with state and federal regulatory bodies</td>
<td>0</td>
<td>out of</td>
<td>0</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>A.2-3 Confirms that the provider has been reviewed and approved by an accrediting body or conducts an on-site quality assessment, if the provider is not accredited</td>
<td>0</td>
<td>out of</td>
<td>0</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>A.4 Reconfirms every three years</td>
<td>0</td>
<td>out of</td>
<td>0</td>
<td>#DIV/0!</td>
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CR 8: Assessment of Organizational Providers (continued)

Element D: Assessing Medical Providers

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<tr>
<th>Score</th>
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<tbody>
<tr>
<td>1</td>
<td>The organization assesses contracted medical health care providers against the requirement and within the timeframe in Element A (Source: Medicare Managed Care Manual, Chapter 6 § 70)</td>
<td></td>
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<td>The organization meets the requirement</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>The organization does not meet the requirement</td>
<td></td>
</tr>
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Element D: Review and Approval for CMS Organizational Providers

| A.1 Confirms that the provider is in good standing with state and federal regulatory bodies | 0 | out of | 0 | #DIV/0! | |
# Delegation Oversight Annual Audit Tool 2020 Documentation

## Credentialing and Recredentialing

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<th>COMMENTS</th>
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<tr>
<td>A.2-3 Confirms that the provider has been reviewed and approved by an accrediting body or conducts an on-site quality assessment, if the provider is not accredited</td>
<td>0</td>
<td>out of 0</td>
<td>0</td>
<td>#DIV/0!</td>
<td></td>
</tr>
<tr>
<td>A.4 Reconfirms every three years</td>
<td>0</td>
<td>out of 0</td>
<td>0</td>
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### Element D: Assessing Medical Providers for CMS Organizational Providers

1. The organization assesses contracted medical health care providers.

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<td>Met (90-100%) on file review</td>
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<td>Not Met (0-89%) on file review</td>
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Delegation Oversight Annual Audit Tool 2020 Documentation
 Credentialing and Recredentialing

Delegate: 

Reviewed By: 

Review Date: 

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<td>Element F: Accreditation/Certification of Free-Standing Surgical Centers in California - CH&amp;SC</td>
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</tr>
<tr>
<td>1 The organization has documentation of assessment of free-standing surgical centers to ensure that if the organizational provider is not accredited by an agency accepted by the State of California, the provider is certified to participate in the Medicare Program, in compliance with California Health and Safety Code § 1248.1</td>
<td>Score</td>
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</thead>
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<tr>
<td>Documentation is present that the organization completed an assessment of free-standing surgical centers</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No documentation is present of a completed assessment</td>
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## Delegation Oversight Annual Audit Tool 2020 Documentation

### Credentialing and Recredentialing

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<tr>
<td>CR 9: Delegation of CR</td>
<td></td>
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</table>

If the delegate delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. The delegate remains accountable for credentialing and recredentialing its practitioners, even if it delegates all or part of these activities. The IPA can utilize an NCQA accredited CVO only.

#### Element A: Written Delegation Agreement

The written delegation document:

- There must be a written description of all delegated credentialing for all delegated medical groups

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<th>Is mutually agreed upon</th>
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<tbody>
<tr>
<td>Score</td>
<td>2</td>
<td>Describes the delegated activities and responsibilities of the organization and the delegated entity.</td>
</tr>
<tr>
<td>Score</td>
<td>3</td>
<td>Requires at least semi-annual reporting of the delegated entity to the organization</td>
</tr>
<tr>
<td>Score</td>
<td>4</td>
<td>Describes the process by which the IPA evaluates the delegated entity’s performance</td>
</tr>
<tr>
<td>Score</td>
<td>5</td>
<td>Specifies the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making</td>
</tr>
<tr>
<td>Score</td>
<td>6</td>
<td>Describes the remedies available to the IPA if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement</td>
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<td>The organization meets all 6 factors</td>
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<td>The organization meets 3-4 factors</td>
<td>The organization meets 1-2 factors</td>
<td>The organization meets no factors</td>
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Delegation Oversight Annual Audit Tool 2020 Documentation  
Credentialing and Recredentialing

Delegate:  
Reviewed By:  
Review Date:  

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<th>COMMENTS</th>
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</thead>
</table>

46 of 53
## Delegation Oversight Annual Audit Tool 2020 Documentation
### Credentialing and Recredentialing

### CR 9: Delegation of CR (continued)

If the delegation arrangement includes the use of protected health information by the delegate, the delegation document also includes the following provisions:

When delegates have access to the IPA’s protected health information (PHI) on members or practitioners, or create such information in the course of their work, the mutually agreed upon document must ensure that the information will remain protected.

HIPAA regulations define a covered entity as a health plan, health care clearinghouse or health care provider that transmits any health information by electronic means in connection with an electronic health care transaction.

If the delegation agreement does not include the use of PHI in any form, an affirmative statement to that fact in the delegation agreement is sufficient, but is not required

### Element B: Provision for Protected Health Information

<table>
<thead>
<tr>
<th>Score</th>
<th>Element</th>
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</thead>
<tbody>
<tr>
<td>*</td>
<td>1 A list of the allowed uses of protected health information</td>
</tr>
<tr>
<td>*</td>
<td>2 A description of delegate safeguards to protect the information from inappropriate use or further disclosure</td>
</tr>
<tr>
<td>*</td>
<td>3 A stipulation that the delegate will ensure that sub-delegates have similar safeguards</td>
</tr>
<tr>
<td>*</td>
<td>4 A stipulation that the delegate will provide individuals with access to their protected health information</td>
</tr>
<tr>
<td>*</td>
<td>5 A stipulation that the delegate will inform the IPA if inappropriate uses of the information occur</td>
</tr>
<tr>
<td>*</td>
<td>6 A stipulation that the delegate will ensure protected health information is returned, destroyed or protected if the delegation agreement ends</td>
</tr>
</tbody>
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### SCORING

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<td>High (90-100%) on file for all 6 factors</td>
<td>High (90-100%) or medium (60-89%) on file review for 5 factors and low (0-59%) on no more than 1 factor</td>
<td>High (90-100%) or medium (60-89%) on file review for 4 factors and low (0-59%) on no more than 2 factors</td>
<td>Low (0-59%) on file review for 3 or more factors</td>
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Delegation Oversight Annual Audit Tool 2020 Documentation  
Credentialing and Recredentialing

| Delegation: |  |
| Reviewed By: |  |
| Review Date: |  |

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**CR 9: Delegation of CR (continued)**

#### Element C: Pre-Delegation Evaluation

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1. For new delegation agreements initiated in the look-back period, the IPA evaluated delegate capacity to meet NCQA requirements before delegation began.

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<tr>
<td>The organization has evaluated delegate capacity before the delegation process was signed</td>
<td>No scoring option</td>
<td>The organization evaluated delegate capacity after the delegation document was signed</td>
<td>No scoring option</td>
<td>The organization did not evaluate delegate capacity</td>
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<tr>
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<tbody>
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### Delegation Oversight Annual Audit Tool 2020 Documentation

**Credentialing and Recredentialing**

#### Delegate:

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#### Reviewed By:

__________________________

#### Review Date:

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<tr>
<td>Element D: Review of Credentialing Process</td>
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For delegation arrangements in effect for 12 months or longer, the IPA:

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<tbody>
<tr>
<td>1. Annually reviews its delegate's credentialing policies and procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Annually evaluates delegate performance against NCQA standards for delegated activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Semiannually evaluates regular reports, as specified in Element A</td>
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| TOTAL | 0 |

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#### SCORING (CMS)

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Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

Delegate: 

Reviewed By: 

Review Date: 

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<tr>
<td>Element E: Opportunities for Improvement</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. For delegation arrangements that have been in effect for more than 12 months, at least once in the last year that delegation has been in effect, the IPA has identified and followed up on opportunities for improvement, if applicable</td>
<td>Score</td>
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**SCORING**

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<tbody>
<tr>
<td></td>
<td>At least once in the past year that the delegation agreement has been in effect, the organization has acted on identified problems if any</td>
<td>No scoring option</td>
<td>The organization has taken inappropriate or weak action</td>
<td>No scoring option</td>
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</table>

**SCORING (CMS)**

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### Delegation Oversight Annual Audit Tool 2020 Documentation

**Credentialing and Recredentialing**

**Delegate:**

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**Reviewed By:**

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**Review Date:**

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<td>CR 10: Identification of HIV/AIDS Specialists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The organization has documents and implements a method for identifying HIV/AIDS Specialists. The organization is accountable for identifying practitioners who qualify as HIV/AIDS Specialists to whom appropriate members may be given a standing or extended referral when the member's condition requires the specialist medical care over a prolonged period of time or is life-threatening, degenerative or disabling, to a specialist or specialty care center that has expertise in treating HIV/AIDS, in accordance with California Health and Safety Codes.</td>
<td></td>
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</table>

#### Element A: Written Process

| Score | | |
|-------|---------|
| 1 | The IPA 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. |

**SCORING**  

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<tr>
<td>There is a written process delineating how screening and identification is achieved.</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No scoring option</td>
<td>No written process</td>
</tr>
</tbody>
</table>

#### Element B: Evidence of Implementation

| Score | | |
|-------|---------|
| 1 | On an annual basis, the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist, according to California State regulations. This does not require screening of all the group's physicians - only of those that potentially may qualify and wish to be listed as HIV/AIDS specialists; e.g. PCPs, Internist Specialists, and/or Infectious Disease Physicians. It may be that the department responsible for standing referrals performs the annual survey instead of the credentialing department. This would meet the intent of this requirement. |

---

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Delegation Oversight Annual Audit Tool 2020 Documentation
Credentialing and Recredentialing

<table>
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<tr>
<td></td>
<td>There is evidence that annual screening has occurred</td>
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<td>No scoring option</td>
<td>No scoring option</td>
<td>No screening has occurred</td>
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SCORE POLICY NAME Page(s) Section COMMENTS
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### Delegation Oversight Annual Audit Tool 2020 Documentation

**Credentialing and Recredentialing**

**Score Policy Name**: Page(s) Section Comments

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<tr>
<td>Element C: Distribution of Findings</td>
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<td></td>
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<tr>
<td>1 The list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals</td>
<td>1</td>
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</thead>
<tbody>
<tr>
<td>List is available to the surveyor and has been given to the appropriate department</td>
<td>No scoring option</td>
<td>List is available, but has not been given to the appropriate department</td>
<td>No scoring option</td>
<td>No list</td>
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Delegated IPA Care Management Review Tool
Medi-Cal

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<tr>
<td>a. Member Name</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>b. IEHP ID# or DOB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Date Case Opened (or Referred to Waiver, CCS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>d. Case Closure Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Reason for Closure / Case Outcome Documented</td>
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<td></td>
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<tr>
<td>f. Referral Source</td>
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<tr>
<td>g. Referral Reason</td>
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<tr>
<td>h. Care Plan Documented</td>
<td></td>
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</tr>
<tr>
<td>i. Diagnosis Noted</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>j. Problem(s) / Issues Identified</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>k. Goal(s) Identified</td>
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<td>l. Interventions Documented or Noted</td>
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<td>m. Care Plan Sent to PCP</td>
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<td>n. Communication w/ Member Documented</td>
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**IPA Denial Log Review Tool**

**Medi-Cal**

| (a) Denial Tracking Number | (b) File Type | (c) Request Date | (d) Decision Date | (e) Initial Notification | (f) Written Notification | (g) Practitioner Written Notification | (h) Practitioner Written Notification - Initial | (i) Practitioner Written Notification - Decision | (j) Practitioner Written Notification - Points | (k) Members Services | (l) Approved Letters | (m) Initial Notification | (n) Points | (o) Points Possible | (p) Practitioner Reason | (q) Member Reason | (r) Practitioner Appeal | (s) Member Appeal | (t) Practitioner Expedited | (u) Obtained Criterion | (v) Initial | (w) Language | (x) Lob | (y) State Hearing | (z) Medi-Cal Ombudsman | (aa) DMHC w/TTY & Website |
|---------------------------|--------------|-----------------|------------------|------------------------|------------------------|-------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|----------------------|------------------|------------------|----------------|-----------------|----------------|-----------------|-----------------|----------------|----------------|----------------|------------------|----------------|----------------|
| 0                         |              | 0               | 0                | 0                      | 0                      | 0                             | 0                                             | 0                                             | 0                                             | 0                    | 0                | 0                | 0              | 0                | 0              | 0               | 0               | 0               | 0                | 0                | 0                | 0                |

**Total Number of Files Reviewed:** 0

**Instructions:** IEHP randomly selects 30 denials from delegate's 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 “N/A” if the information is not applicable. Each file has a maximum score of 12.

**Comments:**

Rev. 12/17/15; 8/30/2016
<table>
<thead>
<tr>
<th>FUNCTIONAL AREA</th>
<th>CLAIMS</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>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Claims Audit – 01/19 - 12/19 (9 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Audit Type: ____ Audit Date: ____ What was the compliance level for the audit performed? (If an Annual Audit &amp; Verification Audit are performed in the same year, only the Annual Audit Score will apply.)</td>
<td>3</td>
<td>Must pass the audit as outlined in Audit Guide.</td>
<td></td>
<td>Annual Audit: Pass =3, Conditional Pass=2, Non-Compliant=1, Fail=0 Verification Audit: Pass=1, Non-Compliant=0</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Were all Claims Universes submitted timely, accurately and completed in their entirety?</td>
<td>1</td>
<td>Provides Claims Universe by due date</td>
<td>YES=1; NO=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Were all Claims Audit documents submitted timely, accurately and completed in their entirety?</td>
<td>1</td>
<td>Provides Audit Documents by due date</td>
<td>YES=1; NO=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>If the IPA received a Pass, Conditional Pass, Non-Complaint or Failed Score, how many CAPs were required?</td>
<td>1</td>
<td>No more than one CAP</td>
<td>0-1 CAP=1 &gt;1 CAP=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Were CAPs submitted timely?</td>
<td>1</td>
<td>Provides CAP by due date</td>
<td>YES=1; NO=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Was a Verification Audit required at any time during the year due to the score of the audit performed in Section A?</td>
<td>1</td>
<td>No Verification Audit required during timeframe</td>
<td>NO=1; YES=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Was a Focused Audit performed at any time during the year?</td>
<td>1</td>
<td>No Focused Audit required during timeframe</td>
<td>NO=1; YES=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Claims Reports – 01/19 - 12/19 (5 points)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>How many months were the MTRs submitted timely, accurately and completed in their entirety?</td>
<td>2</td>
<td>Reports submitted to IEHP by the 15th of the month due</td>
<td>10-12 Months=2; 7-9 Months=1; Under 7 Months=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Were all quarterly reports and the annual report submitted timely, accurately and completed in their entirety?</td>
<td>1</td>
<td>Reports submitted to IEHP by the last day of the month following the end of the quarter</td>
<td>YES=1; NO=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>How many extensions were granted over the year?</td>
<td>1</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>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Did the IPA report whether or not they had any deficiencies through out the year?</td>
<td>1</td>
<td>The IPA must report even if they had no deficiencies</td>
<td>YES=1; NO=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Claims Appeals – 01/19 - 12/19 (4 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Did the IPA have any appealed claims?</td>
<td>4</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>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>If Provider had appealed claims:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>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>3</td>
<td>Score is equal or less than 24%</td>
<td>100%-75% =0; 74%-50%=1; 49%-25%=2; &lt;25%=3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>What percentage of all IPA denials were overturned and paid by IEHP?</td>
<td>1</td>
<td>Score less than or equal to 10%</td>
<td>0-10%=1; &gt;10%=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Member Claim Bills Activity (Bills received by Members for non-payment or balance due for underpayment) - 01/19 - 12/19 (2 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Did the IPA have any Member Claim Bill activities?</td>
<td>2</td>
<td>No Member Bills</td>
<td>0 Member Bills=2; Member Bill activity=Go to Question 3Ba</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>If IPA had Member Claim Bill activities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>What percentage of Member Claim Bill cases received did IEHP pay to pay and deduct from the IPA's capitation?</td>
<td>2</td>
<td>Score less than or equal to 25%</td>
<td>0-25%=2; &lt;25%=0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CLAIMS POINTS SCORED:** 20 0
<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>
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<tbody>
<tr>
<td>COMMUNICATION</td>
<td></td>
<td></td>
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<tr>
<td>II</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1 Communication of PCP Changes – 01/19 - 12/19 (4 points)</td>
<td></td>
<td></td>
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</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></td>
<td></td>
<td>Provides 60-day advance notification for all changes</td>
<td>100%-75%=4; 74%-50%=2; &lt;50%=0</td>
</tr>
<tr>
<td>2 Bi-annual Review of Specialty and Ancillary Network - 01/19 - 12/19 (4 points)</td>
<td></td>
<td></td>
<td></td>
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<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></td>
<td></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>
</tr>
<tr>
<td>3 Monthly Review of Admitter/Hospitalist Report - 01/19 - 12/19 (3 points)</td>
<td></td>
<td></td>
<td></td>
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</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></td>
<td></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>
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<tr>
<td>ENCOUNTER DATA POINTS SCORED:</td>
<td>11</td>
<td>0</td>
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<td>ENCOUNTER DATA</td>
<td>Pts</td>
<td>Raw Score</td>
<td>Pts</td>
<td>IEHP Expectation</td>
<td>IEHP Scoring</td>
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<tr>
<td>III</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Monthly Data Submission – 2018 (8 points)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A Are IPA submissions meeting IEHP validity requirements?</td>
<td>4</td>
<td></td>
<td></td>
<td>See standards outlined in Policy 21A</td>
<td>100%=4; 99%-75%=3; 74%-50%=1; &lt;50%=0</td>
</tr>
<tr>
<td>B Are IPA submissions meeting IEHP adequacy requirements?</td>
<td>4</td>
<td></td>
<td></td>
<td>See standards outlined in Policy 21A</td>
<td>100%=4; 99%-75%=3; 74%-50%=1; &lt;50%=0</td>
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<tr>
<td>ENCOUNTER DATA POINTS SCORED:</td>
<td>8</td>
<td></td>
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<tr>
<td>FINANCE</td>
<td>Pts</td>
<td>Raw Score</td>
<td>Pts</td>
<td>IEHP Expectation</td>
<td>IEHP Scoring</td>
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<tr>
<td>IV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Financial Viability – Calendar Year 2019 Submissions (10 points)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A Does the IPA submit their quarterly financial reports within the required timeframe?</td>
<td>1</td>
<td></td>
<td></td>
<td>Reports submitted to IEHP by the 15th of the month due</td>
<td>100%=1; &lt;100%=0</td>
</tr>
<tr>
<td>B Did the IPA always pass IEHP's quarterly financial viability test the first time?</td>
<td>1</td>
<td></td>
<td></td>
<td>Passed quarterly financial viability test each quarter; no corrective action needed</td>
<td>PASS=1, FAIL=0</td>
</tr>
<tr>
<td>C Did the IPA pass DMHC’s quarterly financial viability test each quarter?</td>
<td>2</td>
<td></td>
<td></td>
<td>Passed quarterly financial viability test each quarter; no corrective action needed</td>
<td>PASS=2, FAIL=0</td>
</tr>
<tr>
<td>D Did the IPA submit the current Audited Annual Financial Statement within the required timeframe?</td>
<td>2</td>
<td></td>
<td></td>
<td>Provided as requested by IEHP</td>
<td>YES=2, NO=0</td>
</tr>
<tr>
<td>E Did the IPA pass the Audited Annual Financial Viability Test?</td>
<td>2</td>
<td></td>
<td></td>
<td>Passed quarterly financial viability test each quarter; no corrective action needed</td>
<td>PASS=2, FAIL=0</td>
</tr>
<tr>
<td>F Did the IPA secure the required Letter of Credit (LOC)?</td>
<td>2</td>
<td></td>
<td></td>
<td>Provided as requested by IEHP</td>
<td>YES=2, NO=0</td>
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<tr>
<td>FINANCE POINTS SCORED:</td>
<td>10</td>
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## GRIEVANCES

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<tr>
<th>FUNCTIONAL AREA</th>
<th>Pts Poss</th>
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<th>Pts Score</th>
<th>IEHP Expectation</th>
<th>IEHP Scoring</th>
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</thead>
<tbody>
<tr>
<td>V</td>
<td></td>
<td></td>
<td></td>
<td>Total possible points:</td>
<td>6</td>
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<tr>
<td>1 Member Grievances (Rec'd by IPA) – 01/19 - 12/19 (3 points)</td>
<td></td>
<td></td>
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<tr>
<td>A Are grievance responses received timely from the IPA?</td>
<td>3</td>
<td>Score is 90% received within 14 days</td>
<td>100-90%=3; 89-70%=2; &lt;70%=0</td>
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<tr>
<td>2 Member Appeals : 01/19 - 12/19 (3 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A How many appeals were overturned?</td>
<td>3</td>
<td>Score is ≤ 25%</td>
<td>≤ 25% = 3; &gt; 25% = 0</td>
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**GRIEVANCES POINTS SCORED:** 6

## DELEGATION OVERSIGHT AUDIT RESULTS -2019

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<tr>
<th>FUNCTIONAL AREA</th>
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<th>Pts Score</th>
<th>IEHP Expectation</th>
<th>IEHP Scoring</th>
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<tbody>
<tr>
<td>VI</td>
<td></td>
<td></td>
<td></td>
<td>Total possible points:</td>
<td>13</td>
</tr>
<tr>
<td>1 Quality 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>Must score a minimum of 96% to pass audit. Score based upon initial audit score</td>
<td>100-96%=1; &lt; 96%=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Utilization Management (1 points)</td>
<td></td>
<td></td>
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<tr>
<td>A Delegation Oversight Audit score:</td>
<td>1</td>
<td>Must score a minimum of 96% to pass audit. Score based upon initial audit score</td>
<td>100-96%=1; &lt; 96%=0</td>
<td></td>
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</tr>
<tr>
<td>3 Credentialing (1 points)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A Delegation Oversight Audit score:</td>
<td>1</td>
<td>Must score a minimum of 96% to pass audit. Score based upon initial audit score</td>
<td>100-96%=2; &lt; 96%=0</td>
<td></td>
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</tr>
<tr>
<td>4 Credential File Review (2 points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Delegation Oversight Audit score:</td>
<td>2</td>
<td>Must score a minimum of 96% to pass audit. Score based upon initial audit score</td>
<td>100-96%=2; 95-80%=1; &lt; 80%=0</td>
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</tr>
<tr>
<td>5 Recredential File Review (2 points)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A Delegation Oversight Audit score:</td>
<td>2</td>
<td>Must score a minimum of 96% to pass audit. Score based upon initial audit score</td>
<td>100-96%=2; 95-80%=1; &lt; 80%=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 HDO File Review (2 points)</td>
<td></td>
<td></td>
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<tr>
<td>A Delegation Oversight Audit score:</td>
<td>2</td>
<td>Must score a minimum of 96% to pass audit. Score based upon initial audit score</td>
<td>100-96%=2; 95-80%=1; &lt; 80%=0</td>
<td></td>
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</tr>
<tr>
<td>7 Care Management (1 Points)</td>
<td></td>
<td></td>
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<tr>
<td>A Delegation Oversight Audit Score:</td>
<td>1</td>
<td>Must score a minimum of 96% to pass audit. Score based upon initial audit score</td>
<td>100-96%=1; &lt; 96%=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Compliance (1 Points)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A Delegation Oversight Audit Score:</td>
<td>1</td>
<td>Must score a minimum of 96% to pass audit. Score based upon initial audit score</td>
<td>100-96%=1; &lt; 96%=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Tool Roadmapped (1 Points)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A DOA Tool Completely Roadmapped and available at time of the IPAs Audit</td>
<td>1</td>
<td>Entire DOA Tool needs to be completed</td>
<td>Complete Tool=1; Incomplete/None=0</td>
<td></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>All DOA documentation requests submitted by due date</td>
<td>YES=1; NO=0</td>
<td></td>
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</table>

**DELEGATION OVERSIGHT AUDIT RESULTS PTS SCORED:** 13
<table>
<thead>
<tr>
<th>FUNCTIONAL AREA</th>
<th>Pts</th>
<th>Raw Score</th>
<th>Pts Score</th>
<th>IEHP Expectation</th>
<th>IEHP Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VII DELEGATE REPORTING AND MEMBER ACCESS AUDIT</strong></td>
<td></td>
<td></td>
<td></td>
<td>Total possible points: 32</td>
<td></td>
</tr>
<tr>
<td>1 Monthly Reports – 01/19 - 12/19 (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>4</td>
<td>Compliant with IEHP turn around timeframes 90% of the time.</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
<td></td>
</tr>
<tr>
<td>B Does the Delegate utilize the correct denial letter templates?</td>
<td>4</td>
<td>4</td>
<td>Delegate utilizes IEHP approved denial letter templates with correct attachments.</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
<td></td>
</tr>
<tr>
<td>C Is the Delegate compliant with all denial guidelines?</td>
<td>4</td>
<td>4</td>
<td>Complaint with IEHP overall Denial process 90% of the time.</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
<td></td>
</tr>
<tr>
<td>D Is the Delegate compliant with all approval guidelines?</td>
<td>4</td>
<td>4</td>
<td>Complaint with IEHP overall approval process 80% of the time.</td>
<td>100-90% = 4; 89-75% = 2; &lt; 75% = 0</td>
<td></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>4</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>
<td></td>
</tr>
<tr>
<td>2 Reports - 01/19 - 12/19 (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>4</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>
<td></td>
</tr>
<tr>
<td>3 Member Access 01/19 - 12/19 (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>Score is ≥ to 75%</td>
<td>100%-75%=2; 74%-50%=1; &lt;50%=0</td>
<td></td>
<td></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>Score is ≥ to 75%</td>
<td>100%-75%=2; 74%-50%=1; &lt;50%=0</td>
<td></td>
<td></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>Score is ≥ to 75%</td>
<td>100%-75%=2; 74%-50%=1; &lt;50%=0</td>
<td></td>
<td></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>Score is ≥ to 75%</td>
<td>100%-75%=2; 74%-50%=1; &lt;50%=0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SCORING SUMMARY***

<table>
<thead>
<tr>
<th>TOTAL POINTS SCORED</th>
<th>TOTAL POINTS POSSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I CLAIMS</td>
<td>0</td>
</tr>
<tr>
<td>II COMMUNICATION</td>
<td>0</td>
</tr>
<tr>
<td>III ENCOUNTER DATA</td>
<td>0</td>
</tr>
<tr>
<td>IV FINANCE</td>
<td>0</td>
</tr>
<tr>
<td>V GRIEVANCES</td>
<td>0</td>
</tr>
<tr>
<td>VI DELEGATION OVERSIGHT AUDIT RESULTS</td>
<td>0</td>
</tr>
<tr>
<td>VII DELEGATE REPORTING AND MEMBER ACCESS AUDIT</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL POINTS</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL PERCENTAGE</strong></td>
<td>0%</td>
</tr>
</tbody>
</table>

**# CONTRACT YEARS AWARDED**

- Providers achieving the following percentages: are awarded a contract term of:
  - 95% or above: 3 years
  - 85% to 94.99%: 2 years
  - 80% to 84.99%: 1 year
  - Less than 80%: Non-renewal

*Any functional area not reviewed in the PET timeframe will not be included as part of the total score
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 □ Social Needs □ Rx □ High Utilization □ Behavioral Health □ 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 □ Severe psychoses □ New cerebral vascular accident □ Trauma (current) □ Metastatic cancer/pediatric cancer □ Decompensating neurological conditions □ Complex pain management control issues □ Multiple chronic illnesses-uncontrolled

Utilization Triggers
□ 6 or more ER visits in the past 12 months □ 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 □ Projected cost of care within a 12-month period anticipated to be >$100,000 (including high-cost medications and/or DME)

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)

©2017 Inland Empire Health Plan. All Rights Reserved. CM-697775
<table>
<thead>
<tr>
<th>Member First Name</th>
<th>Member Last Name</th>
<th>IEHP Member ID #</th>
<th>OOB</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>
<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</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></td>
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</tbody>
</table>

Identify the number of:
New Opened Cases:
Previously Opened Cases:
Total Cases reported for this month:
Utilization Management
Delegation Oversight Audit Tool
2019 NCQA Standards

<table>
<thead>
<tr>
<th>IPA:</th>
<th>Date:</th>
<th>UM Total Score:</th>
<th>0%</th>
</tr>
</thead>
</table>

NCQA UM 1: Utilization Program Structure

The organization’s UM program has clearly defined structures and processes, and assigns responsibility to appropriate individuals.

**Element A: Written Program Description**
The organization’s UM program description includes the following:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>% of Requirement Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A written description of the program structure.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Involvement of a designated senior-level physician in UM program implementation.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. The program scope and process used to determine benefit coverage and medical necessity.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Information sources used to determine benefit coverage and medical necessity.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Element B: Physician Involvement**
A senior-level physician is actively involved in implementing the organization’s UM program.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>% of Requirement Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A senior-level physician is actively involved in implementing the organization’s UM program.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Element D: Annual Evaluation**
The organization annually evaluates and updates the UM program, as necessary.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>% of Requirement Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The organization annually evaluates and updates the UM program, as necessary.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

NCQA UM 2: Clinical Criteria for UM Decisions

The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria.

**Element A: UM Criteria**
The organization:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>% of Requirement Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has written UM decision-making criteria that are objective and based on medical evidence.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Has written policies for applying the criteria based on individual needs.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Has written policies for applying the criteria based on an assessment of the local delivery system.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Involves appropriate practitioners in developing, adopting and reviewing criteria.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Element B: Availability of Criteria**
The organization:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>% of Requirement Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. States in writing how practitioners can obtain UM criteria.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Makes the criteria available to its practitioners upon request.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Element C: Consistency in Applying Criteria**
At least annually, the organization:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>% of Requirement Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Acts on opportunities to improve consistency, if applicable.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
### NCQA UM 3: Communication Services

The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

**Element A: Access to Staff**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Staff can receive inbound communication regarding UM issues after normal business hours.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. TDD/TTY services for members who need them.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Language assistance for members to discuss UM issues.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Requirements Element A</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

### NCQA UM 4: Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM decisions.

**Element A: Licensed Health Professionals**

The organization has written procedures:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Requiring appropriately licensed professionals to supervise all medical necessity decisions.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Specifying the type of personnel responsible for each level of UM decision making.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Requirements Element A</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Element B: Use of Practitioners for UM Decisions**

The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Education, training or professional experience in medical or clinical practice.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. A current clinical license to practice or an administrative license to review UM cases.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Requirements Element B</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

**Element C: Practitioner Review of Nonbehavioral Healthcare Denials**

The organization uses a physician or other health care professional, as appropriate, to review nonbehavioral healthcare denial based on medical necessity.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The organization uses a physician or other health care professional, as appropriate, to review nonbehavioral healthcare denial based on medical necessity.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Requirements Element C</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Element G: Affirmative Statement About Incentives**

The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. UM decision making is based only on appropriateness of care and service and existence of coverage.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Requirements Element G</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
### NCQA UM 5: Timeliness of UM Decisions

#### Element A: Timeliness of Nonbehavioral Healthcare UM Decision Making

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. For Medicare and Medicaid urgent concurrent decisions, the organization makes decisions within 72 hours of receipt of the request</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. For urgent preservice decisions, the organization makes decisions within 72 hours of receipt of the request</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. For nonurgent preservice decisions, the organization makes decisions within 15 calendar days of receipt of the request</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. For postservice decisions, the organization makes decisions within 30 calendar days of receipt of the request</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

#### Element B: Notification of Nonbehavioral Healthcare Decisions

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. For urgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. For nonurgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. For postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

#### Element G: UM Timeliness Report

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nonbehavioral UM decision making.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Notification of nonbehavioral UM decisions.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### NCQA UM 6: Clinical Information

#### Element A: Relevant Information for Nonbehavioral Decisions

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Comment / Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.</td>
<td>X</td>
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</table>

Updated 12/28/2018
### NCQA UM 7: Denial Notices

**Element A: Discussing a Denial With a Reviewer**

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<tr>
<th>Requirement</th>
<th>Score</th>
<th>% of Requirement Met</th>
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<tbody>
<tr>
<td>0.5 1</td>
<td>0</td>
<td>0%</td>
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</table>

**COMMENTS:**

- The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer.

#### Supporting Documentation (Include page and section numbers where applicable)

### Element B: Written Notification of Nonbehavioral Healthcare Denials

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>% of Requirement Met</th>
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</thead>
<tbody>
<tr>
<td>0.5 1</td>
<td>0</td>
<td>0%</td>
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</table>

**COMMENTS:**

- The organization’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.

### Element C: Nonbehavioral Healthcare Notice of Appeal Rights/Process

<table>
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<tr>
<th>Requirement</th>
<th>Score</th>
<th>% of Requirement Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5 1</td>
<td>0</td>
<td>0%</td>
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</table>

**COMMENTS:**

- The organization’s written non-behavioral healthcare denial notification to members and their treating practitioners contains the following information:

1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
2. An explanation of the appeal process, including members’ rights to representation and appeal time frames.
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.
**Referral Universe**

<table>
<thead>
<tr>
<th>IPA Auth/Tracking number</th>
<th>Member Name</th>
<th>IEHP ID Number</th>
<th>Priority of Referral*</th>
<th>Date Request Received</th>
<th>Time Request Received (urgent requests)</th>
<th>Requesting Provider</th>
<th>Requested Provider</th>
<th>Specialty</th>
<th>Service Requested</th>
<th>Service Category</th>
<th>Diagnosis</th>
<th>Referral Disposition/Decision**</th>
<th>Reason for Denial/Modification/Cancellation***</th>
<th>Decision date</th>
<th>Decision time (Urgent requests)</th>
<th>Date notice mailed to Member</th>
<th>Date Provider Notified</th>
<th>Date Effactualated***</th>
</tr>
</thead>
</table>

* Priority of Referral: Urgent, Routine, Concurrent, Post-Service  
** Referral Disposition/Decision: Approved, Modified/Partial Approved, Denied, Cancelled  
*** Reason for denial/modification: Not medically necessary, not a covered benefit, carve out, out of network, etc.  
**** Date Effactualated: Date of effectuation/when was the authorization available in the claims system
## 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>
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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
Delegated IPA Delegation Oversight Audit Tool
Sub-Contracted Facility/Agency Services and Delegated Functions

This form is to be completed for all ancillary services where the 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.

### ANCILLARY SERVICE REVIEW

<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>
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<tr>
<td>2. Home Health Agency</td>
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<td>3. DME, Orthotics, Prosthesis</td>
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<td>4. Mental Health</td>
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<tr>
<td>5. Short-term Rehabilitation; P.T./O.T.</td>
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<td>6. Short-term Rehabilitation; Speech</td>
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<td>7. Hospice</td>
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<td>8. Infusion Center</td>
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<td>9. Renal Dialysis</td>
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<td>10. Family Planning</td>
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<td>11. Chiropractor</td>
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<td>12. Skilled Nursing Facilities</td>
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<td>13. Tertiary Care Facility</td>
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<td>15. Ultrasound MRI/CT</td>
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<td>16. Laboratory</td>
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<td>17. Surgi-Centers</td>
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<td>18. Urgent Care Centers</td>
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<td>19. Transportation (ambulance, ambulances)</td>
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Note: The Delegated Credentialing function is evaluated separately.
**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>
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</table>

**Second Opinion Reason Codes:**

**Reason 1:** The Member questions the reasonableness or necessity of recommended surgical procedures.

**Reason 2:** The Member questions a diagnosis or plan or care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition.

**Reason 3:** If clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/Specialist is unable to diagnose the condition and the Member requests an additional diagnosis.

**Reason 4:** If the treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment.

**Reason 5:** The Member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care.

**Legend:**  
MC = Medi-Cal
<table>
<thead>
<tr>
<th>IPA Contact Personnel</th>
<th>Phone</th>
<th>FAX</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPA Administrator</td>
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<tr>
<td>Medical Director</td>
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<tr>
<td>QM Chairperson</td>
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<tr>
<td>QM Contact/Title</td>
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<tr>
<td>UM Chairperson</td>
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<tr>
<td>UM Contact/Title</td>
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<tr>
<td>CM Contact/Title</td>
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<tr>
<td>Credentialing Contact/Title</td>
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<tr>
<td>Provider Relations Contact/Title</td>
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<tr>
<td>Compliance Contact/Title</td>
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<tr>
<td>Case Management Contact/Title</td>
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</tbody>
</table>

**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>
<tr>
<td>Total number of OB's:</td>
<td></td>
<td>Total number of Pediatricians:</td>
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</tbody>
</table>

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></th>
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<tbody>
<tr>
<td>Date of initial contract agreement:</td>
<td></td>
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<tr>
<td>City/ State/Country:</td>
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<td>Phone:</td>
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<td>Fax:</td>
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<tr>
<td>Delegated Functions:</td>
<td>Care Management</td>
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</tbody>
</table>
IPA California Children's Services (CCS) Review Tool

<table>
<thead>
<tr>
<th>File #:</th>
<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 panaled 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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</thead>
<tbody>
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<td>Total Score 0</td>
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</table>

Instructions: IEHP randomly selects 5 California Children’s Services (CCS) files from delegate’s 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 “N/A” if the information is not applicable. Weighted elements are (d), (g), and (h). Possible score is 100.
<table>
<thead>
<tr>
<th>File #1:</th>
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<tbody>
<tr>
<td>File #2:</td>
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<td>File #3:</td>
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<td>File #4:</td>
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<tr>
<td>File #5:</td>
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</tbody>
</table>

CCS Audit Tool
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>
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<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>
<tr>
<td>Delegate Name: IPA NAME</td>
<td>Date Submitted:</td>
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<td>------------------------</td>
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<tr>
<td>Report for Month of:</td>
<td>Submitted By:</td>
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<table>
<thead>
<tr>
<th>Member First Name</th>
<th>Member Last Name</th>
<th>IEHP Member ID #</th>
<th>DOB</th>
<th>*County</th>
<th>Date Identified</th>
<th>Date of Referral by IPA</th>
<th>CCS Eligible Diagnosis</th>
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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>
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<tbody>
<tr>
<td>Quality Management and Improvement</td>
<td>Semi Annual QM Work Plan - Evaluation</td>
<td>Bi-annually</td>
<td>Aug 15 and Feb 15</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Annual QM Work Plan - Initial Annual QM Program Description</td>
<td>Annually</td>
<td>Feb 28</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>
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<td>Monthly Denial Files</td>
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<td>Monthly Second Opinion Log</td>
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<td>Monthly Approval File Review</td>
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<td></td>
<td>Monthly Long-Term Care (LTC) Data Sheet</td>
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<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>
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</tr>
<tr>
<td></td>
<td>Annual UM Program Description</td>
<td>Annually</td>
<td>Feb 28</td>
<td></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>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly CM File Review</td>
<td></td>
<td></td>
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</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. | SFTP Server |

* 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>As required for precontractual and annual DOA</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>As Required</td>
<td>After Credentialing approval</td>
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<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>By the 15th of the following month, after Committee approval</td>
<td></td>
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</tr>
<tr>
<td>Claims</td>
<td>Monthly Claims Timeliness Report</td>
<td>Monthly</td>
<td>15th of each month</td>
<td>SFTP Server</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, July 31, October 31, January 31</td>
<td></td>
</tr>
<tr>
<td>Compliance</td>
<td>Annual Compliance Plan Program Description</td>
<td>Annually</td>
<td>As required for DOA</td>
<td>SFTP Server</td>
</tr>
<tr>
<td></td>
<td>Annual Fraud Waste and Abuse (FWA) Program Description</td>
<td></td>
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<td></td>
<td>Annual HIPAA Program Description</td>
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</tbody>
</table>
ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>IEHP Responsibilities</th>
<th>Delegate Responsibilities</th>
<th>Frequency of Reporting</th>
<th>Process for Evaluating Delegates Performance</th>
<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement Program Structure (NCQA QI1, Elements A, B, C and D)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members 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</td>
<td>Semi-Annual and Annual</td>
<td>IPA is not delegated for this function, however IEHP will review the IPA’s Policies and Procedures. Semi-Annually and Annually as part of the DOA</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
</tr>
</tbody>
</table>

* MUST PASS Element
| Quality Improvement Program Structure (NCQA QI1, Elements A, B, C and D (continued)) | guidelines for Policies and Procedures via IEHP Provider Manual. | linguistically diverse membership to:  
  a. Reduce health care disparities in clinical areas.  
  b. Improve cultural competency in materials and communications.  
  c. Improve network adequacy to meet the needs of underserved groups.  
  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. | 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_25D 3. |

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<thead>
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</thead>
<tbody>
<tr>
<td>Quality Improvement Program Structure (NCQA QI1, Elements A, B, C and D (continued))</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual</td>
<td>C. The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service. 3. Analysis and evaluation of the overall effectiveness of the QI program and its progress toward influencing networkwide safe clinical practices with a summary addressing: a. Adequacy of QI program resources. b. QI Committee structure. c. Practitioner participation and leadership</td>
<td>Semi-Annual and Annual</td>
<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. Additional review of committee meetings as part of the DOA.</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
</tr>
</tbody>
</table>
| Quality Improvement Program Structure (NCQA QI1, Elements A, B, C and D (continued)) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual | involvement in the QI program.  
  d. Need to restructure or change the QI program for the subsequent year.  
  D. QI Committee Responsibilities:  
  1. Recommends policy decisions  
  2. Analyzes and evaluates the results of QI activities  
  3. Ensures practitioner participation in the QI program through planning, design, implementation or review.  
  4. Identifies needed actions.  
  5. Ensures follow-up, as appropriate. | Semi-Annual and Annual | 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.  
  Additional review of committee meetings as part of the DOA. | See Corrective Action Plan (CAP) Requirements in MC_25D 3. |

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</thead>
<tbody>
<tr>
<td>Quality Improvement Program Operations (NCQA MED8 Element D)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The organization annually makes information about its QI program available to members.</td>
<td>Semi-Annual and Annual</td>
<td>IPA is not delegated for this function, however IEHP will review the IPA’s policies and procedures. Semi-Annually and Annually as part of the DOA</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
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</tbody>
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* 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>
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<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>[TR1] 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_25D 3.</td>
</tr>
</tbody>
</table>

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

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<thead>
<tr>
<th>Delegated Activity</th>
<th>IEHP Responsibilities</th>
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<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>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_25D 3.</td>
</tr>
</tbody>
</table>

* MUST PASS Element
### 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. 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.</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_25D 3.</td>
</tr>
</tbody>
</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. | e. The UM program’s role in the QI program, including how the organization collects UM information and uses it for QI activities.  
   f. The organization’s process for handling appeals and making appeal determinations.  
   2. Involvement of a designated senior-level physician in UM program implementation.  
   3. The program scope and process used to determine benefit coverage and medical necessity including:  
      a. How the organization develops and selects criteria  
      b. How the organization reviews, updates, and modifies criteria  

* MUST PASS Element
## 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>
|                     | benefit coverage and medical necessity. | 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. |                      |                                              |                                                               |

* MUST PASS Element
Clinical Criteria for UM Decisions (NCQA UM2 Elements A and C)

<table>
<thead>
<tr>
<th>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</th>
<th>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.</th>
<th>Monthly UM Logs</th>
<th>Annual audit of IPA policies and procedures, workplan, program, and committee meetings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has written UM decision-making criteria that are objective and based on medical evidence.</td>
<td>Monthly log and random denial file selection review.</td>
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<tr>
<td>2. Has written policies for applying the criteria based on individual needs; considers at least the following individual characteristics when applying criteria:</td>
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<tr>
<td>a. Age.</td>
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<tr>
<td>b. Comorbidities.</td>
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<td></td>
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<tr>
<td>c. Complications.</td>
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<tr>
<td>e. Psychosocial situation.</td>
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<tr>
<td>f. Home environment, when applicable.</td>
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</tbody>
</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.  
MONTHLY UM Logs  

### 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.
### ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>IEHP Responsibilities</th>
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</table>

consistency, if applicable.
| Communication Services (NCQA UM3 Element A) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | Members and practitioners can access staff to discuss UM issues.  
A. The IPA provides the following communication services for members and practitioners:  
1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.  
2. Staff can receive inbound communication regarding UM issues after normal business hours.  
   a. Telephone  
   b. Email  
   c. Fax  
3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.  
4. TDD/TTY services for Members who need them.  
5. The IPA refers Members to IEHP who need language assistance for | N/A | Annual audit of IPA policies and procedures and Annual Appointment Availability and Access Study Survey | See Corrective Action Plan (CAP) Requirements in MC_25D 3. |

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

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<th>Delegated Activity</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Members to discuss UM issues.</td>
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</tbody>
</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. | Monthly UM Logs | Annual audit of IPA policies and procedures, workplan, program, committee meetings and Ownership and Control documentation.  

* MUST PASS Element
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 for medical necessity determinations.
# ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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</thead>
<tbody>
<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>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
</tr>
</tbody>
</table>

Appropriate Professionals (NCQA UM4 Elements A, B, C* and F, MED9 Element D (continued))

IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.

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.

Monthly UM Logs

[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.]

Annual audit of IPA policies and procedures, workplan, program, committee meetings and Ownership and Control documentation.

Monthly log and random denial and approval file selection review.

* MUST PASS Element

Revised Date: 01/01/2020
Page 21 of 64
| 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.  
### ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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<tr>
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<th>IEHP Responsibilities</th>
<th>Delegate Responsibilities</th>
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<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
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<tbody>
<tr>
<td></td>
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<td>of the decision to Practitioners and Members within fourteen (14) calendar days of the request.</td>
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<td>4. Post-Service Decisions: The IPA gives electronic or written notification of the decision to Practitioners and members and written notification to the Member within thirty (30) calendar days of the request.</td>
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<tbody>
<tr>
<td>Clinical Information (NCQA UM6 Element A)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA uses all information relevant to a member’s care when it makes coverage decisions A. There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.</td>
<td>Monthly</td>
<td>Annual audit of IPA policies and procedures, workplan, program, and committee meetings. Monthly log and random denial and approval file selection review.</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
</tr>
<tr>
<td>Denial Notices (NCQA UM7 Elements A, B* and C*)</td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via</td>
<td>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.</td>
<td>Monthly</td>
<td>Annual audit of IPA policies and procedures, workplan, program, and committee meetings. Monthly log and random denial file review.</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
</tr>
</tbody>
</table>
| **IEHP Provider Manual.** | **A.** The IPA gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer.  
**B.** The IPA’s written notification of nonbehavioral healthcare denials, provided to Members and their treating Practitioners, contains the following information*:  
1. The specific reasons for the denial, in easily understandable language.  
2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision in based.  
3. A statement that Members can obtain a copy of the actual benefit provision, guideline, protocol or other similar | **Monthly** | **Annual audit of IPA policies and procedures, workplan, program, and committee meetings.**  
**Monthly log and random denial file review.**  
**Annual audit of IPA policies and procedures, workplan, program, and committee meetings.**  
**Monthly log and random denial file review.** | **See Corrective Action Plan (CAP) Requirements in MC_25D 3.** |

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<tbody>
<tr>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>criterion on which the denial decision was based, upon request.</td>
<td></td>
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</tr>
<tr>
<td>C. The IPA’s written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information*:</td>
<td>1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.</td>
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</tr>
<tr>
<td>2. An explanation of the appeal process, including Members’ rights to representation and appeal time frames.</td>
<td>a. Includes a statement that members may be represented by anyone they choose, including an attorney.</td>
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</tbody>
</table>
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
### 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>
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<tbody>
<tr>
<td></td>
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<td>review can occur concurrently with the internal appeals process for urgent care.</td>
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<thead>
<tr>
<th>UM System Controls (NCQA UM12 Element A*)</th>
<th>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</th>
<th>The IPA has policies and procedures describing its system controls specific to UM denial notification dates that*:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Define the date of receipt consistent with NCQA requirements.</td>
<td>1. Define the date of receipt consistent with NCQA requirements.</td>
</tr>
<tr>
<td></td>
<td>2. Define the date of written notification consistent with NCQA requirements.</td>
<td>2. Define the date of written notification consistent with NCQA requirements.</td>
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<tr>
<td></td>
<td>3. Describe the process for recording dates in systems.</td>
<td>3. Describe the process for recording dates in systems.</td>
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<tr>
<td></td>
<td>4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.</td>
<td>4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.</td>
</tr>
<tr>
<td></td>
<td>5. Specify how the system tracks modified dates.</td>
<td>5. Specify how the system tracks modified dates.</td>
</tr>
<tr>
<td></td>
<td>6. Describe system security controls in place to protect data from unauthorized modification.</td>
<td>6. Describe system security controls in place to protect data from unauthorized modification.</td>
</tr>
</tbody>
</table>

Annually, at minimum

Annual audit of Delegate’s policies and procedures


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

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<tr>
<td>7.</td>
<td></td>
<td>Describe how the organization audits the processes and procedures in factors 1-6.</td>
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</tbody>
</table>
| **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 review of second opinion logs and annual audit of IPA policies and procedures | See Corrective Action Plan (CAP) Requirements in MC_25D 3. |
## ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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</tr>
</thead>
</table>
| CM 1: Care Management | IEHP will provide IPAs with guidelines for Policies and Procedures, and guidelines for Care Management Training via IEHP Provider Manual. | IPA’s must submit a monthly care management log that includes the following:  
1. Member name (First, Last)  
2. Member ID number  
3. Date of Birth  
4. Referral Source  
5. Reason for referral to CM  
6. Case Status (Open or Closed)  
7. Case Open Date (or Ref to Waiver, CCS, IRC, etc.)  
8. Individualized Care Plan Documented  
9. Diagnosis (ICD-10 description)  
10. Problems/Issues Identified  
11. Goals Identified  
12. Interventions Documented  
13. Care Plan Sent to PCP Documented  
14. Communication w/Member Documented  
15. Case Closure Date  
16. Reason for Closure/Case Outcome Documented  
A. Members who remain in Care Management for consecutive months must have an activity update each month  
B. Members who are stratified as Complex (CCM), must be referred to IEHP’s Care Management team.  
C. Complex Case Management (CCM) referrals must include:  
1. IPA Care Plan  
2. IPA Interventions  
3. IPA Case Documentation | Monthly | Annual audit of IPA policies and procedures.  
<table>
<thead>
<tr>
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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. County 3. Date Identified 4. Date of referral 5. CCS approved diagnosis 6. State file (CCS #) 7. PCP and/or Specialist 8. CCS Status</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_25D 3.</td>
</tr>
</tbody>
</table>

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## ATTACHMENT VI: DELINEATION OF CREDENTIALING and REREDENTIALING

<table>
<thead>
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</thead>
<tbody>
<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>Delegate has policies and procedures that specify: 1. The types of practitioners it credentials and recredentials. 2. The verification sources it uses. 3. The criteria for credentialing and recredentialing. 4. The process for making credentialing and recredentialing decisions. 5. The process for managing credentialing files that meet the organization’s established criteria. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. 7. The process for notifying practitioners if information obtained during the organization’s credentialing process varies substantially from the information they provided to the organization.</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_25D 3.</td>
</tr>
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</thead>
</table>
| Practitioner Credentialing Guidelines (NCQA CR1 Element A (continued))              | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | 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. | Annually, at minimum | Annual audit of Delegate’s policies and procedures | See Corrective Action Plan (CAP) Requirements in MC_25D 3. |

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</thead>
<tbody>
<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>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>Monthly, at minimum</td>
<td>Annual audit of Delegate’s policies and procedures</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
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<tbody>
<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>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>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>
<td></td>
</tr>
<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_25D 3.</td>
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</tbody>
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## ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECredentialing

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<tbody>
<tr>
<td></td>
<td></td>
<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></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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## ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialING

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<tbody>
<tr>
<td>CMS/DHCS</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate’s recredentialing policies and procedures require information from quality improvement activities and member complaints in the recredentialing decision making process.</td>
<td>Annually, at minimum</td>
<td>Audit of Delegate’s policies and procedures</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
</tr>
</tbody>
</table>

(Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD 02-03 and Exhibit A, Attachment 4 of Plan Contract)
<table>
<thead>
<tr>
<th>Credentialing Committee (NCQA CR2 Element A)</th>
<th>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</th>
<th>Delegate’s Credentialing Committee:</th>
<th>Annually, at minimum</th>
<th>Audit of Delegate’s policies and procedures and Credentialing Committee meeting minutes</th>
<th>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Uses participating practitioners to provide advice and expertise for credentialing decisions.</td>
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<td></td>
<td>2. Reviews credentials for practitioners who do not meet established thresholds.</td>
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<tr>
<td></td>
<td></td>
<td>a. Reviews the credentials of practitioners who do not meet the organization’s criteria for participation in the network.</td>
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<td></td>
<td>b. Gives thoughtful consideration to credentialing information.</td>
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<td></td>
<td>c. Documents discussions about credentialing in meeting minutes.</td>
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<td>3. Ensures that files that meet established criteria are reviewed and approved by a medical director or designated physician.</td>
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</tr>
<tr>
<td>Verification of Credentials (NCQA CR3 Element A*)</td>
<td>IEHP will provide Delegate with</td>
<td>A. Delegate verifies that the following are within the prescribed time limits*:</td>
<td>Annually, at minimum</td>
<td>IEHP reviews verification of</td>
<td>See Corrective Action Plan (CAP)</td>
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## ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialing

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<tbody>
<tr>
<td></td>
<td>guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>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.</td>
<td>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></td>
<td>Requirements in MC_25D 3.</td>
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</table>
### ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialing

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</thead>
</table>
| Sanction Information (NCQA CR3 Element B*), (DHCS), (CMS) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | 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. | 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_25D 3. |

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## ATTACHMENT VI: DELINEATION OF CREDENTIALED AND RE-CREDENTIALED

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</table>
| Credentialing Application (NCQA CR3 Element C*)        | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | C. Delegate verifies that applications for credentialing include the following*:  
1. Reasons for inability to perform the essential functions of the position.  
2. Lack of present illegal drug use.  
3. History of loss of license and felony convictions.  
4. History of loss or limitations of privileges or disciplinary actions.  
5. Current malpractice insurance coverage.  
6. Current and signed attestation confirming the correctness and completeness of the application. | Annually, at minimum | 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 | See Corrective Action Plan (CAP) Requirements in MC_25D 3. |
## ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECredentialing

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</thead>
<tbody>
<tr>
<td>Practitioner must have clinical privileges in good standing.</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</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_25D 3.</td>
</tr>
<tr>
<td>CMS (Medicare Managed Care Manual, Chapter 6 § 60.3), DMHC (DMHC TAG 6/09/14), DHCS (All Plan Letter (APL) 17-019)</td>
<td>(Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD Policy Letter 02-03 and DMHC TAG 10/11)</td>
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<tr>
<td>CMS/DHCS Review of Performance Information</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_25D 3.</td>
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### ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialing

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<tbody>
<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><strong>A.</strong> 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_25D 3.</td>
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## ATTACHMENT VI: Delineation of Credentialing and Recredentialing

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<tbody>
<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>
</tr>
<tr>
<td></td>
<td>1. Accessibility equipment.</td>
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<td></td>
<td>2. Physical accessibility.</td>
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<td>3. Physical appearance.</td>
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<td></td>
<td>4. Adequacy of waiting and examining room space.</td>
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<td></td>
<td>5. Adequacy of medical/treatment medical record keeping.</td>
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* MUST PASS Element
### Site Visits and Ongoing Monitoring (NCQA MED3 Element B)

IEHP implements appropriate interventions by:

1. Continually monitoring member complaints for all practitioner sites.
2. Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met.
3. Instituting actions to improve offices that do not meet thresholds.
4. Evaluating the effectiveness of the actions at least every six months, until deficient offices meet the thresholds.
5. Documenting follow-up visits for offices that had subsequent deficiencies.

Delegate is responsible for ensuring the providers are compliant with IEHP Facility Site Review and Medical Record Audits.

| Not Applicable | Not Applicable | Not Applicable |

* MUST PASS Element
### ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialing

<table>
<thead>
<tr>
<th>Delegated Activity</th>
<th>IEHP Responsibilities</th>
<th>Delegate Responsibilities</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ongoing Monitoring and Interventions (NCQA CR5 Element A)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality by:</td>
<td>Annually, at minimum</td>
<td>IEHP reviews the organization’s policies and procedures, monitoring reports, and documentation of interventions</td>
<td>Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan’s Credentialing Manager, with the delegate’s plan of action for the identified provider and date it was reviewed by their Credentialing/Peer Review Committee. See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
</tr>
</tbody>
</table>

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.

* MUST PASS Element
| DHCS– Monitoring Medi-Cal Suspended and Ineligible Provider Reports | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | 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) | Annually, at minimum | IEHP reviews the organization’s policies and procedures, monitoring reports, and documentation of interventions  
Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan’s Credentialing Manager, with the delegate’s plan of action for the identified provider and date the provider was reviewed by their Credentialing/Peer Review Committee. | See Corrective Action Plan (CAP) Requirements in MC_25D 3. |
### ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialing

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</tr>
</thead>
<tbody>
<tr>
<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.</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_25D 3.</td>
</tr>
<tr>
<td>Actions Against Practitioners (NCQA CR6 Element A)</td>
<td></td>
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</tr>
</tbody>
</table>

A. Delegate has policies and procedures for:

1. The range of actions available to the organization.
2. Making the appeal process known to practitioners.
## ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREREDENTIALING

<table>
<thead>
<tr>
<th>Delegated Activity</th>
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<th>Delegate Responsibilities</th>
<th>Frequency of Reporting</th>
<th>Process for Evaluating Delegates Performance</th>
<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and Approval of Providers (NCQA CR7 Element A)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>Delegate’s policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the provider is not accredited.</td>
<td>Annually, at minimum</td>
<td>IEHP reviews Delegate’s policies and procedures</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</td>
</tr>
</tbody>
</table>
## ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECredentialING

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<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Delegate maintains a checklist, spreadsheet or other record that it assessed providers against the requirements.</td>
<td></td>
<td></td>
<td></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_25D 3.</td>
</tr>
</tbody>
</table>
Written Delegation Agreement (NCQA CR8 Element A)

| IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | Delegate remains responsible for credentialing and recredentialing its practitioners, even if its delegates all or part of these activities. The written delegation agreement: 1. Is mutually agreed upon. 2. Describes the delegated activities and the responsibilities of IEHP and the 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. 6. Describes the remedies available to IEHP if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. | Annually, at minimum | IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates. | See Corrective Action Plan (CAP) Requirements in MC_25D 3. |

* MUST PASS Element
### ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialing

<table>
<thead>
<tr>
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<th>Corrective Actions if Delegate Fails to Meet Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>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_25D 3</td>
</tr>
<tr>
<td>Predelegation 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_25D 3</td>
</tr>
</tbody>
</table>
## ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialing

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</tr>
</thead>
<tbody>
<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_25D 3.</td>
</tr>
</tbody>
</table>

* MUST PASS Element
## ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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</tr>
</thead>
<tbody>
<tr>
<td>Opportunities for Improvement</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_25D 3.</td>
</tr>
</tbody>
</table>
## ATTACHMENT VI: DELINEATION OF CREDENTIALING and REcredentialing

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<tbody>
<tr>
<td>Privacy and Confidentiality (NCQA MED4 Element A)</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The organization adopts written policies and procedures that address: 1. Information included in notification of privacy practices. 2. Access to PHI. 3. The process for members to request restrictions on use and disclosure of PHI. 4. The process for members to request amendments to PHI. 5. The process for members to request an accounting of disclosures of PHI. 6. Internal protection of oral, written and electronic information across the organization.</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_25D3.</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_25D3.</td>
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</tr>
<tr>
<td>Delegated Activity</td>
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<tr>
<td>Evidence of Implementation</td>
<td>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>On an annual basis, delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS, specialist according to California State Regulations</td>
<td>Annually, at minimum</td>
<td>IEHP reviews evidence that the organization identified or reconfirmed the appropriate qualified physicians</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</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_25D 3.</td>
</tr>
</tbody>
</table>
## ATTACHMENT VII: DELINEATION OF ENCOUNTER DATA

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>ENC 1: Encounter Data Reporting</td>
<td>The Delegate is required by DMHC, CMS and DHCS to submit Encounter Data for the effective management of IEHP health care delivery system. A. Data must be submitted using the HIPAA compliant 5010 837 file format. B. The Encounter Data must be complete and accurate. C. Submit complete Encounter data within ninety (90) days after each month of service.</td>
<td>Submit Encounter Data within ninety (90) days after each month of service</td>
<td>Initial Onsite Assessment Monthly assessment of encounter data submission rates</td>
<td>See Corrective Action Plan (CAP) Requirements in MC_25D 3. IEHP may withhold no more than one percent (1%) of the monthly Capitation Payment for failure to submit complete and accurate Encounter Data within ninety (90) days after each month of service.</td>
<td></td>
</tr>
</tbody>
</table>
## ATTACHMENT VIII: DELINEATION OF CLAIMS ADJUDICATION

<table>
<thead>
<tr>
<th>Delegated Activity</th>
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</table>
| AB1455: Claims Payment Performance and Dispute Resolution Mechanism | 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. | The Delegate must accurately process claims and resolve disputes within contracted and regulatory timeframes as established by IEHP and outlined in the IEHP Audit Guide. | • Provide a copy of the Monthly Timeliness Report (MTR) by the 15th of each month  
• 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  
• Provide a copy of the Annual Claims Payment and Provider Dispute Mechanism Report (Annual Report) by November 30th of each year | Please refer to MC_20G. | See Corrective Action Plan (CAP) Requirements in MC_20D. |

* MUST PASS Element
### ATTACHMENT IX: DELINEATION OF FRAUD, WASTE, AND ABUSE / HIPAA

<table>
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</table>
| Compliance Program (CMS MA Manual Ch. 21) | 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;  
B. Compliance Officer, Compliance Committee and High-Level Oversight;  
C. Effective Training and Education;  
D. Effective Lines of Communication;  
E. Well-Publicized Disciplinary Standards;  

* MUST PASS Element
### ATTACHMENT IX: DELINEATION OF FRAUD, WASTE, AND ABUSE / HIPAA

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<tbody>
<tr>
<td>Fraud, Waste and Abuse (42 CFR 423.504, Part D Manual Ch. 9, CMS MA Manual Ch. 11 Section 20)</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</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_25D 3.</td>
</tr>
</tbody>
</table>

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/or IEHP.
### ATTACHMENT IX: DELINEATION OF FRAUD, WASTE, AND ABUSE / HIPAA

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<tbody>
<tr>
<td><strong>HIPAA/ Title 45 CFR; HITECH Act ARRA COMIA</strong></td>
<td>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</td>
<td>The IPA maintains policies and procedures required by HIPAA and ARRA.</td>
<td>Annual DOA</td>
<td>Initial Onsite Assessment</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>B. Member access to PHI and amendment/restriction process</td>
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<td></td>
<td>C. (CMS) Auditing/Monitoring of Business Associates, First Tier, Downstream and Related Entities</td>
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<tr>
<td></td>
<td></td>
<td>D. Security of Facilities and Information Systems</td>
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<td>E. Record Retention</td>
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<td>F. Non-retaliation for exercising rights provided by the Privacy Rule.</td>
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<td></td>
<td>G. Reporting incidents of HIPAA non-compliance to IEHP</td>
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<tr>
<td></td>
<td></td>
<td>A privacy officer has been designated by the IPA.</td>
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<td></td>
<td></td>
<td>There are appropriate administrative, technical and physical safeguards to prevent intentional or unintentional use or disclosure of PHI.</td>
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</tbody>
</table>

* MUST PASS Element
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.

<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>All sections of the DOA tool documented with road mapping 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</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
<td>Program, Plan and Description</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Quality Improvement (QI) 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</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>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 (NCQA Certified Organizations)**

<table>
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<td>Program, Plan and Description</td>
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<td>✔️</td>
<td>Annual Work Plan</td>
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<tr>
<td>✔️</td>
<td>Annual Program Evaluation</td>
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<tr>
<td>✔️</td>
<td>Policies and Procedures</td>
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<tr>
<td>✔️</td>
<td>Committee meeting minutes from last twelve (12) months for:</td>
<td></td>
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<tr>
<td>✔️</td>
<td>- Board of Directors</td>
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<tr>
<td>✔️</td>
<td>- Utilization Management Committee</td>
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<tr>
<td>✔️</td>
<td>Subcommittee Meeting Minutes</td>
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</tr>
<tr>
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**Inland Empire Health Plan**  
**Delegation Oversight Audit Tool 2020**  
**Audit Preparation Instructions**  
**Medi-Cal (NCQA Certified Organizations)**

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| | | - 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. |

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<tr>
<td>✓</td>
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<td>NCQA Certification to show accredited elements</td>
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### Inland Empire Health Plan

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<td>Policy and File review will include, but not limited to, review for the following items:</td>
</tr>
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<td></td>
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</tr>
<tr>
<td></td>
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<td>- Medicare Opt-Out Review</td>
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<td>- Medi-Cal Suspended &amp; Ineligible</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>- Delegation Agreements for all Sub-Delegation Arrangements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- HIV/AIDS Identification Process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- DEA Verifications within 180 calendar days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Work History verification within 180 calendar days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Hospital Admitting Privileges</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>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>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>Delegation Agreements with any sub-delegated provider</td>
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<tr>
<td>✓</td>
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<td>HIV/AIDS Annual Survey</td>
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<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>
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### Inland Empire Health Plan
#### Delegation Oversight Audit Tool 2020
##### Audit Preparation Instructions
###### Medi-Cal (NCQA Certified Organizations)

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<tr>
<th></th>
<th><strong>Annual Risk Assessment</strong></th>
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<tbody>
<tr>
<td></td>
<td><strong>Grievance and Appeals Identification Training</strong></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>
</tr>
<tr>
<td></td>
<td><strong>Employee Universe:</strong> 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. <em>Universe_Employees</em> of the Compliance tool for required template.</td>
</tr>
<tr>
<td></td>
<td><strong>Reported Issues Universe:</strong> 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. <strong>Do not include privacy and security incidents as those have been requested in a different universe.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Privacy Incident Universe:</strong> 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. <em>Universe_Privacy Incidents</em> of the Compliance tool for required template.</td>
</tr>
<tr>
<td></td>
<td><strong>Audit &amp; Monitoring Universe:</strong> 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. <em>Universe_A&amp;M Activities</em> of the Compliance tool for required template.</td>
</tr>
</tbody>
</table>
### Inland Empire Health Plan
**Delegation Oversight Audit Tool 2020**
**Audit Preparation Instructions**
**Medi-Cal (NCQA Certified Organizations)**

<table>
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<tr>
<th><strong>✓</strong></th>
<th><strong>Downstream Entity/Subcontractors Universe:</strong> 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>
</table>

| **✓** | **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:**

- a. New Hire Screening of List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), and Medi-Cal Suspended & Ineligible List (S&I)
- b. Monthly Screening performed of LEIE, SAM, and Medi-Cal S&I for a sample of three consecutive months.
- c. New hire confidentiality statement upon hire or start
- d. Annual confidentiality statement
- e. New hire Privacy & Security training upon hire or start
- f. Annual Privacy & Security training
- g. New Hire General Compliance training upon hire or start
- h. Annual General Compliance training
- i. New Hire FWA Training upon hire or start
- j. Annual FWA training
- k. New Hire distribution of Standards of Conduct upon hire or start
- l. Annual distribution of Standards of Conduct. |

| **✓** | **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
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### Medi-Cal (NCQA Certified Organizations)

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<thead>
<tr>
<th>DESKTOP</th>
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<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>

A sample of five (5) FWA investigations will be selected from the Reported Issues Universe. Evidence of the following will be required:

- a. Suspected FWA was promptly investigated
- b. Suspected FWA was reported to IEHP with 10 days of becoming aware; and
- c. Suspected FWA was reported to Regulatory Agencies within required timeframes.

A sample of five (5) privacy and security investigations will be selected from the Privacy and Security Incidents Universe. Evidence of the following will be required:

- a. Notice of Privacy Practices was sent to the Member;
- b. Date incident was reported to the Privacy /Compliance Office/Officer
- c. Completion of a Risk Assessment for issue/investigation;
- d. Notification was sent to IEHP within HIPAA BAA Requirements of discovery of a suspected breach; and
- e. Corrective actions taken, if applicable.

A sample of five (5) FDR/Subcontractors will be selected from the FDR_Subcontractor 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; and

Evidence of Offshore Contracting Oversight.
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>
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<tr>
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<th>DELEGATION OVERSIGHT</th>
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<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 <em>road mapping</em> 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>
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<td>Ownership and Control Documentation (submitted annually)</td>
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<th>QUALITY MANAGEMENT (QM)</th>
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<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></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>Annual Work Plan</td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>Annual Program Evaluation</td>
</tr>
<tr>
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<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>
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<td>Semi-Annual Reports for Health Plan for the last twelve (12) months;</td>
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<tr>
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<td>Standards of Medical Care Access Policy and Procedure</td>
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<td>- Utilization Management Committee</td>
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<td>Subcommittee Meeting Minutes (If unable to submit meeting minutes please let us know and IEHP will go onsite to review)</td>
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**DESKTOP** | **ON-SITE** | **CREDENTIALING**  
--- | --- | ---  
✓ | | Recredentialing files selected by the IEHP auditor, will be provided and requested to be available in the order they are listed  
✓ | | 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.  
✓ | | 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  
**DESKTOP** | **ON-SITE** | **COMPLIANCE (Look back period of 07/2019 to 06/2020)**  
--- | --- | ---  
✓ | | Compliance policies and procedures  
✓ | | Fraud, Waste and Abuse policies and procedures  
✓ | | HIPAA Privacy and Security policies and procedures  
✓ | | Sanction/Exclusion Screening Process policies and procedures  
✓ | | Standards of Conduct
### Delegation Oversight Audit Tool 2020
**Audit Preparation Instructions**

#### Medi-Cal

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<tr>
<th>DESKTOP</th>
<th>ON-SITE</th>
<th>COMPLIANCE (Look back period of 07/2019 to 06/2020)</th>
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</thead>
<tbody>
<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>
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<tr>
<td>✓</td>
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<td>Annual Audit Plan</td>
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<td>✓</td>
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<td>Annual Risk Assessment</td>
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<td>✓</td>
<td></td>
<td>Grievance and Appeals Identification Training</td>
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<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>
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<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. <strong>Do not include privacy and security incidents as those have been requested in a different universe.</strong></td>
</tr>
<tr>
<td>✓</td>
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<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...</td>
</tr>
</tbody>
</table>
### Audit Preparation Instructions

#### Medi-Cal

**DESKTOP** | **ON-SITE** | **COMPLIANCE (Look back period of 07/2019 to 06/2020)**
---|---|---
| | | template.

- **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. Refer to tab *D. Universe_A&M Activities* of the Compliance tool for required template.

- **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.

- A sample of ten (10) employees will be selected from the Employee Universe by IEHP for which evidence of the following will be requested:
  - **New Hires:**
    1. 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)
    2. New hire confidentiality statement upon hire or start
    3. New hire Compliance, FWA, and Privacy & Security training upon hire or start
    4. Standards/Code of Conduct distribution
  - **Established Employees:**
    1. Monthly Screening performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of three consecutive months.
  - **New hire Confidentiality Statement**
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<th>DESKTOP</th>
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<th>COMPLIANCE (Look back period of 07/2019 to 06/2020)</th>
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<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>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>
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<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>
<td></td>
<td></td>
<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>
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<td></td>
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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>
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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>
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<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>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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</tbody>
</table>
Inland Empire Health Plan  
Delegation Oversight Audit Tool 2020  
Audit Preparation Instructions  
Medi-Cal

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<th>COMPLIANCE (Look back period of 07/2019 to 06/2020)</th>
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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>d) Evidence of Offshore Contracting Oversight.</td>
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<th>PROVIDER DIRECTORY</th>
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<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>
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<td>IPA Deliverable</td>
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<td>CY 2020 Reporting Period</td>
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<td>IPA Oversight-</td>
<td>Monthly Referral</td>
<td>1/1-1/31</td>
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<td>IPA Oversight-</td>
<td>Monthly Second</td>
<td>2/1-2/28</td>
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<td>IPA Oversight-</td>
<td>Monthly Denial Files</td>
<td>3/1-3/31</td>
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<tr>
<td>Care Management Log</td>
<td>Monthly</td>
<td>4/1-4/30</td>
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</tbody>
</table>

IPA Medi-Cal Calendar Year Reporting Period 2020

**Guidelines for Care Management**

**IPA Oversight-**

- Monthly Referral Universe
- Monthly Second Opinion Log
- Monthly Denial Files

**Regulatory Measure(s)**

- IPA Oversight / Year/ Month
- FDR Oversight
## Medi-Cal Provider Reporting Requirements Schedule

### IPA Medi-Cal Calendar Year Reporting Period 2020

<table>
<thead>
<tr>
<th>IPA Deliverable</th>
<th>Report Frequency</th>
<th>CY 2020 Reporting Period</th>
<th>Date Due to IEHP</th>
<th>Policy Number(s)</th>
<th>Department(s)</th>
<th>File Naming Convention</th>
<th>SFTP Folder</th>
<th>Regulatory Measure(s)</th>
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<td>California Children Services (CCS) Log</td>
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<td>February 15, 2020</td>
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# Medi-Cal Provider Reporting Requirements Schedule

## IPA Medi-Cal Calendar Year Reporting Period 2020

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</table>
### Medi-Cal Provider Reporting Requirements Schedule

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<th>IPA Deliverable</th>
<th>Report Frequency</th>
<th>CY 2020 Reporting Period</th>
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<th>File Naming Convention</th>
<th>SFTP Folder</th>
<th>Regulatory Measure(s)</th>
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<td>Monthly</td>
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## Medi-Cal Provider Reporting Requirements Schedule

### IPA Medi-Cal Calendar Year Reporting Period 2020

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<th>CY 2020 Reporting Period</th>
<th>Date Due to IEHP</th>
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<th>Department(s)</th>
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<td>MC 23A Program Description</td>
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## Medi-Cal Provider Reporting Requirements Schedule

**IPA Medi-Cal Calendar Year Reporting Period 2020**

<table>
<thead>
<tr>
<th>IPA Deliverable</th>
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<td>MC 23C Fraud Waste and Abuse</td>
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<td>Code of Federal Regulations, Title 42, Part 422 and 423; Code of Federal Regulations, Title 42, §438.608 and §455.2; Federal False Claims Act, US Code, Title 31; Health &amp; Safety Code §1348; Welfare &amp; Institutions Code, §14043.1; CMS 2007 MA-PDP Contract H5640, Attachment A</td>
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<td>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>MC 05B - IEHP Medi-Cal Provider Policy and Procedure Manual and Attachment 13 IPA Medi-Cal Delegation Agreement</td>
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<td>Email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a></td>
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