
18. PROVIDER NETWORK

- A. Primary Care Physician**
 - 1. IPA and Hospital Affiliations**
-

APPLIES TO:

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

POLICY:

- A. Primary Care Physicians (PCPs) may have a maximum of two (2) unique IEHP DualChoice Provider IPA/Hospital Affiliations, except in rural areas where PCP coverage is limited due to geographic location. PCPs may have a maximum of three (3) unique IEHP DualChoice Provider IPA/Hospital Affiliations at the discretion of IEHP.

PROCEDURES:

- A. A PCP must spend a minimum of sixteen (16) hours per week at each participating location with the exception of Residency Teaching Clinics and Rural Clinics who may be exempt from the minimum sixteen (16) hour on site requirement for PCPs as outlined in Policy 6D, “Residency Teaching Clinics” and Policy 6E, “Rural Clinics.”
- B. Attending physicians receiving Membership assignment as a PCP at a residency teaching clinic or at a rural clinic must be on-site a minimum of eight (8) hours per week.
- C. A PCP is allowed a maximum of two (2) unique Provider IPA/Hospital Affiliations under the following circumstances:
 - 1. The PCP has two (2) offices within IEHP’s service area and spends a minimum of sixteen (16) hours per week at each site.
 - 2. The PCP has one (1) office but has an admitter or covering hospitalist agreement at two (2) IEHP contracted Hospitals that are both located within the PCP’s geography, as deemed by IEHP.
 - 3. The above is allowed as long as the PCP is contracted with an IPA that meets the criteria specified in Policies 18F, “Specialty Panel” and 18H, “Hospital Affiliations.”
- D. Given the above criteria, a PCP may join a maximum of two (2) different IPAs for IEHP DualChoice and/or may admit Members to a maximum of two (2) IEHP contracted Hospitals to comply with the two (2) Provider IPA/Hospital Affiliations rule, with the exception of PCPs with rural clinics which are allowed three (3) IEHP DualChoice Provider IPA/Hospital Affiliations as long as they fit the criteria as outlined in Policy 6E, “Rural Clinics.”

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- E. A PCP may not transfer their assigned Membership with one (1) Provider IPA/Hospital Affiliation to another Provider IPA/Hospital Affiliation unless a written notification has been submitted to IEHP specifying that they will no longer continue with one of their Provider affiliations and that Provider Affiliation will be terminated. IEHP does not allow Providers to transfer Members back and forth between their existing Provider IPA/Hospital Affiliations due to the undue burden it places on Members being transferred from one IPA or hospital relationship to another. If a PCP has decided not to continue a relationship with an IPA or hospital, that Provider Affiliation must be terminated in order for Members to be transferred to the PCP's other or new Provider Affiliation.
- F. IEHP will allow PCPs to have two (2) IPA affiliations at one (1) site linked to one (1) hospital as long as that IPA meets the criteria specified in Policies 18F, "Specialty Panel" and 18H, "Hospital Affiliations."
- G. IEHP verifies IPA and Hospital affiliation privileges and geographic distribution as stated in Policy 5D, "Hospital Privileges."

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18. PROVIDER NETWORK

A. Primary Care Physician 2. Enrollment Capacity

APPLIES TO:

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

POLICY:

- A. IEHP follows Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) regulatory requirements for network adequacy of our Provider network to assure the required one full-time equivalent (FTE) Primary Care Physician (PCP) per two thousand (2,000) Member ratio. This ratio is calculated on the Plan’s PCP network as a whole and is not applied to an individual PCP.
- B. IEHP’s general standards for enrollment levels to ensure that our overall contracted network satisfies regulatory requirements is as follows:
- | | |
|----------------------------------|-----------|
| 1. Primary Care Physicians (PCP) | 1 : 2,000 |
| 2. Physician Extenders | 1 : 1,000 |
| 3. Total Physicians | 1 : 1,200 |
- C. IEHP also requires that FTE physician supervisor to non-physician medical practitioners (Physician Extenders) ratios do not exceed the following:
- | | |
|---|-------|
| 1. Nurse Practitioners (NP) | 1 : 4 |
| 2. Certified Nurse Midwives (CNM) | 1 : 3 |
| 3. Physician Assistants (PA) | 1 : 4 |
| 4. Maximum of four (4) Non-Physician Medical Practitioners in any combination that does not include more than three (3) midwives. | |
- D. IEHP has adopted the above FTE ratios for all Practitioners serving all Members.
- E. PCPs are defined as Family Practice, Internal Medicine, Pediatrics, General Practice, Preventive Medicine, or OB/GYN Physicians.
- F. Non-physician medical Practitioners, also known as physician extenders, are defined as NPs, CNMs and PAs.
- G. In accordance with Title VI of the Civil Rights Act and Title 42, Code of Federal Regulations, Section 442.110, all Members must receive access to all covered services without restriction based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

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- H. IEHP requires Providers to provide covered services to all Members assigned to them at an appropriate facility without imposing restrictions as listed in Policy G.
- I. IEHP ensures the participation of a broad range of safety net and traditional-Providers, within its service areas by maintaining contracts with and active outreach to these Providers.
- J. IEHP will include any safety net or traditional Provider that meets credentialing and/or quality standards, and is willing to provide services under the same terms and conditions that the plan requires for similar Providers.
- K. PCPs have a general standard for an enrollment capacity of two thousand (2,000) Members to ensure access standards are met. All PCPs must be willing to accept a minimum enrollment requirement, unless otherwise approved. The general standard for PCPs increases if there is associated mid-level Providers as noted above.
- L. PCPs that reach the general standard enrollment capacity will be monitored by the Provider Services department for access related issues on a monthly basis to assess if the PCP's enrollment panels should be closed or limited to new enrollment to ensure compliance with access standards.
- M. PCPs should be located within ten (10) miles or thirty (30) minutes drive time of a Member's residence, when applicable. IEHP may approve exceptions to this standard in certain circumstances, including but not limited to PCPs located in areas that are underserved or where no medical delivery system exists.

PROCEDURES:

- A. Each PCP is listed in the IEHP data system as having a general standard for an enrollment capacity of two thousand (2,000) Members. If a PCP has two (2) IEHP Provider Affiliation Numbers, each Provider Affiliation Number is assigned an enrollment capacity that when combined meets the general recommended enrollment capacity.
- B. For each physician extender supervised by a PCP at the same location, the above recommended enrollment capacity can be increased by one thousand (1,000) Members per physician extender.
 - 1. IEHP must credential the physician extender which includes a copy of the Supervisory certificate and Delegation of Services Agreement between the physician and physician extender, if applicable, in order to increase the PCP's enrollment capacity.
 - 2. PCPs must meet all applicable statutory and regulatory requirements for the supervision of physician extenders.

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3. Only one (1) PCP can be designated the supervising physician for a physician extender at any unique Provider site. Physician extenders are allowed a maximum of two (2) unique supervisors respectively at two (2) unique locations.
- C. As stated in Policy 9A, “Access Standards,” a PCP must be physically on-site a minimum of sixteen (16) hours per week for each approved PCP site.
- D. Providers are required to offer the same hours of operation for appointments or walk in to all patients regardless of line of business.
- E. All participating Pediatric, Family Practice and General Practice PCPs must be willing to accept a minimum of five hundred (500) Members in all contracted lines of business combined, unless otherwise approved. Participating Internal Medicine PCPs must be willing to accept a minimum of two hundred fifty (250) Members in all contracted lines of business combined, unless otherwise approved. PCPs reaching the minimum limit may elect to not participate in the auto assignment process and Member choice process by contacting IEHP and requesting that their enrollment panels to set to a “Closed” status.
- F. PCPs are listed in the IEHP Provider Directory and receive Members through auto assignment and Member choice, unless otherwise requested.
 1. PCPs requesting age restrictions outside of those listed in Policy 5A, “IEHP Practitioner Guidelines,” do not receive Members through auto assignment.
- G. A PCP can limit the growth of his/her IEHP enrollment by requesting in writing to be listed in the Provider Directory as “Closed” to Member assignment if they have met the minimum enrollment requirement of Members for their specialty, unless otherwise approved. If a PCP has not met the minimum enrollment requirement of Members for their specialty, a PCP can request to NOT be included in the auto assignment process for defaulted Members but not Member choice, have the minimum requirement unless otherwise approved.
- H. Once the general standard for enrollment capacity is met, PCPs are monitored for access related issues as identified through the report “Weekly Access Grievances by PCP” supplied to the Provider Services department by the QM Team. If a PCP is identified with grievances related to access, an assessment will occur to determine if the grievances warrant that the PCP be closed or limited to new enrollment.
- I. At least annually, IEHP assesses its network capacity as it pertains to the standards stated herein. IEHP takes corrective action as necessary with Providers to ensure its network continuously satisfies IEHP requirements.
- J. On an ongoing basis, IEHP reviews and monitors its overall PCP capacity to ensure adequate access regardless of enrollment capacity.
- K. If IEHP is notified or otherwise becomes aware that a safety net or traditional Provider is within its service area but not currently contracted, IEHP staff actively outreaches to that Provider to obtain a contract. If the Provider meets credentialing and/or quality standards,

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and is willing to participate under the terms and conditions for similar Providers, IEHP will contract with that Provider.

REFERENCE:

- A. Title VI of the Civil Rights Act and Title 42, Code of Federal Regulations, § 442.110.

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18. PROVIDER NETWORK

B. Provider Directory

APPLIES TO:

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

POLICY:

- A. IEHP publishes a Provider Directory on a monthly basis.
- B. Each Provider Directory contains information on IPAs and Hospitals, Primary Care Physicians (PCPs), OB/GYNs, Specialists, Behavioral Health Providers, Behavioral Health Treatment (BHT) Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, and other Providers (e.g. Nurse Practitioners (NPs), Physician Assistants (PAs), Acupuncturists, Midwives, and Dentists) who have been credentialed and are contracted with IEHP directly or through a subcontracted agreement with network IPAs.
- C. Each PCP is listed individually in the Provider Directory to help facilitate the selection process by the Member.
- D. Based on IEHP PCP/IPA affiliations, a PCP can be listed twice in the Provider Directory, with the exception of those Physicians who also service IEHP rural areas.
- E. A PCP with two (2) IPA/Hospital affiliations, credentialed and board certified in two (2) IEHP approved specialties, can be listed a maximum of four (4) times in the Provider Directory.
- F. A listing of all contracted IPAs, Hospitals, PCP, Specialists, OB/GYNs, Behavioral Health Providers, BHT Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, and other Providers are included in the Provider Directory.
- G. IEHP also maintains a Web-based Provider Directory including other Provider Directory links for IEHP contracted Provider Networks, referred to as the Doctor Search, to provide Members and prospective Members with the most updated IEHP Provider Network including IPAs, Hospitals, PCPs, Specialists, OB/GYNs, Behavioral Health Providers, BHT Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, and other Providers.
- H. If a contracted Provider informs IEHP Provider Services or Contracts directly of a Provider Directory change or inaccuracy, IEHP will make that change to the IEHP internal systems or inform the delegated Provider of the inaccuracy in their Directory. When the internal systems are updated the network updates are reflected on the web-based directory by the following day.

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B. Provider Directory

- I. IEHP investigates each time it receives a report of a potential Provider Directory inaccuracy. Provider Services or Contracts reaches out to the Provider within five (5) business days of the inaccuracy report for confirmation of the following:
 - 1. Contracting Provider is no longer accepting new patients for any line of business.
 - 2. Removal of Provider or Provider group who has retired, ceased to practice, or no longer under contract with IEHP for any reason.
 - 3. Change in Provider's practice location or update of demographic information.
 - 4. Any information that affects the content or accuracy of the Provider Directory.
- J. Upon confirmation of the correct Provider information, a request if needed is sent to update IEHP's internal systems. When the internal systems are updated the network updates are reflected on the web-based directory by the following day.
- K. As part of IEHP's monitoring process, on an annual basis, IEHP requires delegated contracted entities (such as Kaiser Permanente, Delta Dental, and American Specialty Health (ASH)) provide a report of identified/reported inaccuracies and the timeframe of the correction as stated in Policy 13G, "Delegation Oversight Audit".

PROCEDURES:

- A. IEHP publishes the Provider Directory on a monthly basis to provide existing and potential Members with current information and changes in IEHP's network.
- B. Members, potential Members or other requestors can receive the IEHP Provider Directory through the following:
 - 1. IEHP mails a copy of the Provider Directory directly to new Members upon enrollment with IEHP.
 - 2. Members, potential Members, or other requestors may call IEHP Member Services Department directly at (877) 273-4347 to receive a copy within five (5) days.
 - 3. Members can also access the Doctor Search online at www.iehp.org. All network updates are reflected on web-based Provider Directory the same day.
- C. The IEHP Provider Directory contains information regarding IEHP's network practitioners, the following elements which are subject to change based on Program requirements, including but not limited to:
 - 1. Headers to indicate City or Region Names (in alphabetical order);
 - 2. Specialty (e.g Family Medicine) including board certification if any;
 - 3. Provider Name (last, first – listed alphabetically);
 - 4. Gender;
 - 5. Eye Exams or Frame and Lens only (Vision Provider only);

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6. Provider's office email address, where the mail is intended for Member communication, regularly monitored and maintained in a manner consistent with State and Federal health privacy laws. The Provider will also attest to the security of the email address;
 7. Street Address, City and Zip Code;
 8. California license number and type of license;
 9. Age Restriction;
 10. Appointment Needed;
 11. Federally Qualified Health Center (FQHC);
 12. Board Certified;
 13. Telephone Number (including area code);
 14. Affiliated Hospital;
 15. Hospital Admitting Privileges
 16. Affiliated IPA/Clinic;
 17. IEHP Assigned Doctor Number;
 18. National Provider Identifier (NPI) Number;
 19. Languages (other than English) spoken by clinical staff including Physician;
 20. Business Hours and Days of operations;
 21. Bus Route Information;
 22. Panel Status (indication on whether a Provider is accepting new Patients, existing Patients only, not accepting new Patients at this time or if they are only available to see Patients by referral or only through a hospital or facility);
 23. Accessibility Level; and
 24. Extended Office Hours (Providers who are open before 8am, open after 5pm, or open weekends are 'bolded').
- D. The Provider Directory also includes instructions for Members on how to use the Directory for selecting a Provider.
- E. IEHP requires all contracted Providers who are not accepting new Members to direct an enrollee or potential enrollee seeking to become a new Member to IEHP for additional assistance in finding a Provider and to the DHCS to report any potential Directory inaccuracy.
- F. IEHP maintains 100% verification of the elements listed above by faxing verification requests and calling each practitioner that doesn't respond to the written request. If IEHP

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B. Provider Directory

can not verify a Provider's information at a minimum once every three hundred sixty-five (365) days, IEHP will notify the Provider of pending Directory removal ten (10) business days prior to removal. Non-responsive Providers will be removed from the Directory at the next required update, except for general acute care hospitals.

- G. IEHP may omit a Provider, Provider Group, or category of Providers similarly situated, from its directory if one of the following conditions are met:
1. Upon submission of a signed statement from an individual Provider to IEHP that the Provider is currently enrolled in the Safe at Home Program;
 2. Upon submission of a signed statement from an individual Provider to IEHP that the Provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services;
 3. Upon submission of a signed statement from a person authorized by a Provider group to IEHP stating that a facility or any of its Providers, employees, volunteers, or Members is or was the target of threats or acts of violence within one (1) year of the date of the statement; or
 4. Upon the Department's prior approval pursuant to a finding of good cause or extraordinary circumstances.
- H. Due to population mix in Riverside and San Bernardino Counties, IEHP evaluates the Spanish speaking capability of practitioner's and their staff who have indicated they have capabilities to speak Spanish, at the time of entry into the network and annually through language competency audits, before this designation is listed in the Provider Directory as outlined in Policies 9H1, "Cultural and Linguistic Services - Foreign Language Capabilities" and 9H2, "Cultural and Linguistic Services – Spanish Language Competency Audits" for more information. DHCS currently has designated Spanish as the only threshold language in Riverside and San Bernardino Counties.
- I. IEHP posts a report every six (6) months on the secure Provider website of the most current listing of contracted and credentialed PCPs, Specialists, OB/GYNs, Physician Extenders and Ancillary Providers including their hospital affiliation. All IPAs must examine these lists carefully in order to ensure the validity and integrity of the information provided.
- J. Any errors in the information listed should be reported to IEHP Provider Services within five (5) days of receipt in order to update the Directory.
- K. Provider shall inform IEHP within five (5) business days when either of the following occur:
1. Provider is not accepting new patients; or

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B. Provider Directory

2. If Provider had previously not accepted new patients, Provider is currently accepting new patients. (Cal. Health and Safety Code § 1367.27(j)(1).)
- L. IEHP investigates each time it receives a report of a potential Directory inaccuracy. IEHP will investigate by contacting the affected Provider within five (5) business days, and document the receipt, investigation and outcome of each reported potential Directory inaccuracy. IEHP will verify the accuracy of the information or update the Provider Directory within thirty (30) calendar days.
- M. Changes made to the Provider Directory information as a result of any investigation will take place at the next required update, or the next scheduled update thereafter as applicable to the online Directory.

REFERENCES:

- A. California Health and Safety Code § 1367.27.
- B. Senate Bill (SB) 137.

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C. PCP, Vision and Behavioral Health Provider Network Changes

APPLIES TO:

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

POLICY:

- A. PCPs must provide sixty (60) days advance written notice to IEHP and their IPA regarding any changes in their operations including address, IPA and/or hospital affiliation.
- B. Vision and Behavioral Health Providers must provide sixty (60) days advance written notice to IEHP of any changes in their clinic operation.
- C. IPAs are required to submit coverage plans sixty (60) days in advance of the effective date whenever they are notified that a subcontracted PCP is relocating or terminating their IPA affiliation as outlined in Section 18D1, “IPA Reported Provider Changes - PCP Termination.”
- D. IEHP allows changes in Hospital and IPA affiliations; however PCPs should review their current contractual clauses regarding contract termination with their IPA before terminating the agreement.

PROCEDURES:

PCP Change in Affiliations

- A. PCPs must send written notification informing IEHP and their IPAs of a change in IPA and/or hospital affiliation forty-five (45) days prior to the effective date of the change. PCPs must send written notification informing IEHP and their IPAs of a change in Hospital affiliation thirty (30) days prior to the effective date of change.
- B. IPAs have sixty (60) days from the effective date of a PCP’s IPA affiliation change to submit the initial credentialing packet to IEHP. Failure to do so will result in freezing of PCP to new membership assignment for sixty (60) days from the effective date of the IPA affiliation change or possible termination.
- C. For IPA changes, IEHP verifies that the new IPA has an approved specialty network in accordance with Policy 18F, “Specialty Panel;” if the hospital changes the new IPA has an approved hospital link and the PCP has privileges or admitting arrangements in place at the new Hospital; and a signature page of the agreement between the PCP and IPA has been submitted to IEHP by the new IPA. Once all information is verified, the new affiliation is accepted and processed then the PCP is assigned a new Provider IPA/Hospital Affiliation.

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C. PCP, Vision and Behavioral Health Provider Network Changes

- D. Members are transferred from the old Provider IPA/Hospital Affiliation to the new ProviderIPA/Hospital Affiliation on the first day of the month when the change is deemed effective by IEHP.
1. An IPA change becomes effective on the first of the month following sixty (60) days from the date notification is received by IEHP, unless otherwise approved by Provider Relations Management with a different date.
 2. A Hospital change becomes effective on the first of the month following sixty (60) days from the date notification is received by IEHP, unless otherwise approved by Provider Relations Management with a different date.
- E. Once all information is verified, IEHP sends a letter to the PCP with a copy to the old IPA and new IPA, if applicable, informing the PCP of his/her new Provider IPA/Hospital Affiliation, effective date of the change, and status of his/her membership (See Attachment, “Change in IPA Affiliation Letter” in Section 18).
- F. The above procedures for Member assignment may be modified due to circumstances that, in the judgment of the IEHP Chief Medical Officer or Chief Network Officer, are in the best interest of the Member.

PCP Changes in Office Location

- A. IPAs and PCPs must provide written notification to IEHP that a PCP is relocating to another office within IEHP’s geographic service area sixty (60) days prior to the relocation.
- B. If a sixty (60) day advance notice is not received, the PCP is frozen to Member auto assignment not Member choice enrollment for a period of sixty (60) days from the date IEHP received notification from the IPA.
- C. When geographically appropriate, Members remain with the PCP unless the PCP moves to a different geographic area, defined as ten (10) miles, from the PCP’s old location.
- D. If a PCP moves to a different geographic area, IEHP reassigns Members to a new PCP that has the capacity and can accommodate the affected Member. IEHP cannot guarantee that a Member remains part of the IPA’s network.
- E. If the PCP practiced in a hospital-based clinic, county clinic, teaching clinic, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Indian Tribal Clinic (ITC), or other site IEHP determined to function as a clinic in which PCPs are employed, the Member will will remain assigned to the clinic where the PCP practices and the Member can continue care at the clinic.
- F. The above procedure for Member assignment may be modified due to circumstances that in the judgment of the IEHP Chief Medical Officer or the Chief Network Officer are not in the best interest of the Member.

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C. PCP, Vision and Behavioral Health Provider Network Changes

- G. IPA and PCPs need to submit written notification to IEHP Provider Services when there is a change in other office operations. For example, but not limited to a change in phone or fax number, office hours, specialty, and/or capacity status.

Vision and Behavioral Health (BH) Provider Change in Office Location

- A. Vision and BH Providers must submit written notification to IEHP that they are relocating to another office within IEHP's geographic service area sixty (60) days prior to the relocation.
- B. Vision and BH Providers need to submit written notification to IEHP Provider Services when there is a change in other office operations. For example, a change in phone or fax number, office hours, specialty, and/or capacity status.

Vision and Behavioral Health (BH) Provider Termination

- A. Vision Providers and BH Providers no longer interested in participation in the IEHP network must submit a minimum of sixty (60) day written notice of intent to terminate.
- B. When a BH Provider is unable to continue to provide treatment for an IEHP Member, either due to going on medical leave, maternity leave, vacation, military duty, etc., the BH Provider or the Providers' office is responsible for coordinating the transition of impacted IEHP Members to other appropriate IEHP BH Providers to avoid patient abandonment. IEHP BH Providers are expected to follow all licensing board requirements and maintain ethical standards of practice while care is being transitioned.
- C. When a BH Provider is being terminated, the BH Provider or the BH Provider's office needs to cooperate with IEHP BH Department in developing a transition plan for impacted IEHP Members that ensures Members are not abandoned and that BH Providers are compliant with their licensing board requirements and maintain ethical standards of practice. In order to coordinate the transition of IEHP Members, BH Providers may be required to provide a list of active IEHP Members who will need to be transitioned to another BH Provider, treatment records, and/or medication lists with the IEHP BH Department.

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D. IPA Reported Provider Changes

1. PCP Termination

APPLIES TO:

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

POLICY:

- A. All IPAs must provide IEHP with a sixty (60) day advance written notice of any significant changes in the IPA’s network, including the termination of a Primary Care Physician (PCP).
- B. IEHP retains the right to obligate the IPA to provide medical services for existing Members for the entire sixty (60) day period.
- C. IEHP notifies affected Members at least thirty (30) days prior to the effective date of termination of a PCP.
- D. IEHP monitors IPA compliance with policy on an annual basis.

PROCEDURES:

- A. IEHP requires an advance sixty (60) day written notification from the IPA that a PCP is **terminating** as an IEHP network PCP whether voluntary or involuntary, if possible. The notice must include a coverage plan where applicable and supporting documentation/letter from PCP as to reason for termination.
 - 1. Upon receipt of the sixty (60) days advance notification, IEHP works with the IPA to develop a coverage plan in order to determine Member transfers.
 - 2. IEHP reviews submitted coverage plans and either approves, denies, or requests additional information within two (2) working days of the receipt of information from the IPA.
 - 3. If the same PCP status (i.e., age limitations, geographic location, etc.) as that of the original PCP cannot be achieved or an acceptable coverage plan is not received thirty (30) days prior to the effective date of termination of a PCP, IEHP reassigns these Members to a new PCP within IEHP’s geographic service area who has the capacity and can accommodate the affected Members. IEHP does not guarantee that Members remain part of the IPA’s network.
 - 4. Once all information is verified and an appropriate PCP is established for Member transfer, IEHP sends a letter to the Member notifying him/her of the impending termination and of the new PCP assignment. The letter informs Members of their right to select their own PCP (See Attachments, “Member PCP Term Notification Letter – English” and “Member PCP Term Notification Letter – Spanish” in Section 18). Notification to the Members occurs five (5) working days after IEHP approves the submitted coverage plan and submits internal notification of systems at least thirty (30) days prior to the effective date of the impending termination.

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D. IPA Reported Provider Changes

1. PCP Termination

5. Notification of the change is also sent to the IPA and PCP confirming the termination date and transfer of Members (See Attachments, “Compliant Termination Letter” and Non-Compliant Letter” in Section 18).
- B. In situations where less than sixty (60) days advance notice is received. IEHP will notify the Member within five (5) working days from the date IEHP learns the PCP has termed and makes a good faith effort to allow the Member up to thirty (30) days to make an alternate PCP change.
1. The IPA may provide coverage by a PCP not credentialed for participation in the IEHP network as stated in Policy 18I, “Leave of Absence.”
 2. If the PCP’s status (i.e., age limitations, geographic location, etc.) cannot be achieved, IEHP reassigns these Members to a new PCP within IEHP’s geographical service area that has the capacity and can accommodate the affected Members. IEHP does not guarantee that Members remain part of the IPA’s network.
 3. Upon verification of all information, and an appropriate PCP is selected for Member transfer, IEHP sends a letter to the Member notifying him/her of the impending termination and of the new PCP assignment. The letter informs the Member of his/her right to select another PCP (See Attachments, “Member PCP Term Notification Letter – English” and “Member PCP Term Notification Letter – Spanish” in Section 18). Notification to the Member occurs at least thirty (30) days prior to the effective date of the impending termination.
 4. Once IEHP establishes an effective date for the PCP termination and Member transfer, IEHP sends the IPA and PCP a written notification regarding the effective date of the termination and transfer of Members who have not selected a PCP (See Attachment, “Non-Compliant Termination Letter” in Section 18).

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D. IPA Reported Provider Changes

2. Specialty Provider Termination

APPLIES TO:

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

POLICY:

- A. All IPAs must provide IEHP with a sixty (60) day advance written notice of any significant changes in the IPA’s network, including the termination of a specialty Provider.
- B. IEHP requires IPAs to notify Members in writing thirty (30) days prior to the effective date of a specialist’s termination, or determination by the IPA to terminate a Specialist.
- C. IPAs will ensure Members under care, including women in their 2nd or 3rd trimester, maintain uninterrupted care with the same specialist, as outlined in Policy 12A5, “Care Management Requirements - Continuity of Care”.
- D. IPAs are not required to continue care with Providers terminated for quality issues, fraudulent behavior or criminal activity.
- E. IEHP monitors IPA compliance with all notification requirements on an annual basis.

PROCEDURES:

- A. IPAs must provide IEHP with a sixty (60) day advance written notice of the termination of a specialty Provider from the IEHP network. IPAs are responsible for identifying Members currently under the care of a terming specialist, and providing ongoing care as noted below.
 - 1. The written notification from the IPA to IEHP must include a list of all the Members who have seen the specialist two (2) or more times in the preceding twelve (12) month period, are currently under on-going care, or have an open referral, as well as a copy of the notification letter sent to Members as stated below.
- B. IPAs must send written notification to Members thirty (30) days prior to the effective date of the specialist’s termination or a determination by the IPA to terminate the specialty Provider’s affiliation with the IPA or IEHP (See Attachments, “Specialist Termed Member Notification – English” and “Specialist Termed Member Notification – Spanish” in Section 18). As applicable, the notice to Members must include the right of the Member to continue care under the specialist as outlined in Policy 12A5, “Care Management Requirements - Continuity of Care.” The written notification from the IPA must be sent to all Members that:

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D. IPA Reported Provider Changes

2. Specialty Provider Termination

1. Have seen the specialist two (2) or more times within the preceding twelve (12) month period; or
 2. Are currently under on-going care; or
 3. Have an open referral.
- C. After receiving written notification from the IPA, the specialty Provider is terminated in IEHP's system with the effective date of the termination.
- D. IEHP reserves the right to make final decisions regarding continuity of care for all Members.
- E. Members have the right to review IEHP final decisions, as well as obtain copies of this policy. Members desiring review of a decision, or wanting a copy of this policy, should contact IEHP at (877) 273-4347.
- F. IEHP monitors IPA compliance with notification requirements on a quarterly and annual basis, as part of its oversight of the IPA's specialty network, as outlined in Policy 18F, "Specialty Panel," and Policy 5C, "IEHP Quality Oversight of Participating Practitioners."
- G. IEHP monitors IPA compliance with notification requirement on an annual basis, as part of the IPA performances evaluation tool, as stated in Policy 23F, "IPA Performance Evaluation."

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Chief Title: Chief Medical Officer	Revision Date:	January 1, 2018

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E. Management Services Organization Changes

APPLIES TO:

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

POLICY:

- A. IEHP evaluates all Management Services Organizations (MSOs) that are contracted with IPAs to ensure that they can meet IEHP operational requirements and standards.
- B. Any IPA wishing to contract with a new MSO must provide adequate notice to IEHP so that a pre-contractual audit can be performed to ensure that the MSO can meet IEHP operational requirements and standards.
- C. Prior to being included in IEHP's Provider network, the IPA or MSO must meet IEHP's contractual, financial, administrative and quality standards.
- D. IEHP performs an on-site audit of the IPA or MSO to review information provided in the pre-contractual response.
- E. In the event that an IPA wishes to change MSOs, the IPA must provide IEHP a ninety (90) day advance written notice of the change.
- F. The new MSO will be subject to a pre-contractual audit prior to approval.
- G. The IPA must submit a transition plan of services fifteen (15) days prior to change from the existing MSO to the new MSO.
- H. If the MSO does not meet IEHP standards, the IPA is not allowed to transition to the new MSO. For new IPAs, failure to have an MSO or in house staff and procedure that meet minimum standards will result in all contracting efforts being halted.
- I. In the event that a MSO contracted with an IPA experiences significant operational or financial failures that result in the termination of the IPA, IEHP reserves the right to eliminate the MSO or its principals for future management services for any of our currently contracted or new IPAs.
- J. If the MSO is providing management services for more than one currently contracted IPA in the IEHP network and is undergoing significant operational or financial failures a review will be performed to ensure that the MSO is meeting IEHP operational requirements and standards for each contracted IPA.
- K. If the MSO is providing management services for more than one currently contracted IPA in the IEHP network and is in good standing, a new pre-contractual audit may be waived.

PROCEDURES:

- A. In the event an IPA decides to change its MSO or to bring MSO functions under the umbrella of the IPA, the IPA must:

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E. Management Services Organization Changes

1. Provide IEHP with a ninety (90) day advance written notice if the MSO is not currently affiliated with IEHP; or
 2. Provide IEHP with a sixty (60) day advance written notice if the MSO is already affiliated with IEHP;
 3. Provide IEHP with a copy of the signed MSO agreement; and
 4. Submit the applicable, revised sections of the pre-contractual for services that the new MSO is responsible for performing on behalf of the IPA.
- B. IEHP requires any MSO to have:
1. Been in business for at least two (2) years;
 2. Managed a minimum of two (2) fully capitated HMO contracts for two (2) years;
 3. A local satellite office or be available to travel to the two (2) counties, when necessary;
 4. Capitation payments sent directly to the IPA; and
 5. Performed management services that meet or exceed the performance of the previous MSO, if applicable, as measured by the outcome of the Medical Management Audit and subsequent audits as appropriate.
- C. Prior to the effective date of change in management, IEHP performs an on-site audit of the new MSO.
- D. If the IPA/MSO is unable to pass the IEHP audit, the IPA/MSO is required to contract with an existing IEHP MSO or maintain their current relationship to continue participation in the IEHP network.
- E. Failure by the IPA to comply with the above notification requirements may result in the IPA being frozen to new enrollment and network expansion, may incur financial penalties or may be terminated from the IEHP network.
- F. IEHP does not approve of new MSOs that have significant ownership or officer overlap with the IPA owners of officers.

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F. Specialty Panel

APPLIES TO:

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

POLICY:

- A. State Regulators mandate the types of specialists required in IEHP’s network (See Attachment, “Specialty Panel Worksheet” in Section 18 for required specialties).
- B. In accordance with Title VI of the Civil Rights Act and Title 42, Code of Federal Regulations, Section 442.110, all Members must receive access to all covered services without restriction based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.
- C. IEHP requires IPAs to provide covered services to all Members assigned to them at an appropriate facility without imposing restrictions as listed in Policy B.
- D. IEHP requires IPAs to submit a complete listing of their specialty network including specialists, contracted hospitalists, admitters, extenders and ancillary Providers to identify the IPA’s current provider network.
- E. IEHP monitors the specialty network including specialists, hospitalists, admitters, extenders and ancillaries for each affiliated Hospital on a semi-annual basis.
- F. Prior to establishing a “link” to a network hospital and prior to receiving enrollment in a given geographic area:
 - 1. All IPAs must submit a complete IPA Hospital Link Responsibility Grid in the format required by IEHP (See Attachment, “IPA Hospital Link Responsibility Grid – IEHP DualChoice” in Section 18) hospitalist or admitters and ancillary Providers, contracted and credentialed, that have privileges at IEHP contracted hospitals. Upon receipt of a complete specialty network, IEHP will schedule the review of the data according to the current needs of the plan as they relate to access and network adequacy.
 - 2. A complete specialty network of physicians is defined as consisting of a minimum of two (2) unique Providers for every specialty listed in this policy and two (2) unique Providers contracted with the IPA in every specialty in each local geographic service area as it relates to the hospital affiliation. A specialist Provider who has offices in several geographic regions counts as one (1) unique specialist regardless of the number of hospitals at which the specialist has privileges.

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3. For inpatient utilization oversight, the use of on-site hospitalists is required.
 4. IEHP requires IPAs to have all IEHP specialists under contract within twenty (20) miles or thirty (30) minutes of a Member's residence, via public or private transportation.
- G. IEHP has identified its high-volume specialists based on demographics and number of encounters. To ensure that Members have adequate access to such high-volume specialists, IEHP and the IPA (when applicable) must maintain the following minimum ratios of high-volume specialty Providers to Members:
1. OB/GYNs 1: 25,000
 2. Physical Therapist 1:10,000
 3. Orthopedic Surgery 1: 5,000
 4. Ophthalmology 1: 4,167
 5. Cardiology 1: 3,704
- I. IEHP has identified its high impact Specialists based on Utilization data such as Claims and encounters on an annual basis. To ensure that the Members have adequate access to such highly impacted Specialists, IEHP maintains the following minimum ratios of high-impact specialty Providers to Members.
1. Hematology 1:8,000
 2. Oncology 1:8,000
- H. IEHP has identified its high-volume Behavioral Health Providers based on demographics and number of encounters. To ensure that the Members have adequate access to such high-volume Behavioral Health Providers, IEHP maintains the following minimum ratios of high-volume Behavioral Health Providers to Members:
1. Mental Health Practitioners 1: 7,000
 2. Marriage and Family Therapist 1: 7,000
 3. Licensed Clinical Social Worker 1: 7,000
 4. Psychiatrists 1: 7,000
 5. Psychologists 1: 7,000

DEFINITIONS:

- A. A Specialist is defined as a Physician who is board certified or has training that meets American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) requirements as applicable in the specialty of medical care provided.

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- B. A high-volume Specialist is defined as a Physician located in an expected high-volume geographic area or in high-volume specialties or both and most likely provides services to the largest segment of the membership.
- C. A high-impact Specialist is defined as a Physician that treats conditions that have mortality and morbidity rates and where treatment requires significant resources.

PROCEDURES:

- A. In order for an IPA to establish a link (affiliation) at an IEHP contracted Hospital, the IPA must submit via the format approved by IEHP the following core specialty network of physicians, contracted and credentialed, and at a minimum two (2) unique physicians and two (2) unique physician contracts for each specialty in place that have admitting privileges at the designated Hospital (unless other inpatient coverage as delineated in Policy 5D “Hospital Privileges”):
1. Cardiology;
 2. Dermatology;
 3. Gastroenterology;
 4. General Surgery;
 5. Neurology;
 6. OB/GYN;
 7. Orthopedics Surgery;
 8. Otolaryngology;
 9. Ophthalmology; and
 10. Oncology/Hematology.
- B. Prior to receiving enrollment at this established link the IPA must ensure that the following specialty network of physicians, consisting of a minimum of two (2) unique Providers and two (2) unique Provider contracts per specialty are contracted and credentialed within the local geographic service area of the linked Hospital (See Attachment, “Hospital Geographic Service Areas” in Section 18 for geography coverage):
1. Allergy and Immunology;
 2. Cardiac/Thoracic Surgery;
 3. Endocrinology;
 4. Infectious Disease/HIV Specialist;
 5. Nephrology;

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6. Neurosurgery (if the Hospital provides this service);
 7. Pain Management
 8. Pediatric Subspecialties (as applicable);
 - a) Pediatric Cardiology
 - b) Pediatric Gastroenterology
 - c) Pediatric Ophthalmology
 - d) Pediatric Neurology
 - e) Pediatric Orthopedics
 9. Pediatric Surgery (as applicable);
 10. Physical and Speech Therapy
 11. Physical Medicine and Rehabilitation;
 12. Plastic Surgery;
 13. Podiatry;
 14. Pulmonary Medicine;
 15. Rheumatology;
 16. Urology; and
 17. Ancillary Provider.
 - a) Audiology
 - b) Diagnostic Radiology
 - c) DME
 - d) Home Health
 - e) Home Infusion Agency
 - f) Imaging/Diagnostic/X-Ray
 - g) Laboratory
 - h) Radiology
- C. If the network hospitals within the affiliated Hospital's local geography do not offer these services, the IPA is not required to have the corresponding specialty in place as outlined above, but must make regionally appropriate arrangements with other Hospitals in the IEHP network. IEHP will verify availability of specialists before approving regionally appropriate arrangements.

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- D. After receiving the complete specialty network presented by the IPA, the Director of Provider Relations will determine the scheduling of the network review and approval in accordance with access and network adequacy requirements. Once confirmed, the Provider Relations Manager or Provider Services Representative will advise the IPA when the specialty network will be reviewed and provide an estimate of an effective date of the new affiliation, dependent upon the completeness of the specialty network presented.
- E. In the event that a Member is at the linked or non-linked Hospital and requires a consult from a specialty physician that the IPA does not have under contract at that Hospital, the IPA must arrange and pay the specialist for the consulting services rendered at the rate required by the specialist.
- F. Specialists are required to offer the same hours of operation for appointments or walk in to all patients, regardless of line of business.
- G. In the event that a Member must be transferred to another hospital due to a lack of a contracted specialist that is available at the hospital, the IPA will be financially responsible for the transfer transportation costs.
- H. In certain instances when services required are unavailable within the IEHP network, the IPA must arrange for the provision of specialty services from Providers outside the contracted network to ensure uninterrupted care to Members and timely access as outlined in Policy 9A, "Access Standards." IPA must initiate and execute a Letter of Agreement (LOA) for services rendered outside the network. IPA must ensure that the cost to the Member should be no greater than it would be if the services were provided in-network.
- I. On a semi-annual basis, IEHP posts the IPA's specialty network roster on its secure provider website including adult/pediatric hospitalists, adult/pediatric admitters, extenders, and ancillary Providers submitted previously by the IPA to IEHP that identifies the IPA's current provider network that includes:
1. Practitioner name;
 2. Address;
 3. Phone number;
 4. License number;
 5. Specialty type;
 6. Hospital affiliations;
 7. IPA credentialing committee dates;
 8. For obstetricians only, the hospitals they deliver; and
 9. IPAs are required to verify and update the above information. Specific reporting requirements are delineated in Policy 5C, "IEHP Quality Oversight of Participating Practitioners."

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- J. IPAs are required to update all information located on the secure provider website within thirty (30) days of the information being made available online.
- K. Failure of the IPA to complete the required updates in a timely manner including written termination notifications of specialist as stated in Policy 18D2, “IPA Reported Provider Changes - Specialty Provider Termination,” may result in freezing the IPA for a period up to sixty (60) days.
- L. IEHP reviews the information provided by the IPA and tracks the specialty network including adult/pediatric hospitalists, adult/pediatric admitters, extenders and ancillary Providers of each IPA geographically to identify any “holes,” missing required specialist(s) or lacking hospital or geographic coverage.
- M. Upon identification of such deficiencies, IEHP has thirty (30) days to respond to the IPA outlining the deficiencies and specifying the timeframe to cure those deficiencies.
- N. Depending on the impact to either the Member or Hospital, IEHP may immediately freeze the affected IPA/Hospital link or the IPA from receiving any new enrollment until such deficiencies are corrected.
- O. If the IPA is unable to correct the deficiencies within the allotted timeframe, IEHP may transfer the existing enrollment from the affected IPA to other IPAs that have adequate specialty networks and terminate linkage.
- P. No enrollment is given to any new PCP until the IPA’s specialty network at the affiliated hospital has been approved by IEHP.

REFERENCES:

- A. Title VI of the Civil Rights Act and Title 42, Code of Federal Regulations, Section 442.110.
- B. CMS Health Service Delivery (HSD) CY 2017 Provider and Facility Specialties and Network Adequacy Criteria Guidance and Methodology.

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G. Provider Resources

APPLIES TO:

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

POLICY:

- A. IEHP provides various informational resources to Providers to assist them in carrying out their contractual obligations. Among those resources are the following:
1. Joint Operations Meeting (JOMs)
 2. Care Management Teams
 3. IEHP Provider Relations Team
 4. Nurse Educators
 5. Medicare Sales Team
 6. IEHP University
 7. Provider Newsletter (The Heartbeat)
 8. Provider Staff Newsletter (Scrub Talk)
 9. Special Provider Notices
 10. IEHP Website - www.iehp.org
 11. Other resources as made available
- B. IEHP expects IPAs to communicate IEHP’s policies and procedures to contracted PCPs and specialists. In most cases, IEHP sends correspondence directly to IPAs, relying on them to disseminate the information to its Providers in a timely manner.
- C. Some situations require that IEHP directly notify PCPs or Specialists. In such situations, IEHP uses its best efforts to provide IPAs with a copy of the correspondence five (5) days prior to mailing to Practitioners, when applicable.
- D. IEHP provides clinical performance data and Member experience data or results, as applicable when requested by Providers and/or Delegates.
- E. Additionally, IEHP communicates directly to Providers on information or program updates through newsletters, physician surveys, blast fax, fliers, Provider website and other programs where IEHP works directly with Providers. Such communications are delivered directly to participating Providers, IPAs, and Hospitals concurrently. Prior notification is not provided by IEHP in these cases.
- F. On instances where Providers are unable to receive faxes, IEHP communications or updates are mailed or e-mailed directly to the Providers depending on their preference. Provider

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G. Provider Resources

Services Admin Team maintains an exception table list of these Providers with their mailing address or email address.

- G. It is crucial to the success of each Provider to develop relationships and communication between its practitioners, ancillary Providers, and contracted partners.

PROCEDURES:

A. Joint Operations Meetings (JOMs)

1. JOMs create a forum to discuss issues and ideas concerning care for Members, and to allow IEHP a method of monitoring plan administration responsibilities delegated to the Providers.
2. IEHP attempts to meet with each IPA at a minimum annually.
3. Periodically, JOMs focusing on IPA/Hospital coordination and communication are held (when necessary or as requested with each IPA/Hospital relationship).
4. In addition, IEHP also holds JOMs individually with contracted Hospitals.
5. All JOMs are held within IEHP's geographical service area regardless of MSO location.

B. Care Management Teams:

1. IEHP has Care Management Teams that serve as an informational resource for IEHP Team Members, Providers, and contracted IPAs on information including but not limited to:
 - a. Continuity of Care Regulatory Guidelines
 - b. Long Term Services and Supports (referrals, benefits, etc.)
 - 1) Community Based Adult Services (CBAS)
 - 2) In Home Supportive Services (IHSS)
2. Care Management Teams are comprised of Care Management Nurses and Coordinators.
3. An Interdisciplinary Care Team (ICT) is offered to Members to coordinate delivery of services and benefits when a need is demonstrated and in accordance with Member's functional status, assessed need and Care Plan. Members may request an ICT meeting at anytime through communication with IEHP or Delegate staff. The Care Manager coordinates invitation notices to Providers and caregivers as needed.
4. Member, Provider and practitioner issues, excluding Member eligibility, should be directed to the Care Management Teams. These issues may include:
 - a. Access issues
 - b. Case management

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- c. Discharge planning
- d. Coordination of care
- e. Medical care standards
- f. Waiver programs

C. IEHP Provider Relations Team:

1. The IEHP Provider Relations Team serves as an information resources for IEHP Member Services Representatives, Providers (both participating and nonparticipating), contracted IPAs, Hospitals, and Ancillary Providers.
2. The IEHP Provider Relations Team is comprised of Provider Services Representatives and Provider Call Center Representatives.
3. Provider and Practitioner issues, including Member eligibility, should be directed to the IEHP Provider Relations Team. These issues may include:
 - a. Access issues
 - b. Global Quality P4P Program
 - c. Pay for Performance (P4P)
 - d. Reconciliation of capitation to eligibility
 - e. Benefits
 - f. Credentialing Issues
 - g. Provider Network Issues
 - h. Encounter Data
 - i. Claims
 - j. Referrals
 - k. Vision Issues
 - l. Vision Referral Request
 - m. Referral Authorization status
 - n. Request for in-service training
 - o. Behavioral Health
 - p. Website Issues
4. Provider Services Representatives:
 - a. IEHP Provider Services Representatives (PSRs) are trained in accordance with regulations set forth by the State Programs Regulations.

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- b. IEHP Provider Services Representatives provide detailed information about IEHP benefits, IEHP programs, and managed care concepts to IEHP practitioners and serve as the focal point for Provider office staff to obtain information about IEHP programs, DHCS, CMS, and other regulatory issues, as applicable.
- c. For the purposes of visits the Provider Services Representatives are assigned geographic areas to visit IEHP practitioners. Provider Services Representatives are assigned by IPA or geographically for directly contracted Providers.
- d. On an initial, periodic and Provider requested basis, Provider Services Representatives provide training to Providers and their staff covering an array of topics, including but not limited to:
 - 1) Encounter Data Submission Requirements
 - 2) Prior Authorization Requests
 - 3) Website Tools
 - Pay for Performance (P4P)
 - Electronic Referrals
 - Health Education Referrals
 - Care Plans
 - Member Health Records
 - Online formulary search
 - Staying Healthy Assessment (SHA)
 - IEHP Guidelines for Care Management
 - Member Preventive Care Rosters
 - ICD Code Training
- e. Claims
 - 1) Provider Dispute Resolution (PDR) Process
 - 2) Correct Billing Entities and Division of Financial Responsibility
 - 3) Prohibition of balance billing Members
- f. Program updates and communications
 - 1) Review of blast faxes sent in previous quarter
- g. Providers and their staff are encouraged to ask questions with their IEHP Provider Services Representatives, especially to help the staff understand complex State regulations concerning IEHP DualChoice Program beneficiaries.

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D. IEHP Contracts Service Team

1. Provider Contracting Services Representatives:

- a. IEHP Provider Contracting Services Representatives (PCSRs) are trained in accordance with regulations set forth by the State Programs Regulations.
- b. IEHP Provider Contracting Services Representatives provide detailed information about IEHP benefits, IEHP programs, and managed care concepts to IEHP Ancillary Providers and hospitals, and serve as the focal point for staff to obtain information about IEHP programs, DHCS, CMS and other regulatory issues, as applicable.
- c. For the purposes of visits the Provider Contracting Services Representatives are assigned geographic areas to visit IEHP Ancillary Providers and Hospitals.
- d. On an initial, periodic and Provider requested basis, Provider Contracting Services Representatives provide training to Providers and their staff covering an array of topics, including but not limited to:
 - 1) Prior Authorization Requests
 - 2) Member Eligibility
 - 3) Website Tools
 - Electronic Referrals
 - Care Plans
 - Member Health Records
 - Online formulary search
 - IEHP Guidelines for Care Management
 - Compliance Training and FWA
 - ICD Code Training
 - POLST Registry
 - 4) Claims
 - Electronic Referrals
 - Care Plans
 - Member Health Records
 - Online formulary search
 - IEHP Guidelines for Care Management
 - Compliance Training and FWA

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G. Provider Resources

- ICD Code Training
 - POLST Registry
- 5) Claim Status
 - 6) Clean Claim requirements
 - 7) Provider Dispute Resolution (PDR) Process
 - 8) Correct Billing Entities and Division of Financial Responsibility
 - 9) Prohibition of balance billing Members
- e. Program updates and communications
- 1) Review of blast faxes sent in previous quarter
- f. Providers and their staff are encouraged to ask questions with their IEHP Provider Contracting Services Representatives, especially to help the staff understand complex State regulations concerning Medi-Cal Program beneficiaries.
- E. Nurse Educators
1. Nurse Educators develop Provider Trainings for areas determined to be of concern such as HEDIS measures, Quality Improvement initiatives and Medical Record documentation.
 2. Provider on-site trainings to the Provider network in areas determined to be of concern. Coordinate trainings with other departments such as Provider Services, Contracting and Medical Management.
 3. Perform Facility Site Audit and Medical Record Audits trainings for Primary Care Physicians.
- F. Medicare Sales Team
1. IEHP Medicare Sales Team is trained in accordance with regulations set forth by the Centers for Medicare and Medicaid Services (CMS).
 2. The IEHP Medicare Sales Team provides detailed information about the IEHP DualChoice including the benefits available to IEHP DualChoice Members.
- G. IEHP University:
1. On an annual basis or when applicable, IEHP conducts a one (1) day training seminar (“IEHP University”) for IPA and Hospital key staff.
 2. IEHP offers various IEHP plan administration “courses” for the IPA and Hospital key staff to choose from.
 3. Each IPA and Hospital is required to send a minimum of three (3) key staff members to each IEHP University.

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H. Provider Newsletter (The Heartbeat)

1. The Heartbeat is a newsletter that is distributed by mail to all IEHP Providers and practitioners on a bi-annual basis.
2. The Provider Newsletter informs Providers and practitioners of any policy, benefit, service, program or regulatory changes.
3. The Provider Newsletter also informs Providers and practitioners of featured health education programs available to Members, results of quality studies or other quality of care related information.

I. Provider Staff Newsletter (Scrub Talk)

1. Scrub Talk is a newsletter distributed by mail to all IEHP Provider staff on a bi-annual basis.
2. The purpose of the Scrub Talk Newsletter is to establish an important link with office staff to foster network cohesiveness and stability.
3. Scrub Talk features articles and helpful tips to assist Provider's staff with information or services that are available to them.
4. Scrub Talk features "Stress Busters" to help Provider staff to be more productive in the performance of their daily duties.

J. Special Provider Notices

1. Regulatory changes made by DHCS, DHMC, or CMS are communicated to our Providers.
2. The Provider Services Department determines the need for such special notices.

K. IEHP Website – www.iehp.org

1. IEHP's website is a valuable business tool created to provide our Providers with twenty-four (24) hours, seven (7) days a week access to IEHP resources.
2. IEHP's website has an enhanced security system that provides additional levels of security to Providers. These features ensure HIPAA privacy, security compliance and limit employee access to claims, clinical, P4P and other reimbursement information.
3. Providers are encouraged to use the IEHP website in an effort to go 100% paperless.
4. To monitor compliance, each month the IEHP's Application Support Team generates Website Statistics Report for management review. It provides online activity summary of Providers who have accessed various pages of the website. The Director of Provider Services distributes the report to the appropriate Provider Services staff to analyze data and propose follow up actions as needed.
5. IEHP strives to provide our Provider Network with all the tools necessary to deliver the highest quality of care. These include:

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G. Provider Resources

- a. Non Secure Site
 - 1) Doctor Search
 - 2) Provider Portal
 - 3) Provider Manual
 - Medi-Cal
 - Medicare DualChoice
 - 4) EDI Manual
 - 5) Benefits Manual
 - Medi-Cal
 - IEHP DualChoice Cal MediConnect and Plan Benefits and Cost Sharing
 - 6) Correspondence
 - 7) Pharmaceutical Services
 - Academic Detailing
 - Clinical Information
 - Clinical Practice Guidelines
 - Diabetes DME Coverage
 - Disease Therapy Management Program
 - High Risk Medications
 - Medication Therapy Management
 - Prior Authorization Drug Treatment Criteria
 - Pharmacy Pain Management
 - Safety Resources
 - Drug MAC
 - IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan)
 - Formulary
 - PA Submission Tool
 - Pharmacy Forms
 - Pharmacy Manuals
 - Pharmacy Network Lists

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G. Provider Resources

- Pharmacy P4P Program
 - Pharmacy Quality Ratings
 - Pharmacy PA Universal Form
 - Provider Communications
- 8) Compliance
- Code of Business Conduct and Ethics
 - Compliance Forms
 - Compliance Training
 - Contact the Office of the Inspector General
 - Fraud Prevention
 - Frequently Asked Questions
- 9) Special Programs
- Baby-N-Me
 - IEHP Gender Health
 - MyPath Program
- 10) P4P Program
- Overview
 - P4P Correspondences
 - P4P Forms
 - Schedules
- 11) Forms
- IEHP no longer supplies forms to Providers. Forms are available online at www.iehp.org. Providers are expected to obtain forms from the website in lieu of requesting delivery of forms from their PSR.
 - PM 160s
 - Staying Healthy Assessment (SHA) Forms
 - Pediatric Growth Charts
 - All other forms provided online
- 12) Vision
- Vision Forms

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- Vision Updates
- 13) Health Education
 - Health Education Activities
 - Health Education Brochures
 - Patient Education Resources
 - Provider Education Resources
- 14) Behavioral Health (BH)
 - BH FAQs
 - Behavioral Health Forms
 - BH Updates
 - Behavioral health Integration Initiative (BHI-I)
- 15) Utilization Management Criteria
 - Behavioral Health
 - Dental
 - Dermatology
 - Diagnostic Testing
 - DME and Medical Supplies
 - ENT
 - Gynecology and Obstetrics
 - Neurology
 - Oncology
 - Orthopedic
 - Other
 - Pain Management
 - Pediatric
 - Surgical Procedures
- 16) Health Plan Updates
 - Cal MediConnect Plan
 - Immunization Updates

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G. Provider Resources

- Flu Updates
- BH Updates
- P4P Updates
- 17) Neuro Vitality Center
- 18) Newsletters
 - Heartbeat
 - Scrub Talk
- 19) Additional Resources
 - Accessible Clinics Program
 - ADA and Beyond
 - Enforcement
 - Facts and Information
 - Legal Obligations
 - Technical Assistance
 - California Children Services (CCS)
 - Care After Hours
 - Community Based Adult Services (CBAS)
 - Contracted Urgent Care Facilities
 - Fraud Prevention
 - LabCorp Patient Service Centers
 - Medi-Cal Rates and Codes
 - Medicare Beneficiary Identifier (MBI)_
 - Medicare Outpatient Observation Notice (MOON)
 - Medicare Physician Fee Schedule
 - Nondiscrimination Language
 - Online Cultural Competency Training
 - Office of Minority Health - <https://cccm.thinkculturalhealth.hhs.gov/>
 - CDC - <http://www.cdc.gov/healthliteracy/gettrainingce.html>

18. PROVIDER NETWORK

G. Provider Resources

- U.S. Department of Health and Human Service, Health Resources and Services Administration -
<https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/resources/index.html>
 - Other Resources
 - POLST Registry
 - Proposition 56
 - Public Health Advisory
 - Services for Teen Patients
 - Tobacco Cessation Services
 - Services for Teen Patients
- 20) Educational Opportunities
- Code of Business Conduct and Ethics
 - Compliance Training
 - ICD Code Resources
 - Long Term Support Services
 - Specialty Mental Health Care Coordination
 - IEHP Guidelines for Care Management SPD Awareness Training
 - Staying Healthy Assessment (SHA) Training
- 21) Preventive Services
- Immunizations
- 22) Join our Provider Team
- Provider Network Expansion Fund
- Provider Capital Fund
- IPA
 - Hospitals
 - Screening and Enrollment
 - PCP and Specialist
 - Ancillary
 - Behavioral Health

18. PROVIDER NETWORK

G. Provider Resources

- b. Secure Site Login
 - 1) Home (Landing Page)
 - Updates
 - Provider Network Expansion Fund
 - Department of Public Health
 - Department of Social Services Requirements
 - Forms
 - Special Programs
 - Events and Training
 - SBIRT Services
 - Global Quality P4P Program (For PCPs Only)
 - 2) Eligibility
 - 3) Rosters
 - Assigned Roster
 - CCS
 - Direct Specialty Roster (For Direct Contracted Providers only)
 - Direct Ancillary Roster (For Direct Contracted Providers only)
 - Early Start Roster
 - Health Management
 - Asthma Roster
 - Care Plans and HRAs
 - Diabetes Roster
 - Initial Health Assessment
 - NEMT PCS Roster
 - Nurse Advice Line
 - Preventive Care
 - ADHD Medication (Follow-up Care)
 - Annual Monitoring for Patients on Persistent Medications

18. PROVIDER NETWORK

G. Provider Resources

- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
 - Breast Cancer Screen
 - Cervical Cancer Screen
 - Childhood Immunizations
 - Diabetes Care
 - DualChoice Annual Visit
 - Immunizations for Adolescents
 - Medication Management for People with Asthma
 - Prenatal and Postpartum Care
 - Weight Assessment and Counseling Nutrition and Physical Activity
 - Well Care (0-15 Months)
 - Well Care (3-6 Years)
 - Well Care (Adolescent)
 - Yellow Card
- 4) Encounter
- 5) Pharmacy
- Rx PA/CD Auth Request
 - Medi-Cal Formulary
 - CMC Formulary
 - Prior Authorization Criteria
 - Pharmaceutical Services
- 6) Claims Status
- 7) Behavioral Health
- Referral Request Form
 - Coordination of Care Report
 - BHICCI Program
- 8) Referrals
- Status

18. PROVIDER NETWORK

G. Provider Resources

- Request (Direct Contracted Providers Only)
- 9) Finance
 - Capitation Reports
 - Claims RA
 - P4P RAs
 - Prop 56 RAs
- 10) Pay for Performance (P4P)
 - P4P Entry
 - P4P Status
- 11) Health Education
 - Request
- 12) Vision Providers Only
 - Claims Entry
 - Vision Referral Request
 - Diabetes Care
 - Claims Status
 - Referrals
 - Status
 - Request
 - Finance
 - Claims RAs
 - Prop 56 RAs
- 13) Pharmacy Providers Only
 - Medi-Cal Formulary
 - CMC Formulary
 - Prior Authorization Criteria
 - Pharmaceutical Services
- 14) Behavioral Health Providers Only
 - Referral Request Form

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G. Provider Resources

- Claims Submission
- Coordination of Care Treatment Plan
- BHICCI Program
- Member History

INLAND EMPIRE HEALTH PLAN		
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18. PROVIDER NETWORK

H. Hospital Affiliations

APPLIES TO:

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

POLICY:

- A. To ensure that a contracted Hospital is fully participating in the IEHP network, the IPA must have a minimum of five (5) PCPs and must, as a group, be capable of providing care to Members of all ages and genders and, who admit to the designated Hospital or have an admitting arrangement. The PCPs must be contracted and credentialed by the IPA who links to the contracted Hospital, as delineated in Policy 18F, “Specialty Panel.”
- B. IEHP may choose to approve an IPA to have less than the minimum five (5) individual PCP requirements due to geographic needs of Members and/or to avoid the potential monopolistic situation with its IPA and/or to ensure the opportunity for substantial participation of traditional Providers in the health care delivery system.
- C. IPAs must have established processes for outpatient and inpatient utilization management. For inpatient utilization oversight, the use of on-site Hospitalists is required.
- D. Each PCP office must be within fifteen (15) miles or thirty (30) minutes from the affiliated Hospital. The office should also be in the same county as the affiliated Hospital and you must not pass a different Hospital to get to the affiliated Hospital. In rural areas or in specific situations, IEHP may approve PCP links to Hospitals outside of these standards.
- E. An IPA is not eligible to receive enrollment at a specific hospital until they have met all criteria as listed above.

PROCEDURES:

- A. IPAs must submit a complete PCP credentialing information to IEHP for those PCPs meeting the requirements of A above, as specified in Section 5, “Credentialing and Recredentialing.”
- B. Upon receipt of the credentialing information, IEHP reviews each packet in accordance with Section 5, “Credentialing and Recredentialing” and verifies that the IPA has:
 - 1. A minimum of five (5) PCPs who, as a group, are capable of providing care to Members of all ages and genders (based on the line of business), who admit to the designated Hospital or have admitting arrangements to Hospitalist.
 - 2. A complete specialty network under contract to see Members at the designated Hospital, as stated in Policy 18F, “Specialty Panel.”
- C. If the IPA does not have the required five (5) PCPs who meet the above criteria, IEHP contacts the IPA with the following options:

18. PROVIDER NETWORK

H. Hospital Affiliations

1. Designate another IEHP approved Hospital affiliation for the PCP in the interim until the IPA has the required five (5) PCPs contracted at the designated Hospital.
 2. Have IEHP pend the PCP until the IPA has the required five (5) PCPs contracted at the designated Hospital.
 3. Remove the PCP's application for participation with IEHP.
- D. If Option C1 is chosen, for a new PCP IEHP schedules a facility site review and upon receipt of a passing score, the PCP is eligible to receive Member assignment.
- E. If Option C2 is chosen, for a new PCP IEHP holds the pended file for six (6) months. If after six (6) months the IPA has been unable to contract with five (5) PCPs to admit to the designated Hospital, IEHP designates the PCP file as inactive and does not establish a Hospital link.
- F. If an existing PCP terminates affiliation with an IPA or Hospital, resulting in the IPA having less than a group of five (5) PCPs who are capable of providing care to Members of all ages and genders, the IPA must contract and credential another PCP prior to the PCP's termination date in order to maintain compliance with this policy before IEHP initiates termination of the IPA's Hospital affiliation and transfer of Membership.
- G. In addition, if IEHP does not receive the required sixty (60) day advance notice of the practitioner termination, IEHP may freeze the IPA during this transition period as stated in Policy 18D1, "IPA Reported Provider Changes – PCP Termination."
- H. In the event of the above, IEHP works with those PCPs affected by the termination to help retain the patient/physician relationship.
- I. IEHP monitors the IPA/Hospital link on a monthly basis. If the IPA cannot contract and credential another PCP to complete a group of five (5) PCPs who are capable of providing care to Members of all ages and genders, the IPA/Hospital link may be frozen up to a period of ninety (90) days. If the IPA/Hospital link is not compliant within a ninety (90) day timeframe, the IPA/Hospital link maybe terminated.
- J. The above procedure for IPA/Hospital link termination may be modified due to circumstances that in the judgment of the IEHP Chief Medical Officer or the Executive Director Health Services Operations is not in the best interest of the Member.
- K. In the absence of a contract between an IPA and a Hospital, the IPA may be required to use the rates that exist in the contract between the Hospital and IEHP. IEHP will periodically update the IPA of any such Hospital arrangements.
- L. In certain instances when emergency medical condition arises that requires medical care, to ensure uninterrupted care to Members from a Specialist not currently contracted, IEHP reserves the right to impose payment requirements on the IPA at the IEHP specified rate.

18. PROVIDER NETWORK

H. Hospital Affiliations

- M. On occasional basis, where a health care service was provided by a non-contracted Hospitalist or Specialist at a non-contracted hospital, this unique relationship requires IPAs to pay the Hospitalist or Specialist at the IEHP specified rate.

INLAND EMPIRE HEALTH PLAN		
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18. PROVIDER NETWORK

I. Leave of Absence

APPLIES TO:

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

POLICY:

- A. IPAs must ensure adequate coverage for PCPs on leave of absence for less than two (2) weeks.
- B. IPAs must submit written coverage plans to IEHP for any PCP that is scheduled to be on a leave of absence greater than two (2) weeks.
- C. IPAs must ensure that PCP completes the IEHP PCP leave of absence coverage form and return it to their Provider Services Representative (See Attachment, “IEHP PCP Leave of Absence Coverage Form” in Section 18).
- D. In general, leaves of absence by PCPs greater than ninety (90) days require transfer of assigned Members to another PCP.
- E. A leave of absence is defined as a complete absence from the PCP practice for medical, personal or other reasons, including vacation.

PROCEDURES:

- A. IPAs must ensure an adequate plan of coverage for all PCPs absent from their practice for less than two (2) weeks. Adequate coverage must include:
 - 1. Use of a credentialed IEHP PCP in the appropriate specialty for the practice, either at the PCP site or at another approved IEHP PCP site.
 - 2. The covering PCP must be available at the original PCP site, or another IEHP approved site, at least sixteen (16) hours per week.
 - 3. If coverage is not provided at the same office, a process for informing Members of the covering PCP’s name, phone number and office address utilizing the assigned PCP’s phone number (e.g., voice message) and site (e.g., signs, notices) must be in place.
- B. PCPs planning a leave of absence greater than two (2) weeks must inform their IPA at least sixty (60) days in advance.
- C. IPAs must submit a written coverage plan to IEHP no less than two (2) weeks prior to the PCP’s leave date for all PCPs whose leave of absence is greater than two (2) weeks. The coverage plan must include at a minimum:
 - 1. Name and location of the credentialed IEHP PCP providing coverage.

18. PROVIDER NETWORK

I. Leave of Absence

2. If the covering PCP is not at the same location as the PCP on leave, the plan for informing Members of the covering PCP's name, phone number and office address.
 3. The timeframe coverage is needed.
 4. Any significant change in schedule or hours of coverage from the original PCP site.
- D. For PCPs on a leave of absence greater than ninety (90) days, the IPA must submit either:
1. A plan for reassigning Members to another credentialed IEHP PCP within appropriate geographic proximity and specialty type of PCP; or
 2. A specific request to keep the assigned Members with the original PCP with supporting documentation as to why this is in the best interest of the Members and including a plan for interim coverage.
- E. If a PCP has an unexpected leave of absence or leaves the practice without providing notice, the IPA may submit a non-IEHP credentialed PCP as part of the coverage plan if the following information for the covering PCP is submitted to IEHP within three (3) working days of the unexpected leave of absence:
1. Copy of Provider application.
 2. Copy of current DEA.
 3. Copy of current malpractice certificate.
 4. Copy of current medical license.
 5. Copy of supervising PA certificate, if applicable.
- F. IPAs must provide IEHP a written Member transfer plan within five (5) days when a PCP leaves his/her practice without timely notice.
1. If the IPA plans to have current Members transferred to the covering PCP who is not credentialed for participation in the IEHP network, complete credentialing information must be submitted to IEHP within four (4) weeks of the original event.
- G. IEHP reviews all of the above submitted plans and either approves, denies, or requests additional information within five (5) working days of the receipt of the information from the IPA. If the coverage plan is denied, IEHP may determine reassignment of the Members.
- H. PCPs must complete an IEHP PCP leave of absence coverage form at the time of recredentialing so that IEHP has a record of who will provide services during the PCP's future leave of absence. The PCP must advise the PSR of any changes to this plan if they occur in the interim.

18. PROVIDER NETWORK

I. Leave of Absence

INLAND EMPIRE HEALTH PLAN		
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18. PROVIDER NETWORK

J. IEHP Termination of PCPs, Specialists, Vision, and Behavioral Health Providers

APPLIES TO:

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

POLICY:

- A. IEHP involuntarily terminates PCPs, Specialists, Vision, and Behavioral Health Providers from the IEHP network due to reasons delineated in credentialing and site audit policies.
- B. IEHP notifies Members in writing thirty (30) days prior to the effective date of the determination by IEHP to remove a PCP from participation in the IEHP network.
- C. IEHP or IPA is required to notify Members of a Specialist’s termination from the IEHP network upon receipt of notice from IEHP of the determination to remove a Specialist from participation in the IEHP network. The notification to Members must occur no later than thirty (30) days prior to the effective date of the termination.
- D. IEHP retains the right to obligate the IPA to continue to provide medical services for existing Members in accordance with Policy 12A5, “Care Management Requirements - Continuity of Care.”

PROCEDURES:

PCP Termination

- A. If IEHP is initiating the termination of the PCP due to site review failure, expiration of any credentialing requirements, insufficient access, peer review or quality of care issues or other reasons deemed appropriate by IEHP, and all appeal levels have been exhausted, IEHP notifies the PCP and the IPA (if applicable) that he/she is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, “Peer Review Termination Letter” in Section 18). A copy of the notification to the PCP is sent to the IPA.
- B. IEHP sends affected Members a letter notifying them of the PCP termination no later than thirty (30) days prior to the effective date (See Attachments, “Member PCP Termination Notification Letter – English” and “Member PCP Termination Notification Letter – Spanish” in Section 18). The letter provides the Member with the opportunity to contact IEHP to select a different PCP at least thirty (30) days prior to the effective date of termination of the Member’s current PCP from the IEHP network.
 - 1. In situations where immediate termination of the PCP is required, IEHP makes a good faith effort to allow Members sufficient notice to select a new PCP, however, in order to ensure that there is no interruption in care for the Member, IEHP may immediately transfer the Member and allow the Member to select a

18. PROVIDER NETWORK

J. IEHP Termination of PCPs, Specialists, Vision, and Behavioral Health Providers

PCP retroactively.

- C. IEHP makes an effort to transfer the existing enrollment of the terminated PCP to other PCPs within the affected IPA's network. The final decision regarding Member transfers rests with IEHP.
- D. If Members cannot be transferred within the IPA network due to age limitations or geographic location, IEHP reassigns these Members to a new PCP within IEHP's geographic service area who has the capacity and can accommodate the affected Members. IEHP does not guarantee that Members remain part of the IPA's network.
- E. Once IEHP establishes an effective date for the PCP termination and Member transfer, IEHP:
 - 1. Sends the IPA written notification regarding the effective date of termination and transfer of Members who have not selected a PCP (See Attachments, "Compliant Termination Letter" and "Non-Compliant Termination Letter" in Section 18.)
 - 2. Sends the affected Members a letter notifying them of the change in PCP thirty (30) days in advance of the new effective date. The letter again informs Members of their right to select their own PCP (See Attachments, "Member PCP Termination Notification Letter – English" and "Member PCP Termination Notification Letter – Spanish" in Section 18). Members may contact IEHP Member Services at (877) 273-4347 to select another PCP.

Specialist Termination

- A. If IEHP is initiating the termination of a Specialist due to peer review or quality of care issues and expiration of any credentialing requirements, IEHP notifies the Specialist and their IPA (if applicable) that he/she is being terminated from the IEHP network and the effective date of termination (See Attachment, "Peer Review Termination Letter" in Section 18.)
- B. Upon receipt of the termination notice from IEHP, the IPA must notify Members of the termination in accordance with policy 18D2, "IPA Reported Provider Changes - Specialty Practitioner Termination." The notice to Members must be sent no later than thirty (30) days prior to the effective date and must include the option for Members to continue care with their existing Provider for up to ninety (90) days in accordance with policy 12A5, "Care Management Requirements - Continuity of Care." A sample Member notification is included as Attachments, "Specialist Termed Member Notification – English" and "Specialist Termed Member Notification – Spanish" in Section 18.

Vision Provider Termination

- A. If IEHP is initiating the termination of the Vision Provider due to site review failure, expiration of any credentialing requirements, peer review or quality of care issues or

18. PROVIDER NETWORK

J. IEHP Termination of PCPs, Specialists, Vision, and Behavioral Health Providers

other reasons deemed appropriate by IEHP, and all appeal levels have been exhausted, IEHP notifies the Vision Provider that he/she is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, “Peer Review Termination Letter” in Section 18).

Behavioral Health Provider Termination

- A. If IEHP is initiating the termination of the Behavioral Health (BH) Provider due to site review failure, expiration of any credentialing requirements, peer review or quality of care issues or other reasons deemed appropriate by IEHP, and all appeal levels have been exhausted, IEHP notifies the BH Provider that he/she is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, “Peer Review Termination Letter” in Section 18).
- B. When a BH Provider is being terminated, the BH Provider or the BH Provider’s office needs to cooperate with IEHP BH Department in developing a transition plan for impacted IEHP Members that ensures Members are not abandoned and that BH Providers are compliant with their licensing board requirements and maintain ethical standards of practice. In order to coordinate the transition of IEHP Members, BH Providers may be required to provide a list of active IEHP Members who will need to be transitioned to another BH Provider, treatment records, and/or medication lists with the IEHP BH Department.

INLAND EMPIRE HEALTH PLAN		
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18. PROVIDER NETWORK

K. Hospital Network Participation Standards

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medi-Caid Plan) Hospital Providers.

POLICY:

- A. IEHP is responsible for the initial and ongoing assessment of Hospitals directly contracted with IEHP.
- B. Prior to contracting, IEHP verifies the services available, accreditation status and/or Centers for Medicare and Medicaid Services (CMS) Survey Site Survey, license, and standing with regulatory bodies in compliance with the most current NCQA standards, CMS and regulatory requirements prior to contracting with such organization.
- C. IEHP reconfirms the status of all contracted Hospitals concurrently upon expiration and every contract renewal period, but no less than every three (3) years.
- D. IEHP maintains the appropriate records to document the verification process for contracted Hospitals per the most recent NCQA and CMS guidelines and IEHP requirements.
- E. IEHP does not contract with Hospitals if they appear on the Provider decertification list provided by the Department of Health Care Services (DHCS). Hospitals listed on the decertification list are no longer certified to receive payment from the Medi-Cal Program for services rendered to Medi-Cal beneficiaries as the effective date noted for each Provider. IEHP reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Provider Agreement.
- F. IEHP does not contract with Hospitals if they appear on the list of indicted Providers provided by DHCS. If the Hospital is under investigation and a credible allegation of fraud has been found against the facility, as a result of this investigation IEHP will temporarily suspend/suppress the Hospital contract from the network pending resolution of the fraud allegation.

PROCEDURES:

- A. Hospitals must submit evidence of services provided, accreditation status and or CMS Site Survey, license status, and regulatory standing at the time the Hospital applies to participate in IEHP’s network. Copies of the Hospital’s accreditation certificate, license and most recent regulatory audit results satisfy this requirement.
- B. To contract with and remain in the IEHP network, the Hospital must provide:
 - 1. Inpatient Services

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

- a. Intensive Care Unit;
 - b. Medical Service, Surgical Service or combined Medical/Surgical Service;
 - c. Pediatric Service; and
 - d. Obstetrics/Perinatal Unit (or established arrangements for care approved by the IEHP Chief Medical Officer).
2. Outpatient Services
 - a. Basic Emergency Department physician on-duty; or
 - b. Standby Emergency Department (applicable only for Hospitals located in remote areas), with IEHP Chief Medical Officer approval.
- C. If Hospital offers Behavioral Health services, the following applies:
1. Inpatient Services
 - a. Inpatient hospitalization in semi-private accommodation, unless a private room is medically necessary;
 - b. Secure inpatient psychiatric unit;
 - c. Psychiatric and substance abuse services;
 - d. Ancillary services and supplies, including laboratory and x-ray services;
 - e. Administration of outpatient prescription drugs (take home medications) in instances where continuation of hospital-based treatment must not be interrupted: three (3) day supply minimum; and
 - f. Administration of blood, blood plasma, or its derivatives, including cost of blood, blood plasma, or its derivatives.
 2. Outpatient Services
 - a. Structured outpatient Behavioral Health Program;
 - b. Partial hospitalization services; and
 - c. Others.
- D. The Hospital must be accredited by one of the following accrediting agencies:
1. The Joint Commission (TJC);
 2. Healthcare Facilities Accreditation Program (HFAP);
 3. Behavioral Health – Commission on Accreditation of Rehabilitation Facilities (CARF);
 4. Det Norske Veritas Healthcare (DNV); and
 5. Center for Improvement in Healthcare Quality (CIHQ).

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K. Hospital Network Participation Standards

- E. If a Hospital is accredited by an agency not listed above, the Hospital and IEHP must agree upon an alternate solution that meets IEHP's requirements, including the requirement to complete a site review and/or a CMS Site Survey of the Hospital, as applicable, in addition to meeting other standards as defined by IEHP.
- F. As part of the application review process, and again during each contract renewal period but no less than every three (3) years, IEHP verifies that each Hospital has:
1. A current and unencumbered license;
 2. Current certification The Joint Commission, HFAP, CARF, DNV, as applicable, or an alternative accreditation or site review as determined by IEHP; and
 3. No Medicare/Medicaid sanctions against them.
- G. IEHP expects the Hospital to maintain its accreditation and license status in good standing and/or current at all times during the Hospital's participation in the IEHP network. The Hospital is responsible for providing IEHP with copies of its renewed license and accreditation within thirty (30) days following the expiration of the license and accreditation.
- H. On a monthly basis, the Contracts Administration Coordinator, or designee reviews the Medi-Cal Suspended and Ineligible list to verify Hospitals contracted with the Plan have no Medicaid sanctions and/or uses the sanction screening service OIG Compliance Now or via the following website: <http://www.medi-cal.ca.gov/default.asp>
- I. Additionally, once a month, the Contracts Administration Coordinator, or designee, researches the authorized government websites and/or uses the sanction screening services OIG Compliance Now to verify Hospitals contracted with the Plan have no Medicare/Medicaid sanctions or via the following website:
<http://www.sam.gov> for System for Award Management (SAM)
- J. Licensing and Accreditation must be re-verified at a minimum every three (3) years from the date of the original verification to confirm the Hospital continues to be in good standing with the State and Federal regulatory bodies.
- K. IEHP reserves the right to perform facility site audits when quality of care issues arise and to deny Hospital's participation in the IEHP network if IEHP requirements are not met.
- L. If during the contract period, IEHP becomes aware of a change in the accreditation and/or CMS site Survey, license or certification status, or sanctions, fraudulent activity or other legal or remedial actions have been taken against any Hospital, the Contract Coordinator notifies the Contracts Manager, Medical Director and the Compliance Department at DGStateProgram@IEHP.org within five (5) days of discovering our Provider/Hospital has been added to a disciplinary list. The Director of Provider Contracting informs the Hospital 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 reserves the right to

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Agreement.

REFERENCE:

- A. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-001 and supersedes (APL) 06-007, “Medi-Cal Provider and Subcontract Suspensions, Terminations, and Decertifications.”

INLAND EMPIRE HEALTH PLAN		
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18. PROVIDER NETWORK

L. Providers Charging Members

APPLIES TO:

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

POLICY:

- A. A “Health Care Provider” means any practitioner or professional person, acute care hospital organization, health facility, ancillary Provider or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.
- B. IEHP prohibits contracted Health Care Providers from charging and/or collecting payment from an IEHP DualChoice Member, or other persons on behalf of the Member, for missed appointments.
- C. IEHP prohibits contracted Health Care Providers from charging and/or collecting payment from an IEHP DualChoice Member, or other persons on behalf of the Member, for filling out forms related to the delivery of medical care. Any Provider of health care services shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or any person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.
- D. According to California Health and Safety Code, Section 123110.b, any Member or Member’s representative shall be entitled to copies of all or any portion of the Member medical records that he or she has a right to inspect, upon presenting a written request to the Health Care Provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed twenty-five cents (\$0.25) per page or fifty cents (\$0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. The Health Care Provider shall ensure that the copies are transmitted within fifteen (15) days after receiving the written request.
- E. In circumstances where charging a Member for completion of a form is allowed, fees should be nominal and not to exceed twenty-five cents (\$0.25) per page with a maximum charged allowed of twenty dollars (\$20).
- F. Under no circumstances can a Health Care Provider deny or refuse service to an IEHP Member for non-payment of a missed appointment or lack of payment for co-payments and owed balance or deductibles, as applicable.
- G. Any contracted Health Care Provider who is furnished documentation of a person’s enrollment in the IEHP DualChoice program, shall not seek reimbursement nor attempt to obtain payment for any covered services provided to the IEHP Member other than the participating health plan.

18. PROVIDER NETWORK

L. Providers Charging Members

- H. IEHP Members are not liable for any portion of a bill provided by a Health Care Provider, except non-covered benefits, items, or services.

PROCEDURES:

- A. A Provider cannot charge or bill an IEHP DualChoice Member or IEHP for a covered service, except to:
1. Collect payments due under legal entitlement.
- B. Medicare Cost-Sharing – Coinsurance, copays, and deductibles are \$0 for all Medicare Parts A and B services furnished to IEHP DualChoice Members.
- C. A missed appointment is not a co-payment or a service therefore, Providers cannot charge IEHP DualChoice Members for missed appointments.
- D. The following procedures will be followed when a Provider attempts to charge a Member for any missed appointment:
1. IEHP will call the Provider and educate regarding the inappropriate practice of charging for a missed appointment.
 2. If a Provider insists on charging the Members, IEHP will send a letter educating the Provider. At IEHP's sole discretion, IEHP can provide the Member with a toll free number to report the Provider for fraud.
 3. If a Provider continues the practice of charging for missed appointments, IEHP will request that a CMS Fraud Investigator to contact the Provider.
 4. Under no circumstances can a Provider deny service to a Member for non-payment of a missed appointment charge or other charges to Member when they were not an eligible IEHP Member.
- D. Provider of Service cannot charge or collect payments at anytime for filling out any of the following forms or required medical documentation:
1. WIC referral forms;
 2. PM160 Well Child Visit form;
 3. Lead Testing questionnaire;
 4. Prescriptions;
 5. Yellow Cards and/or any request for the documentation of a Member's immunization history;
 6. Other forms related to the delivery of medical care;
 7. Any forms required for a Member to qualify as eligible for IEHP DualChoice including, but not limited to, Cal Works Forms (CW 61 or an equivalent);

18. PROVIDER NETWORK

L. Providers Charging Members

8. Any forms to facilitate transportation, including applications for paratransit service and Department of Motor Vehicles Disabled Placard Applications;
 9. In-Home Support Services (IHSS) Medical Certification Form SOC 873; and
 10. Any forms related to LTSS benefits including CBAS.
- E. Providers can charge IEHP Members a nominal fee for filling out any of the following forms:
1. History and Physical form that is school specific and the PM 160 will not meet the school requirement;
 2. Sports Physical;
 3. Disability forms; and
 4. Utility Company Medical Baseline Program Applications.
- F. A Health Care Provider that is not paid at billed charges may not pursue any balance billing or collection actions against any IEHP Member. Such collections actions may include:
1. Sending or mailing bills to IEHP Member;
 2. Calling any IEHP Member with demands to pay outstanding balance; and
 3. Referrals to collection agency.
- G. If the Provider of service continues to charge a Member in violation of this policy after being notified to stop, or sends the Member's account to a collections agency, IEHP reserves the right to inform CMS or other regulatory agencies of the violation. In addition, the billing of Members is in violation of IEHP policy, and IEHP takes all necessary actions, up to and including termination of the Provider's participation with IEHP to ensure that such actions stop.

REFERENCE:

- A. California Health and Safety Code, Section 123110.b.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	July 1, 2012
Chief Title: Chief Medical Officer	Revision Date:	January 1, 2019

18. PROVIDER NETWORK

M. Outsourcing Standards and Requirements

APPLIES TO:

- A. This policy applies to all IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) IPAs in IEHP’s network who outsource 1) services requiring the use and/or disclosure of IEHP protected health information (“PHI”) or personally identifiable information (“PII”), as those terms are defined under HIPAA and/or California law; and 2) services requiring physician licensure, in providing services to IEHP.

POLICY:

- A. Outsourcing is a business practice where a service is performed from an outside organization either offshore or onshore. The outsourced vendor provides services to contracted IPAs in IEHP’s network.
1. Onshore Outsourcing: obtaining services from a third-party outside the delegated IPA but within the United States.
 2. Offshore Outsourcing: obtaining services from a third-party outside the delegated IPA and outside of the United States.
- B. With respect to the outsourcing of IEHP PHI and/or PII, the delegated IPAs must perform due diligence on any vendors considered for outsourcing PHI and/or PII before any agreements or contracts are executed to ensure such agreements comply with IEHP’s established standards and requirements.
1. Any delegated IPAs wishing to outsource any service involving PHI and/or PII must obtain written approval from IEHP prior to utilizing such vendors as outlined in **PROCEDURE**, below. Without prior written approval from IEHP, the IPA is not permitted to outsource any of the work outlined in the IPA Agreement. If services were ongoing prior to IPA’s contract with IEHP, IPA shall seek immediate approval by IEHP to apply retrospectively.
 2. Delegated IPAs must ensure that any vendor to whom it has outsourced services involving IEHP PHI or PII complies with all applicable state and federal privacy laws, such as the Health Insurance Portability and Accountability Act (“HIPAA”).
 3. Delegated IPAs are prohibited from outsourcing any services that involve PHI and/or PII to offshore vendors.
- C. With respect to the outsourcing of physician services (i.e. utilization management services), the delegated IPAs must ensure compliance with all State of California requirements regarding in-state physician licensure.
- D. IEHP is firmly committed to complying with all applicable legal and contractual obligations under all state and federal programs, laws, regulations, and directives

18. PROVIDER NETWORK

M. Outsourcing Standards and Requirements

applicable to Medi-Cal, Medicare and other lines-of-business in which IEHP may choose to participate. As a result, delegated IPAs outsourcing services involving IEHP PHI and/or PII, or physician services, are expected to respect and comply, and also require their vendors to comply, with all such applicable obligations.

DEFINITION:

- A. Offshore subcontractor: is defined as First tier, downstream, related entity located outside of one of the fifty (50) U.S. States, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands).

PROCEDURES:

- A. As to outsourcing of business services/activities involving IEHP PHI and/or PII: Delegated IPAs seeking to obtain approval of a vendor who will use and/or disclose IEHP PHI and/or PII shall submit a written request to approve same to IEHP.
1. IEHP will approve or deny the vendor within thirty (30) days of receiving the information detailed in **POLICY**, Section C.
 2. Once IPA has conducted the due diligence outlined below, IPA shall submit a written report detailing the findings.
 3. IPA shall first conduct a background check and verify vendor's services through a minimum of two (2) references. The background check shall consist of:
 - a. Corporate history, reputation, capabilities and financial stability.
 - b. Any subcontracted or outsourced activities provided or currently being provided to comparable entities.
 - c. Assessment of what information/tools is necessary for the vendor to deliver the said product and/or service, and whether the vendor maintains such information/tools.
 4. Should vendor pass the step outlined in subsection **POLICY**, above, the delegated IPA shall perform a detailed assessment of the vendor's ability to maintain data security (i.e. administrative, technical, and physical safeguards required by HIPAA). This assessment may include but is not limited to:
 - a. Review of the entity's current data security and compliance training program.
 - b. Review of technical specifications of anti-virus, firewall and other software being utilized to prevent intrusion.
 - c. Review of company's policy on securing communications.
 - d. Review of company's policy on fraud, waste and abuse.

18. PROVIDER NETWORK

M. Outsourcing Standards and Requirements

5. If the vendor's ability to maintain data security has been successfully assessed, the delegated IPA and the vendor shall enter into an agreement (subject to IEHP's approval) that, at minimum, addresses the following:
 - a. The product and/or service to be delivered by the vendor to IPA.
 - b. A statement clearly indicating vendor's agreement to comply with all applicable provisions under HIPAA and California law relating to the privacy and/or security of the IEHP PHI.
 6. Decisions to accept the vendor to whom the IPA wishes to outsource business services/activities involving IEHP PHI and/or PII are subject to review by the IEHP Compliance Department and approval by IEHP's Chief Network Officer and/or Executive Director Health Services Operations.
- B. As to outsourcing of physician services: Delegated IPAs shall be required to ensure compliance of all vendors as outlined under "**POLICY**, Section C" and shall demonstrate such compliance if requested by IEHP.
- C. Final Decision:
1. IEHP reserves the right to request, modify or terminate the delegated IPA agreement at any time if IPA is non-compliant with IEHP's requirements under this policy.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	July 1, 2015
Chief Title: Chief Medical Officer	Revised Date:	January 1, 2019

18. PROVIDER NETWORK

N. IPA Medical Director Standards

APPLIES TO:

- A. This policy applies to all IPAs providing care to IEHP DualChoice Cal MediConnect Plan (Medicare – Medicaid Plan) Members.

POLICY:

- A. The Medical Director identifies IPA network gaps in primary and specialty care coverage and ensures access to care for IEHP Members. He or she maintains an open professional relationship with the IPA physician network.
- B. The Medical Director is highly encouraged to network with IEHP and other Medical Directors to stay current with recent managed care/industry trends and best practices and act as the communicator back to their organization.
- C. The Medical Director serves as the physician liaison between the IPA, health plan, skilled nursing facilities (SNFs), hospitals and other network Providers.
- D. The Medical Director should be involved in tracking and trending of potential fraud, waste and abuse involving IEHP Members and Providers.
- E. The Medical Director shall serve as chair for clinical committees such as Credentialing, Utilization Management (UM), Quality Management (QM), or Peer Review committees, as applicable.
- F. The Medical Director should promote innovative solutions toward achieving the Triple Aim for IEHP Members.
- G. Preference should be given to hiring Medical Directors with Primary Care experience.

PROCEDURES:

Utilization Management

- A. The Medical Director timely and personally reviews all potential authorization denials and partial approvals (modifications) for:
 - 1. Correct clinical decision-making;
 - 2. Correct application of IEHP approved criteria using the hierarchy appropriate to the line of business per Policy 14A, “Utilization Management Delegation and Monitoring”; and
 - 3. Use of denial language that is simple and at the appropriate grade level, ensuring that both the denial reason and specific criteria not met are understood by the IEHP Member.
- B. The Medical Director provides his or her signature on all denials and partial approvals (modifications) due to lack of medical necessity.

18. PROVIDER NETWORK

N. IPA Medical Director Standards

- C. The Medical Director is immediately available for any urgent or expedited decisions.
- D. The Medical Director provides clinical expertise for Members requiring complex medical care, higher level of care and out of network services.
- E. The Medical Director consults with IPA physicians to ensure correct utilization of UM criteria and initiates outreach to Providers showing a pattern of inappropriate authorization requests.
- F. The Medical Director ultimately ensures that IEHP Members receive any medically necessary services including cases when criteria language appears vague or non-specific.

Quality and Care Management

- A. The Medical Director:
 - 1. Is immediately available to consult on all complex care management and care coordination cases as needed;
 - 2. Reviews all Provider and IPA grievances for adverse trends or Potential Quality Incidents (PQIs);
 - 3. Reaches out to Providers as necessary to ensure timely response to grievance inquiries;
 - 4. Has input on all PQI cases with understanding of community standards for medical care;
 - 5. Has oversight of the IPA Quality Improvement process, policy and strategy; and
 - 6. Has fundamental understanding of National Committee on Quality Assurance (NCQA) metrics, Medi-Cal (or Medicare) regulations and is involved in the IPA metric improvement strategy.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective date:	January 1, 2016
Chief Title: Chief Medical Officer	Revision date:	January 1, 2019

18. PROVIDER NETWORK

Attachments

<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
California Health and Safe Code 123110	18L
Change in Hospital Affiliation Letter	18C
Change in IPA Affiliation Letter	18C
Compliant Termination Letter	18D1, 18I, 18J
Frozen Enrollment Change Status	18A2
Hospital Geographic Service Areas	18F
Limited Enrollment Change Status	18A2
IPA Hospital Link Responsibility Grid – IEHP DualChoice	18F
IEHP PCP Leave of Absence Coverage Form	18I
Member PCP Term Notification Letter – English	18D1, 18I, 18J
Member PCP Term Notification Letter – Spanish	18D1, 18I, 18J
Non Compliant Termination Letter	18D1, 18I, 18J
Over Enrollment Change Letter	18A2
Peer Review Termination Letter	18J
Specialty Panel Worksheet	18F
Specialist Term Member Notification - English	18D2, 18J
Specialist Term Member Notification- Spanish	18D2, 18J



HEALTH AND SAFETY CODE - HSC

DIVISION 106. PERSONAL HEALTH CARE (INCLUDING MATERNAL, CHILD, AND ADOLESCENT) [123100 - 125850] (*Division 106 added by Stats. 1995, Ch. 415, Sec. 8.)*

PART 1. GENERAL ADMINISTRATION [123100 - 123223] (*Part 1 added by Stats. 1995, Ch. 415, Sec. 8.)*

CHAPTER 1. Patient Access to Health Records [123100 - 123149.5] (*Chapter 1 added by Stats. 1995, Ch. 415, Sec. 8.)*

123110. (a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient's personal representative shall be entitled to inspect patient records upon presenting to the health care provider a request for those records and upon payment of reasonable costs, as specified in subdivision (k). However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A health care provider shall permit this inspection during business hours within five working days after receipt of the request. The inspection shall be conducted by the patient or patient's personal representative requesting the inspection, who may be accompanied by one other person of his or her choosing.

(b) (1) Additionally, any patient or patient's personal representative shall be entitled to a paper or electronic copy of all or any portion of the patient records that he or she has a right to inspect, upon presenting a request to the health care provider specifying the records to be copied, together with a fee to defray the costs of producing the copy or summary, as specified in subdivision (k). The health care provider shall ensure that the copies are transmitted within 15 days after receiving the request.

(2) The health care provider shall provide the patient or patient's personal representative with a copy of the record in the form and format requested if it is readily producible in the requested form and format, or, if not, in a readable paper copy form or other form and format as agreed to by the health care provider and the patient or patient's personal representative. If the requested patient records are maintained electronically and if the patient or patient's personal representative requests an electronic copy of those records, the health care provider shall provide them in the electronic form and format requested if they are readily producible in that form and format, or, if not, in a readable electronic form and format as agreed to by the health care provider and the patient or patient's personal representative.

(c) Copies of X-rays or tracings derived from electrocardiography, electroencephalography, or electromyography need not be provided to the patient or patient's personal representative under this section, if the original X-rays or tracings are transmitted to another health care provider upon written request of the patient or patient's personal representative and within 15 days after receipt of the request. The request shall specify the name and address of the health care provider to whom the records are to be delivered. All reasonable costs, not exceeding actual costs, incurred by a health care provider in providing copies pursuant to this subdivision may be charged to the patient or representative requesting the copies.

(d) (1) Notwithstanding any provision of this section, and except as provided in Sections 123115 and 123120, a patient, former patient, or the personal representative of a patient or former patient, is entitled to a copy, at no charge, of the relevant portion of the patient's records, upon presenting to the provider a written request, and proof that the records or supporting forms are needed to support a claim or appeal regarding eligibility for a public benefit program. These programs shall be the Medi-Cal program, the In-Home Supportive Services Program, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, social security disability insurance benefits, Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP) benefits, federal veterans service-connected compensation and nonservice connected pension disability benefits, and CalFresh.

(2) Although a patient shall not be limited to a single request, the patient or patient's personal representative shall be entitled to no more than one copy of any relevant portion of his or her record free of charge.

(3) This subdivision shall not apply to any patient who is represented by a private attorney who is paying for the costs related to the patient's claim or appeal, pending the outcome of that claim or appeal. For purposes of this subdivision, "private attorney" means any attorney not employed by a nonprofit legal services entity.

(e) If the patient's appeal regarding eligibility for a public benefit program specified in subdivision (d) is successful, the hospital or other health care provider may bill the patient, at the rates specified in subdivisions (b) and (c), for the copies of the medical records previously provided free of charge.

(f) If a patient or his or her personal representative requests a record pursuant to subdivision (d), the health care provider shall ensure that the copies are transmitted within 30 days after receiving the written request.

(g) This section shall not be construed to preclude a health care provider from requiring reasonable verification of identity prior to permitting inspection or copying of patient records, provided this requirement is not used oppressively or discriminatorily to frustrate or delay compliance with this section. Nothing in this chapter shall be deemed to supersede any rights that a patient or personal representative might otherwise have or exercise under Section 1158 of the Evidence Code or any other provision of law. Nothing in this chapter shall require a health care provider to retain records longer than required by applicable statutes or administrative regulations.

(h) This chapter shall not be construed to render a health care provider liable for the quality of his or her records or the copies provided in excess of existing law and regulations with respect to the quality of medical records. A health care provider shall not be liable to the patient or any other person for any consequences that result from disclosure of patient records as required by this chapter. A health care provider shall not discriminate against classes or categories of providers in the transmittal of X-rays or other patient records, or copies of these X-rays or records, to other providers as authorized by this section.

Every health care provider shall adopt policies and establish procedures for the uniform transmittal of X-rays and other patient records that effectively prevent the discrimination described in this subdivision. A health care provider may establish reasonable conditions, including a reasonable deposit fee, to ensure the return of original X-rays transmitted to another health care provider, provided the conditions do not discriminate on the basis of, or in a manner related to, the license of the provider to which the X-rays are transmitted.

(i) Any health care provider described in paragraphs (4) to (10), inclusive, of subdivision (a) of Section 123105 who willfully violates this chapter is guilty of unprofessional conduct. Any health care provider described in paragraphs (1) to (3), inclusive, of subdivision (a) of Section 123105 that willfully violates this chapter is guilty of an infraction punishable by a fine of not more than one hundred dollars (\$100). The state agency, board, or commission that issued the health care provider's professional or institutional license shall consider a violation as grounds for disciplinary action with respect to the licensure, including suspension or revocation of the license or certificate.

(j) This section prohibits a health care provider from withholding patient records or summaries of patient records because of an unpaid bill for health care services. Any health care provider who willfully withholds patient records or summaries of patient records because of an unpaid bill for health care services is subject to the sanctions specified in subdivision (i).

(k) (1) Except as provided in subdivision (d), a health care provider may impose a reasonable, cost-based fee for providing a paper or electronic copy or summary of patient records, provided the fee includes only the cost of the following:

(A) Labor for copying the patient records requested by the patient or patient's personal representative, whether in paper or electronic form.

(B) Supplies for creating the paper copy or electronic media if the patient or patient's personal representative requests that the electronic copy be provided on portable media.

(C) Postage, if the patient or patient's personal representative has requested the copy, or the summary or explanation, be mailed.

(D) Preparing an explanation or summary of the patient record, if agreed to by the patient or patient's personal representative.

(2) The fee from a health care provider shall not exceed twenty-five cents (\$0.25) per page for paper copies or fifty cents (\$0.50) per page for records that are copied from microfilm.

(Amended by Stats. 2017, Ch. 626, Sec. 1.5. (SB 575) Effective January 1, 2018.)



INLAND EMPIRE HEALTH PLAN

[Date]

[DOCTOR NAME]

[ADDRESS]

[CITY, CA ZIP]

RE: Change in Hospital Affiliation

Dear [PCP Name]:

This letter is to acknowledge receipt of your letter dated [Date] requesting a hospital affiliation change from [Old Hospital Name] to [New Hospital Name].

In compliance with IEHP's Provider Policy and Procedure Manual, your affiliation with [New Hospital Name] will become effective [Date]. According to IEHP Provider Policy and Procedure Manual, this change is considered compliant.

If you need assistance or clarification, please feel free to contact me at [Phone #].

Sincerely,

[PSR Name]

Provider Services Representative

cc: [Hospital]

[IPA]

[First Name, Last Name], Executive Director of Health Services Operations, IEHP

[First Name, Last Name], Director of Provider Relations, IEHP

[IPA File]

[PCP File]



INLAND EMPIRE HEALTH PLAN

[Date]

[DOCTOR NAME]

[ADDRESS]

[CITY, CA ZIP]

RE: Change in IPA Affiliation

Dear Dr. [PCP Name]:

This is to acknowledge receipt of your letter dated [Date of Letter], requesting that your IPA affiliation be changed to [New IPA Name].

In compliance with IEHP Provider Policy and Procedures, provided there are no credentialing or contract issues, this change will be made effective on the 1st of the month following 60 days from notification - [Effective Date]. Please be advised that though this is an IEHP Policy (18C), you may have different commitments under your contractual agreement with [Old IPA Name].

Administrative issues will remain the responsibility of [Old IPA Name] through [End Date].

If you have questions or concerns, please contact me at [PSR Phone Number].

Sincerely,

[PSR Name]

Provider Services Representative

cc: [Old IPA Name]

[New IPA Name]

[First Name Last Name], Executive Director of Health Services Operations, IEHP

[First Name Last Name], Director of Provider Relations, IEHP

[IPA File]

[PCP File]



INLAND EMPIRE HEALTH PLAN

[Date]

[IPA NAME]
[ADDRESS]
[CITY, CA ZIP]

RE: [PCP Name & Number] TERMINATION

Dear [IPA Contact Name]:

This letter is to acknowledge receipt of your letter dated [Date] requesting the termination of Dr. [Doctor Name] from the IEHP network. Dr. [Doctor Name] will be terminated as an IEHP PCP within [IPA Name] effective [Date] and [his/her] patients will be reassigned to Dr. [New Doctor Name], effective [Date].

Under IEHP Policy 18D, the IPA is required to give IEHP a 60-day advance written notice. This notification of termination is compliant since a 60-day advance written notice was provided.

If you have any questions or concerns, please call me at [PSR Phone #]

Sincerely,

[PSR Name]
Provider Service Representative

cc: [PCP Name]
[Hospital]
[First Name Last Name], Executive Director of Health Services Operations, IEHP
[First Name Last Name], Director of Provider Relations, IEHP



[DATE]

[IPA Contact Name] or [Provider Name]
[IPA NAME]
[Address]
[CITY, STATE ZIP]

RE: [PCP NAME] – Enrollment Status Change

Dear [IPA Contact Name/Provider Name]:

Dear Ms. Stephenson:

This letter is to inform you that [PROVIDER NAME] PCP status has been changed to “Frozen” for Member enrollment due to [REASON FOR FREEZE]. This change will become effective as of [EFFECTIVE DATE]. This freeze applies only to Auto Assignment, HCO Enrollment, Family Assignment and Member Choice.

If you have any questions or concerns, please call me at [PSR PHONE #].

Sincerely,

[PSR NAME]
Provider Services Representative

cc: PCP
IPA
[FIRST NAME LAST NAME], Executive Director of Health Services
Operations, IEHP, 130.d
[FIRST NAME LAST NAME], Director of Provider Services, IEHP
PCP File

HOSPITAL GEOGRAPHIC SERVICE AREAS

Hospital Name	Service Area
Community Hospital of San Bernardino	S1
St. Bernardine Medical Center	S1
Hemet Valley Medical Center	R3
John F. Kennedy Memorial Hospital	R6, E1,E2
Menifee Valley Medical Center	R5
Kaiser Foundation Hospital MVH	R1, E2
Desert Regional Medical Center	R6,E1,E2
Loma Linda University Medical Center - Murrieta	R5
Loma Linda University Medical Center	S1
Temecula Valley Hospital Inc	R5
Loma Linda University Children's Hospital	S1
Arrowhead Regional Medical Center	S1
Parkview Community Hospital Medical Center	R1
Kaiser Fontana	S1
Kaiser Riverside	R1
Corona Regional Medical Center	R4,R5
Riverside University Health Care System	R1
Victor Valley Global Medical Center	S3
Riverside Community Hospital	R1
Pomona Valley Hospital Medical Center	S2
Rancho Springs Medical Center	R5
Inland Valley Regional Medical Center	R5
Redlands Community Hospital	S1
San Geronio Memorial Hospital	R2
Montclair Hospital Medical Center	S2
Barstow Community Hospital	E7
Mountains Community Hospital	E3
Eisenhower Medical Center	R6,E1,E2
St Mary Medical Center	S3

Chino Valley Medical Center	S2
Desert Valley Hospital	S3
Bear Valley Community Healthcare	E3
Hi Desert Medical Center	S3
San Antonio Community Hospital (Medicare only)	S2

HOSPITAL GEOGRAPHIC SERVICE AREAS

R1 Riverside Proper

Mira Loma, Riverside, Nuevo, Perris, Moreno Valley, Glen Avon, Sunny Slope, Rubidoux, Belltown, Pedley, Highgrove, Arnold Heights, Woodcrest, Glen Valley, Mead Valley, Good Hope

R2 The Pass

Banning, Beaumont, Cabazon, Calimesa, Cherry Valley, Eden Hot Springs, San Geronio

R3 Hemet Region

Idyllwild, Hemet, Homeland, Mountain Center, San Jacinto, Winchester, Starchrest, Romoland, Green Acres, Nuevo, Lakeview, Juniper Flats, Gilman Hot Springs, Valle Vista, Pine Cove, Mountain Center

R4 Corona Region

Corona, Norco, El Cerrito, Home Gardens, Rancho California

R5 Temecula Region

Aguanga, Anza, Canyon Lake, Lake Elsinore, Menifee, Murrieta, Sun City, Temecula, Wildomar, Quail Valley, Sedco Hills, El Cariso, Lakelad Village

R6 Low Desert

Cathedral City, Coachella, Desert Hot Springs, Indian Wells, Indio, La Quinta, Mecca, North Palm Springs, Palm Desert, Palm Springs, Rancho Mirage, Thermal, Thousand Palms, Whitewater Springs, Sky Valley, Painted Hills, Desert Haven, Bermuda Dunes

S1 San Bernardino Proper

Bloomington, Colton, Fontana, Grand Terrace, Highland, Patton, Rialto, San Bernardino, Bryn Mawr, Crafton, Loma Linda, Crestmore, Muscoy, Verdemont, Mentone Redlands, Yucaipa

S2 West End San Bernardino

Alta Loma, Chino, Chino Hills, Etiwanda, Guasti, Montclair, Mount Baldy, San Antonio Heights, Ontario, Pomona, Rancho Cucamonga, Upland, Claremont

S3 High Desert

Adelanto, Apple Valley, Hesperia, Lucerne Valley, Oro Grande, Phelan, Pinon Hills, Victorville, Baldy Mesa, Summit

E1 Blythe

Blythe, Ripley, Desert Center, Mesa Verde, Ehrenberg, Eagle Mountain

E2 Yucca/Morongo Valley

Amboy, Cadiz, Landers, Joshua Tree, Morongo Valley, Pioneer Town, Twenty-nine Palms, Yucca Valley, Wonder Valley, Rimrock

E3 Mountains

Angelus Oak, Big Bear City, Big Bear Lake, Blue Jay, Cedar Glen, Cedarpines Park, Crestline, Crest Park, Phelan, Fawnskin, Forest Falls, Green Valley Lake, Lake Arrowhead, Rimforest, Running Springs, Sky Forest, Sugar Loaf, Twin Peaks

E6 Colorado River

Blythe, Big River, Parker Dam

E7 Barstow

Baker, Barstow, Daggett, Fort Irwin, Hinkley, Ludlow, Yermo, Newberry Springs, Desert Center, Lenwood, Helendale



IEHP PCP Leave of Absence Coverage Form

In compliance with IEHP Provider Policy **18.I Leave of Absence**, which requires an adequate coverage plan for all leaves of absence from my practice greater than two (2) weeks,

I, _____, have entered into an Agreement with
(PCP Name)
_____ who will be available to my
(Covering Provider's Name /or Group Name)
IEHP patients for direction of care during my absence.

_____ can be reached at _____,
(Covering Provider's Name/ Group Name) (Telephone #)
located at _____
(Address)

In the event I enter into a different Agreement for coverage during a leave of absence, I will provide IEHP sixty (60) days advance written notification who the covering Provider will be during any future leaves of absence.

I understand the information provided above will be utilized by IEHP when directing my IEHP patients during any leave of absences greater than two (2) weeks. If IEHP does not receive notification of coverage for a leave of absence greater than two (2) weeks, my panel may be frozen until a coverage plan is received or pending my return. A leave of absence greater than ninety (90) days could result in a transfer of assigned Members to another PCP.

Physician Name

Date



IPA HOSPITAL LINK RESPONSIBILITY GRID

IPA RESPONSIBILITY										IEHP PROVIDER SERVICES RESPONSIBILITY				IEHP CREDENTIALING RESPONSIBILITY				
LICENSE#	LAST NAME	FIRST NAME	SUFFIX	DEGREE	SPECIALTY	ADDRESS	CITY	ZIP	COMMENTS	PCP office Miles/Minutes from Hospital	Existing Provider with IPA under IEHP	Choice Letter Required	Provider Profile Contract, & W-9 required	COMMENTS	Meets Specialty Requirements	Hospital Admitting Privileges Type	COMMENTS	Effective date with IPA



[DATE]

[IPA Contact Name] or [Provider Name]
[IPA NAME]
[Address]
[CITY, STATE ZIP]

RE: [PCP NAME] – Enrollment Status Change

Dear [IPA Contact Name/Provider Name]:

This letter is to acknowledge the offices request dated [DATE] requesting that [PCP NAME] status be changed from [CURRENT STATUS] member enrollment to “Limited” member enrollment.

Limited meaning PCP does not receive new Member enrollment through auto-assignment. PCP will receive minimum enrollment only through Member requests, HCO enrollment, or family link or PCP receives reinstated Members. This change will become effective [EFFECTIVE DATE].

If you have any questions or concerns, please call me at [PSR PHONE NUMBER].

Sincerely,

[PSR NAME]
Provider Services Representative

cc: PCP
IPA
[FIRST NAME LAST NAME], Executive Director of Health Services
Operations, IEHP, I.130.d
[FIRST NAME LAST NAME], Director of Provider Services, IEHP

PCP File



December 27, 2018

«IEHP_ID»
«Greeting01»
«Med_Name»
«Add_2» «Add_1»
«City», «STATE» «ZIP_CODE»

Dear «Greeting02»,

«Greeting03» current IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) Primary Care Doctor is «OLDPCPNAME» located at «OldPCPAdd». We want to let you know that as of «mleffec», «OLDPCPNAME» will no longer serve IEHP DualChoice Members.

To make sure there is no interruption in «Greeting03» health care, we have temporarily assigned a new Primary Care Doctor to take care of «Greeting04».

As you know, IEHP DualChoice Members have a choice of hundreds of Doctors listed in the IEHP DualChoice Provider and Pharmacy Directory. If you want to choose another Primary Care Doctor or if you have any questions, please call IEHP DualChoice Member Services toll-free at 1-877-273-IEHP (4347). TTY users should call 1-800-718-4347. If you do NOT choose another Doctor, «NEWPCPNAME» will become «Greeting03» Primary Care Doctor. Listed below are «NEWPCPNAME» office location and the name and address of the hospital «Greeting04» would go to for care.

«NEWPCPNAME»	«NewPHospl»
«NewPAdd»	«NewHosAdd»
«NewPCity», «newpstate» «NewPZip»	«NewHosCity», «NewHosSte» «NewHosZip»
«NewPPhone»	«NewHosPhne»

We will mail you a new IEHP DualChoice ID Card. If you do not get your new IEHP DualChoice ID Card, please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347). TTY users should call 1-800-718-4347. We are open from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

Be assured, all «Greeting03» benefits will stay the same. Thank you for trusting IEHP DualChoice to take care of your health care needs.

Thank you,

IEHP DualChoice
OPS_01_EA_TRM «old_pcp»

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Coordinated Care plan with a Medicare contract and a contract with the California Medicaid program. Enrollment in IEHP DualChoice depends on contract renewal.



diciembre 27, 2018

«IEHP_ID»
«Greeting01»
«Med_Name»
«Add_2» «Add_1»
«City», «STATE» «ZIP_CODE»

Estimado/a «Greeting02»:

Su Doctor de Cuidado Primario actual de IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es el «OLDPCPNAME» con domicilio en «OldPCPAdd». Queremos informarle que a partir del «mleffec», el «OLDPCPNAME» ya no continuará atendiendo a los Miembros de IEHP DualChoice.

Para asegurar que no haya interrupción en su atención médica, hemos asignado provisionalmente a un nuevo Doctor de Cuidado Primario para que lo atienda.

Como usted sabe, los Miembros de IEHP DualChoice pueden elegir entre los cientos de Doctores que se encuentran en el Directorio de Proveedores y Farmacias de IEHP DualChoice. Si desea elegir a otro Doctor de Cuidado Primario o si tiene alguna pregunta, por favor comuníquese a Servicios para Miembros de IEHP DualChoice al «MbrSvcPhn», la llamada es gratuita. Los usuarios de TTY deben llamar al 1-800-718-4347. Si usted NO elige a otro Doctor, el «NEWPCPNAME» será su Doctor de Cuidado Primario. A continuación se indica la dirección del consultorio del «NEWPCPNAME» y, el nombre y la dirección del hospital donde asistirá para atención médica.

«NEWPCPNAME»	«NewPHospl»
«NewPAdd»	«NewHosAdd»
«NewPCity», «newpstate» «NewPZip»	«NewHosCity», «NewHosSte» «NewHosZip»
«NewPPhone»	«NewHosPhne»

Le enviaremos por correo su nueva tarjeta de Identificación de Miembro de IEHP DualChoice. Si no recibe la nueva tarjeta, por favor llame a Servicios para Miembros de IEHP DualChoice al «MbrSvcPhn». Los usuarios de TTY deben llamar al TTY 1(800) 718-4347. Estamos a sus órdenes de 8 a.m. a 8 p.m. (Hora del Pacífico), los 7 días de la semana, incluidos días festivos.

Puede estar seguro, que todos sus beneficios permanecerán iguales. Gracias por confiar en IEHP DualChoice para atender sus necesidades de cuidado médico.

Atentamente,

IEHP DualChoice
OPS_01SA_TRM_«old_pcp»
IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un Plan de Salud que tiene un contrato con ambos Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.



[Date]

[IPA Contact Name]
[IPA Name]
[ADDRESS]
[City, State Zip]

RE: [PCP NAME] TERMINATION

Dear [IPA Contact Name]:

This letter is to acknowledge receipt of your letter dated [Date] requesting the termination of [PCP Name] as a PCP from [PCP Address]. Dr. [PCP Name] membership will be reassigned to Dr. [New PCP Name] to the same location effective [Date].

Under IEHP Policy 18.D, the IPA is required to give IEHP a 60-day advance written notice. This notification of termination is non-compliant due to no 60-day advance written notice was provided.

Because of this requirement IEHP retains the right to obligate the IPA to provide medical services for the PCP's existing patients at the former PCP practice location for up to 60 days. If patient care becomes an issue, efforts will be made to reassign the patients to another PCP; however, there is no guarantee that all patients will remain within your network.

If you have any questions or concerns, please call me at (PHONE NUMBER

Sincerely,

PSR Name
Provider Services Representative

cc: PCP Name
[First Name Last Name], Executive Director of Health Services Operations, IEHP
[First Name Last Name], Director of Provider Relations, IEHP
PCP File



[DATE]

[IPA Contact Name] or [Provider Name]
[IPA NAME]
[Address]
[CITY, STATE ZIP]

RE: [PCP NAME] – Enrollment Status Change

Dear [IPA Contact Name/Provider Name]:

This letter is to inform you that Dr. [PCP NAME] PCP status has been changed to “Closed” for Member enrollment. This change will become effective as of [DATE].

Under IEHP Policy 18 A2, the maximum amount of enrollment that Dr. [PCP NAME] is eligible for is [NUMBER] Members. Currently Dr. [PCP NAME] has [NUMBER] Members and [NUMBER] physician extenders in IEHP’s system. If Dr. [PCP NAME] has additional physician extenders who have not been credentialed, please submit their credentialing applications to increase Dr. [PCP NAME] Member capacity. A maximum of four supervised mid-levels is allowed per PCP to increase capacity to a maximum of 6000 Members.

IEHP will continue to monitor Dr. [PCP NAME]’s enrollment numbers. If Dr. [PCP NAME]’s membership should drop below the maximum amount allowable, IEHP will open Dr. [PCP NAME] to enrollment. This would include Auto Assignment, HCO Enrollment, Family Assignment and Member Choice.

If you have any questions or concerns, please contact me at (909) 890-XXXX.

Sincerely,

PSR NAME
Provider Services Representative

cc: PCP
IPA
[FIRST NAME LAST NAME], Executive Director of Health Services
Operations, IEHP
[FIRST NAME LAST NAME], Director of Provider Relations, IEHP
PCP File

DATE

SENT VIA FEDEX

PROVIDER FIRST NAME M.I. LAST NAME SUFFIX, DEGREE
c/o PRACTICE NAME
ADDRESS
CITY, STATE ZIP

RE: IEHP PEER REVIEW SUBCOMMITTEE DECISION

Dear PROVIDER NAME:

Inland Empire Health Plan (IEHP)'s Peer Review Subcommittee met on (DATE), and reviewed (REASON FOR REVIEW).

Due to evidence documenting (EVIDENCE FOUND), the IEHP Peer Review Subcommittee has made the recommendation to terminate your participation with IEHP.

You have the right to appeal this decision and request a first level appeal, which is held before the IEHP Peer Review Subcommittee. If you wish to request an appeal, your written request must be received within thirty (30) days of receipt of this certified letter. In a Level I appeal, you will have the right to be present and participate in the proceedings. If you request an appeal, please provide me with copies of any additional information, which you would like to have presented at the Peer Review Subcommittee meeting for your appeal. In addition, please let me know if you wish to be present at the meeting.

If your written request for appeal is not received within thirty (30) days of your receipt of this notice, your rights will be considered waived, and any action recommended by the Peer Review Subcommittee will be presented to the Governing Board of IEHP for final action.

A copy of the IEHP Peer Review (Level I) and Credentialing Policy and Procedures is enclosed for your information and further clarification of your rights in the Level I appeal process.

IEHP will report the final decision of the IEHP Governing Board, to the Medical Board of California and/or the National practitioner Data Bank, as required under California business and professions Codes subsection 805 and 45 of Federal Regulations, Part 60.

PHYSICIAN NAME

DATE

Page 2

Should you wish to discuss this matter further, please feel free to contact me at (909)
(PHONE NUMBER)

Sincerely,

SENIOR MEDICAL DIRECTOR'S NAME

Senior Medical Director, IEHP

cc: IPA MEDICAL DIRECTOR'S NAME, IPA NAME
[NAME], Executive Director of Health Services Operations, IEHP
[NAME], Director of Provider Relations, IEHP
[NAME], Medical Director, IEHP
[NAME], Director of Quality Management
[NAME], Provider Services Representative, IEHP
[NAME], Credentialing Contact Title, IPA NAME
Provider File



December 27, 2018

«IEHP_ID»
«FIRST_NAME» «LAST_NAME»
«ADDRESS_2» «ADDRESS_1»
«CITY» «STATE» «ZIP_CODE»

Dear «First_Name»:

A change in our Provider Network has occurred, which might affect your healthcare. Dr. «SpecName», «Pddesc2» Specialist, located at «PAdd1» «PAdd2», «PCity» will no longer be serving IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) members effective «MLEffec».

To make sure there is no interruption in your health care, we suggest that you contact your IEHP DualChoice Primary Care Doctor immediately for help in choosing a new «Pddesc2» Specialist, if necessary.

If you are currently undergoing treatment, it may be possible for you to continue seeing Dr. «SpecName» until your Primary Care Doctor can make other arrangements for a new «Pddesc2» Specialist. It is very important that you discuss finding a new «Pddesc2» Specialist with your Primary Care Doctor as soon as possible.

Please don't wait – this change may affect your care; contact your Primary Care Doctor today to arrange for a new specialist.

If you have any questions, please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347). TTY users should call 1-800-718-4347. We are open from 8:00 am to 8:00 pm (PST), 7 days a week, including holidays.

Be assured, all your benefits will stay the same. Thank you for trusting IEHP DualChoice to take care of your health care needs.

Thank you,

IEHP DualChoice
OPS_25_EA_SPT «SpecialistID»

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.



27 de diciembre de 2018

«IEHP_ID»
«FIRST_NAME» «LAST_NAME»
«ADDRESS_2» «ADDRESS_1»
«CITY», «STATE» «ZIP_CODE»

Estimado/a «First_Name»:

Se ha presentado un cambio en nuestra Red de Proveedores que podría afectar su atención médica. El Dr. «SpecName», Especialista en «Pddesc2», con domicilio en «PAdd1» «PAdd2», «PCity», ya no atenderá a los Miembros de IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) a partir del «MLEffec».

Para garantizar que no haya interrupción en su atención médica, le sugerimos se comunique inmediatamente con su Doctor de Cuidado Primario de IEHP DualChoice para que, de ser necesario, le ayude a elegir un nuevo Especialista en «Pddesc2».

Si actualmente usted está en tratamiento, podría ser posible que continúe visitando al Dr. «SpecName» hasta que su Doctor de Cuidado Primario pueda coordinar el que usted se atienda con un nuevo Especialista en «Pddesc2». Es muy importante que le solicite a su Doctor de Cuidado Primario la búsqueda de un nuevo Especialista en «Pddesc2» tan pronto como sea posible.

Por favor, no espere. Este cambio podría afectar su atención médica; comuníquese con su Doctor de Cuidado Primario hoy mismo para encontrar un nuevo Especialista.

Si tiene alguna pregunta, por favor comuníquese a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347). Los usuarios de TTY deben llamar al 1-800-718-4347. Estamos a sus órdenes de 8 a.m. a 8 p.m. (Hora del Pacífico), los 7 días de la semana, incluidos días festivos.

Puede estar seguro, que todos los beneficios de Ud permanecerán iguales. Gracias por confiar en IEHP DualChoice para atender sus necesidades de cuidado médico.

Atentamente,

IEHP DualChoice
OPS_25_SA_SPT «SpecialistID»

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) es un Plan de Salud que tiene contratos con Medicare y Medi-Cal para proporcionar los beneficios de ambos programas a los afiliados.

IPA/Hospital Link Code:
PSR Reviewer:

Completion Date:

Required 10	Compliant	Non Compliant	Comments/Refer out?
Cardiology			
Dermatology***			
Gastroenterology			
General Surgery			
Neurology			
OB/GYN			
Orthopedics			
Otolaryngology			
Ophthalmology			
Oncology/Hematology			
Geographic Area	Compliant	Non Compliant	Comments/Refer out?
Allergy***			
Cardiac/Thoracic Surgery			
Endocrinology			
Infectious Disease			
Nephrology			
Neurosurgery (If the hospital provides this services)			
Pediatric Subspecialties**			
1.Pediatric Cardiology			
2.Pediatric Gastroenterology			
3.Pediatric Ophthalmology			
4.Pediatric Neurology			
5.Pediatric Orthopedics			
Pain Management			
Pediatric Surgery			
Physical and Speech Therapy ***			
Physical Medicine***			
Plastic Surgery			
Podiatry***			
Pulmonary Medicine			
Rheumatology			
Urology			
Ancillary Providers			
1. Audiology			
2. Diagnostic Radiology			
3. DME			

4. Home Health			
5. Home Infusion Agency			
6. Imaging/Diagnostic/X-Ray			
7. Laboratory			
8. Radiology			

Specialty	Grid Rules
Podiatry	Covers Podiatric Surgery
Orthopedics	Covers Orthopedic Surgery
Neurology	CANNOT cover Neurosurgery

- * If Provider does NOT have hospital privileges – to which Hospital do they refer? Must be within 15 miles/30 minutes (Exception may be made at Provider Relations Manager discretion)
- ** If IPA states they refer to Loma Linda or a neighboring hospital, then they are compliant. Must be within 15 miles/30 minutes (Exception may be made at Provider Relations Manager discretion)
- *** Specialties NOT requiring Hospital Privileges