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## **25. DELEGATION AND OVERSIGHT**

- A. Delegation Oversight
    - 1. Delegated Activities
- 

### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice Delegates.

### **POLICY:**

- A. IEHP evaluates and audits contracted Delegates in accordance with current applicable National Committee for Quality Assurance (NCQA) accreditation standards, Centers for Medicare and Medicaid Services (CMS) regulatory requirements, Department of Health Care Services (DHCS) regulatory requirements, and IEHP standards, modified on an as needed basis.
- B. Delegates agree to be accountable for all responsibilities delegated by IEHP and oversight of any sub-delegated activities, including periodic reporting, as specified in the Delegation Agreement.

### **DEFINITION:**

- A. Delegate- A medical group, health plan, Independent Physician Association (IPA), individual or entity contracted with IEHP to provide administrative services or health care services for a Medicare eligible IEHP Member.

### **PROCEDURES:**

- A. IEHP performs an initial, monthly, and annual audits of the following delegated activities:
  - 1. Quality Management;
  - 2. Utilization Management;
  - 3. Credentialing and Re-credentialing;
  - 4. Care Management; and
  - 5. Claims Process and Payment.
- B. IEHP performs initial, monthly annual and as needed audits of the following regulatory requirements:
  - 1. Compliance (Fraud, Waste, and Abuse Program);
  - 2. HIPAA Security; and
  - 3. Financial Viability.
- C. Each of the above activities describes the elements being evaluated, the frequency of the reporting requirements, and the period of time being evaluated.

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## 25. DELEGATION AND OVERSIGHT

### A. Delegation Oversight

#### 1. Delegated Activities

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1. For each activity, IEHP has identified its expectations and reporting requirements to be achieved (See Attachments, “IPA Delegation Agreement – IEHP DualChoice” and “Medicare Provider Reporting Requirements Schedule” in Section 25).
- C. Delegates identified to be deficient in a delegated activity are required to submit a Corrective Action Plan (CAP). See Policy 25A3, “Delegation Oversight – Corrective Action Plan Requirements.
- D. Failure to submit documentation by the required due dates or failure to participate in a scheduled audit may result in an auto failure of the audit.
- E. IEHP provides each Delegate with the results of auditing and monitoring activities within thirty (30) calendar days of the scheduled audit date.
- F. Delegates can appeal the results of any oversight activity, specialized study, audit and any required CAPs or sanctions to IEHP within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	July 1, 2012
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION AND OVERSIGHT

- A. Delegation Oversight
    - 2. Delegation Oversight Audit
- 

### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice Delegates.

### **POLICY:**

- A. IEHP delegates certain Utilization Management (UM), Care Management (CM), Credentialing/Re-credentialing (CR) activities and activities for Quality Management (QM) and Compliance and Fraud, Waste and Abuse (FWA) Programs, and HIPAA Privacy & Security Program to contracted Delegates that meet IEHP delegation requirements and comply with the most current National Committee for Quality Assurance (NCQA) Health Plan Standards, Department of Health Care Services (DHCS) (when applicable), Centers for Medicare and Medicaid Services (CMS), Department Managed Health Care (DMHC) (when applicable) and IEHP Standards.<sup>1</sup>
- B. IEHP does not delegate Quality Management and Improvement (QI), Preventive Health, Medical Records, Compliance or Member Experience to any non-NCQA accredited entities; however, IEHP does require contracted Delegates to perform specific activities related to these areas.
- C. IEHP audits the Delegates performance in QI, UM, Credentialing/Re-credentialing, Compliance and Fraud, Waste and Abuse (FWA) Programs, HIPAA Privacy & Security Program, CM, Claims and related activities through the Delegation Oversight Audits performed on an annual basis.<sup>2</sup>
- D. IEHP may waive elements of the audit for NCQA accredited or certified entities.
- E. The Delegation Oversight Audit is used as part of the pre-contractual audit for Delegates applying for participation with IEHP.
- F. The Delegation Oversight Audits are performed by IEHP Provider Services, Compliance, Credentialing, QI, UM, Claims and CM Delegation Oversight Staff utilizing the most current NCQA, DHCS, DMHC, CMS, and IEHP standards.
- G. Focused audits may be performed as indicated whenever a quality issue is identified or at the discretion of the Delegation Oversight Committee, Chief Compliance Officer, Executive Compliance Committee, or the IEHP Chief Medical and Chief Quality Officers.
- H. IEHP reserves the right to revoke delegated responsibilities and take other necessary action up to and including termination of contract from those Delegates that fail to meet IEHP requirements.

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<sup>1</sup> Medicare Managed Care Manual, "Introduction," Section 10

<sup>2</sup> Title 42 Code of Federal Regulations (CFR) § 438.230

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## 25. DELEGATION AND OVERSIGHT

- A. Delegation Oversight
    - 2. Delegation Oversight Audit
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### **DEFINITION:**

- A. Delegate -. A medical group, health plan, Independent Physician Association (IPA), individual or entity contracted with IEHP to provide administrative services or health care services for a Medicare eligible IEHP Member.

### **PROCEDURES:**

- A. IEHP audits each Delegate prior to contracting and at least annually to verify compliance with IEHP requirements and continued ability to perform delegated functions.
- B. The Delegation Oversight Audit evaluates the Delegates' capabilities in UM, CM, Credentialing and elements of QI, Compliance, FWA, and HIPAA Privacy & Security.
- C. IEHP is responsible for coordinating and scheduling the audits with the Delegate's staff.
- D. IEHP notifies the Delegate in writing, at least thirty (30) days in advance of the scheduled audit. The Delegate receives audit preparation instructions (See Attachment, "Delegation Oversight Audit Preparation Instructions – IEHP DualChoice" in Section 25) regarding the types of documents to be available at the time of the audit and standard forms to be completed and returned to IEHP prior to the audit.
  - 1. Delegate Biographical Information (See Attachment, "Delegated Biographical Information Sheet" in Section 25).
  - 2. Delegate Sub-Contracted Service by Facility/Agency (See Attachment, "Subcontracted Facility/Agency Services and Delegated Functions" in Section 25).
  - 3. QI documents:
    - a. Quality Management and Improvement (QI) committee and subcommittee meeting minutes, agenda, sign in sheet, and signed confidentiality statement from the auditing period;
      - 1) Recommendations of policy decisions
      - 2) Review and evaluation of QI activities
      - 3) Practitioner participation in the QI program through planning, design, implementation or review Identification and follow up of needed actions
    - b. Semi-Annual Health Plan Reports from the audit period;
    - c. Notification of Termination policy and evidence that Members were notified of practitioner termination;
    - d. Studies, audits and Surveys completed from the audit period; and
    - e. Standards of Medical Care Access Policies and Procedures.



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4. UM documents:
  - a. Annual UM Program Description;
  - b. UM Annual Work Plan;
  - c. UM Annual Evaluation;
  - d. Policies and procedures;
  - e. Policies and procedures of Denial System Controls standards;
  - f. Policies and procedures of Denial System Controls Oversight standards;
  - g. Committee meeting minutes from the audit period:
    - 1) Board of Directors;
    - 2) Utilization Management Committee; and
    - 3) Utilization Management Subcommittee meeting minutes.
  - h. Annual Inter-Rater Reliability (IRR) Audit;
  - i. Semi-Annual Health Plan reports for the audit periods;
  - j. Two (2) examples that demonstrate the use of Board-Certified consultants to assist with medical necessity determinations;
  - k. Criteria for Length of Stay and Medical Necessity used during the past two (2) years;
  - l. Fifteen (15) targeted referral files to include Denials, Modifications, Cancellations and Approvals. The Delegate is responsible for walking IEHP through each referral via the Delegate's medical management system;
  - m. Fifteen (15) BH Approved, Partially Approved, Denied, and Cancelled files selected by IEHP. The Delegate is responsible for walking IEHP through each referral via the Delegate's live medical management system;
  - n. Submission of request for UM Criteria Log;
  - o. Utilization Management statistics from the audit period;
  - p. Evidence that the Affirmative Statement has been distributed to Providers and employees who make UM decisions;
  - q. Evidence, other than via a denial letter, that the Providers have been notified that they may contact a Physician reviewer to discuss denial decisions;
  - r. Provider communications from the audit period;
  - s. Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO)) and Employees (Registered Nurse (RN), Licensed Vocational Nurse (LVN)) who make UM Decisions;

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- t. Copies of most recent mailroom policies; and
  - u. Copies of most recent referral inventory reporting used to manage turnaround time requirements for processing of IEHP referrals.
5. Care Management documents:
- a. Program Plan and Description and CM policies and procedures, including Case Management, Guidelines for Care Management and Care Transitions (if different from UM);
  - b. Ten (10) CM files; and
  - c. Five (5) sample cases with documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services in accordance with California-specific measure CA1.7 on Care Coordination. Please see Provider Policy MA\_25F1, “Medicare MMP Reporting Requirements – IEHP DualChoice” for more information.
6. Credentialing documents:
- a. Policies and Procedures;
  - b. Credentialing System Controls Oversight Reports;
  - c. Policies and procedures of Credentialing System Controls standards;
  - d. Committee meeting minutes including date and voting attendees for the specified look-back period, including:
    - 1) Board of Directors;
    - 2) Quality Management Committee minutes;
    - 3) Credentialing; and
    - 4) Peer Review Committee.
  - e. Credentialing and re-credentialing files – forty (40) credentialing and forty (40) re-credentialing files randomly selected by IEHP;
  - f. Practitioner files of those terminated for quality issues during the specified look-back period;
  - g. Practitioner files that have appealed a decision during the specified look back-period;
  - h. Health Care Delivery Organization files where the IPA is responsible for claims payment for those Organizational Providers, which include but are not limited to:
    - 1) Hospitals
    - 2) Home Health Agencies

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- 3) Skilled Nursing Facilities
  - 4) Free-Standing Surgical Centers
  - 5) Hospices
  - 6) Clinical Laboratories
  - 7) Comprehensive Outpatient Rehabilitation Facilities (CORF)
  - 8) Physical Therapy Providers
  - 9) Speech Pathology Providers
  - 10) Ambulatory Surgery Centers
  - 11) End-Stage Renal Disease Services Providers
  - 12) Outpatient Diabetes Self-Management Training Providers
  - 13) Portable X-Ray Suppliers
  - 14) Rural Health Clinics
  - 15) Federally Qualified Health Centers (FQHC)
- i. Credentialing delegation data, if applicable;
  - j. Delegates checklist, spreadsheet or other record that shows evidence the organization assessed its organizational Providers.
  - k. Documentation of ongoing monitoring of Practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality for the specified look-back period;
  - l. Human Immunodeficiency Virus (HIV/AIDS) Annual Survey to include the written process. Evidence of Implementation and Distribution of Findings; and<sup>3,4</sup>
  - m. Delegation Agreements between the Delegate and it's Sub-delegate(s).
7. Compliance and Fraud, Waste and Abuse (FWA) Documents:
- a. Compliance polices & procedures;
  - b. Fraud, Waste and Abuse (FWA) policies and procedures;
  - c. Sanction/ Exclusion Screening Process policies and procedures;
  - d. Standards/Code of Conduct;

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<sup>3</sup> Health and Safety Code (Health & Saf. Code), § 1374.16

<sup>4</sup> California Code of Regulations (CCR), § 1300.74.16(e)

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- e. Copies of Compliance and FWA Training provided during the audit period;
- f. Compliance Committee Meeting minutes from the last twelve (12) months to include agenda and sign in sheet (attendance);
- g. Annual Compliance Work Plan;
- h. Annual Audit and Monitoring Plan;
- i. Annual Risk Assessment Report;
  - 1) Employee Universe: Submit a list of all current employees, volunteers/interns (who performed job duties related to IEHP's lines of business), and Governing Body Members. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The definition of employees includes full and part time employees as well as temporary employees, contractors, interns, or volunteers;
  - 2) Audit & Monitoring Universe: Submit a list of all audits and monitoring activities the IPA conducted of its delegated functions, including those that were started or completed during the audit period or a copy of the IPA's Audit and Monitoring Plans for the audit period;
  - 3) Downstream Entity/Subcontractors Universe: Submit a list of all downstream entities/subcontractors contracted with the IPA and/or MSO anytime during the audit period, including Individual/Entity Name, detailed description of service provided, contract start and end dates (if applicable);
  - 4) A sample of ten (10) individuals (five (5) hired/started within the audit period and five (5) hired/started prior to the audit period) will be selected from the Employee Universe by IEHP for which documented evidence of the following will be requested:
    - Pre-hire Screening of the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and Medi-Cal Suspended & Ineligible Provider List (S&I).
    - Completion of Compliance and FWA Training within ninety (90) days of hire or start.
    - Evidence the Standards/Code of Conduct was received by these individuals within ninety (90) days of hire or start.
    - Monthly Screening performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of three consecutive months.

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- Completion of Annual Compliance and FWA training
  - Annual distribution of the Standards/Codes of Conduct.
- 5) A sample of five (5) audits and/or monitoring activities will be selected from the IPA's Audit and Monitoring Plans or Audit & Monitoring Activities Universe. Evidence of the following will be required:
- Results/Finding Reports;
  - Activity outcomes were shared with an oversight body, senior leadership, and/or the IPA's Governing Body and corrective actions, if applicable.
- 6) A sample of three (3) Downstream Entities/Subcontractors will be selected from the Downstream Entity/Subcontractor Universe. Evidence of the following will be required:
- Compliance oversight activities were conducted;
  - Activity outcomes were reported to an oversight body, senior leadership, or the IPA's Governing Body and corrective actions were taken, if applicable.
8. Health Insurance Portability and Accountability Act (HIPAA) Privacy Documents
- a. HIPAA Privacy and Security Policies & Procedures;
  - b. Copies of HIPAA Privacy Training provided during the audit period;
  - c. Privacy Incident Universe: Submit a list of reported suspected privacy incidents impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period.
- 1) A sample of five (5) privacy investigations will be selected from the Privacy Incidents Universe. Evidence of the following will be required:
- Date incident was reported to the Privacy/Compliance Office/Officer;
  - Completion of a Privacy Incident Risk Assessment for issue/investigation;
  - Notification was sent to IEHP in accordance with HIPAA BAA Requirements of discovery of a suspected breach; and
  - Corrective actions taken, if applicable.
- 2) A sample of ten (10) employees (five (5) hired within the audit period and five

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(5) hired prior to the audit period) will be selected from the *Employee Universe* by the IEHP Auditor for which evidence of the following will be requested:

- New Hires:
  - Completion of HIPAA Privacy & Security Training upon hire/start
  - Completion of Confidentiality Statement prior to access to PHI
- Established Employees:
  - Completion of HIPAA Privacy & Security Training
  - Annual completion of Confidentiality Statement

#### 9. IT Security

- a. The name of the medical management system(s) used for the utilization management, care management, and claims functions.

#### 10. Other general organizational documents:

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

#### 9. Provider Directory:

- a. Report during the lookback period of the annual audit of identified/reported inaccuracies and the timeframe of the correction in compliance.<sup>5</sup>

### F. In preparation for the audit the Delegate should:

1. Familiarize themselves with DHCS, NCQA, CMS, DMHC and IEHP specific standards; and
2. Conduct self-audits to ensure they meet current standards.

### G. All Delegates are required to provide a written roadmap of where each element is located in the policies and procedures. All sections of the audit tool must be road mapped upon submission.

### H. At the time of the audit, the Delegate must have:

1. All requested documents ready; and
2. Have appropriate staff available for each functional area that is being audited.

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<sup>5</sup> Health and Saf. Code § 1367.27

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## 25. DELEGATION AND OVERSIGHT

### A. Delegation Oversight

#### 2. Delegation Oversight Audit

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#### I. At the time of the audit, IEHP reviews:

1. The Delegate policies and procedures for completeness and compliance with DHCS, NCQA, CMS, and IEHP standards;
2. Committee and Subcommittee Minutes (as applicable);
3. The prior authorization/referral/denial/appeal process for the following:
  - a. Timeliness of UM and appeal decisions for non-urgent and urgent pre-certification, concurrent, and retrospective reviews;
  - b. Professional review of clinical information;
  - c. Clinical criteria for UM and appeal decisions;
  - d. Medical information – relevant clinical information collected to support UM and appeal decision-making;
  - e. Denial notices – clear documentation and communication of reasons for each denial and appeal decision, alternative treatment offered, and correct appeal language;
  - f. Evidence of use of board-certified consultants for medical necessity decisions when applicable; and
  - g. Evidence of current license for Providers and employees (RN and LVN) who make UM decisions.
4. Complex and Care Management (CM) files for demonstration of the CM process for:
  - a. Case finding;
  - b. Assessment and problem identification;
  - c. Care Plans and attainable goals;
  - d. Appropriateness of goals/time frames/monthly updates/follow ups;
  - e. Implementation;
  - f. Monitoring;
  - g. Outcomes; and
  - h. Recommended referral services.
5. Credentialing Must Pass Elements. If the Delegate does not score “MET” in a Must Pass Element, they must submit a corrective action plan (CAP) within thirty (30) calendar days following receipt of final report, which may require a re-survey. The following credentialing requirements are “MUST-PASS” Elements:
  - a. CR 1: Credentialing Policies
    - 1) Element C: Credentialing System Controls

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- 2) Element D: Credentialing System Controls Oversight
- b. CR 3: Credentialing Verifications
  - 1) Element A: Verification of Credentials
    - Delegate must score 90%-100% on at least four (4) factors and 60%-89% on file review for the remaining factors. This is a Met score.
  - 2) Element B: Sanction Information
    - Delegate must score 90%-100% for at least one (1) factors and 60%-89% on file review for the remaining factor. This is a Met score.
  - 3) Element C: Credentialing Application
    - Delegate must score 90%-100% on at least four (4) factors and 60%-89% on file review for the remaining factors. This is a Met score.
- c. CR 4: Recredentialing Cycle Length
  - 1) Element A: Recredentialing Cycle Length
    - Delegate must score 90%-100% on file review. This is a Met score.
6. Credentialing and re-credentialing files:
  - a. All necessary primary source verifications have been performed within the required one hundred eighty (180) day timeframe;
  - b. All required queries have been performed through appropriate verification sources;
  - c. All credentialing and re-credentialing packets have been approved by the IPA's Credentialing Committee;
  - d. All pertinent Quality Assurance (QA), grievance and Member information specific to a given Practitioner, as available, have been considered during the credentialing and re-credentialing process;<sup>6</sup>
  - e. Processes are in place to ensure Provider documentation including licenses, Drug Enforcement Administration (DEA) certificate, Board Certification and malpractice insurance, are kept current;
  - f. Processes are in place to ensure documentation on subcontracted organizational Providers is verified at time of contracting and at least every three (3) years thereafter;
  - g. Re-credentialing of Practitioners was performed within required thirty-six (36)-month timeframe; and

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<sup>6</sup> Medicare Managed Care Manual, "Credentialing, Monitoring, and Recredentialing," Section 60.3



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- h. There is sufficient documentation within each credentialing file to confirm that all primary source verifications, queries and other information reviewed pertinent to the credentialing or re-credentialing decision were received prior to and used in the credentialing and/or re-credentialing decision.
7. Randomly selected ancillary Provider files (i.e., Home Health, Durable Medical Equipment (DME), laboratory) to verify that Health Care Delivery Organizational Providers:
- a. Confirms that the Provider is in good standing with state and federal regulatory bodies; to include review of Sanctions that would prevent the Provider from participation in the IEHP network.
  - b. Confirms that the Provider has been reviewed and approved by an accrediting body (e.g., The Joint Commission (TJC), Accreditation Association for Ambulatory Health Care (AAAHC)), as stated in Policy 25B7, “Assessment of Organizational Providers”;
  - c. Conducts an onsite quality assessment if the Provider is not accredited. The onsite quality assessment will be conducted by IPA’s Quality Management Department. IPA’s assessment process and assessment criteria for each non-accredited Provider with which it contracts will include a process for ensuring that the Provider credentials its Providers, in accordance with NCQA guidelines. A CMS or state review may be used in lieu of a site visit and may not be greater than three (3) years old at the time of verification/approval.
  - d. Ensure that Medicare covered basic benefits are provided only by Providers that have signed participation agreements with CMS and suppliers approved by CMS as meeting conditions for coverage of their services.
  - e. Ensure that the Provider is not on the Medicare Opt-Out listing for service areas covered by IEHP (i.e., Northern and Southern California).<sup>7</sup>
8. Compliance Verifications
- a. Training: General Compliance, FWA, HIPAA Privacy Trainings for new hires and annually for current employees (Temporary or Permanent), Providers, Governing Board, Contractors and Volunteers.
  - b. Distribution of the Standards of Conduct for new hires and annually for current employees.
  - c. Confidentiality Statement for new hires prior to access to PHI and annually thereafter.

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<sup>7</sup> Medicare Managed Care Manual, “Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks”, Section 60.2

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- d. Samples from the A&M activities, Privacy incidents and Downstream Entities/ Subcontractors universe will be tested.
  - e. Screening: Proof of sanctions and exclusions screenings for all new hires and current employees (Temporary or Permanent), Governing Body Members, Contractors, and Volunteers.
- J. IEHP may use the IEHP Credentialing Delegation Oversight Audit (DOA) Tool, Compliance and FWA DOA Audit Tool, Privacy DOA Audit Tool, and the QM/UM/CM DOA Audit Tool which is based upon current NCQA, DHCS, CMS, and IEHP standards or other resources as deemed necessary to sufficiently document information from the examined policies and procedures, committee minutes, files and other documents to NCQA and CMS specific standards, as well as to support the conclusions reached.
- K. The Delegate receives an exit interview with the IEHP auditors at the completion of each session of the Delegation Oversight Audit. This interview identifies areas found to be deficient giving the Delegate an opportunity to provide additional information to clear the deficiency within two (2) business days and highlighting opportunities for improvements that need to be addressed through the Corrective Action Plan (CAP) process.
- L. Within thirty (30) calendar days of the audit, the Delegate receives written notification of the results. The written notification includes a cover letter and completed audit tools noting any deficiencies found during the audit. The cover letter notes the timeframes for corrective action, and any other pertinent information.
- M. Scoring categories for each of the Delegation Oversight Audit are as follows:
- 1. Full Compliance 90-100%
  - 2. Non-compliance <90%
- N. Failure to submit required documentation by the due dates or failure to participate in scheduled audit dates may result in automatic failure of an audit.
- O. All Delegates that score 90% or greater pass that section of the audit. A CAP is required for all scores that fall below 90%. However, a CAP may be issued at the discretion of IEHP, regardless of the score, even if the score is 90% or above. Failure to meet the minimum threshold for any must- pass elements for Credentialing, will result in a CAP response to be submitted to IEHP within thirty (30) calendar days after the receipt of the Delegation Audit Results and must meet IEHP approval. Following the CAP acceptance, IEHP may schedule a focused audit within six (6) months of the CAP Acceptance, that focuses on the failed must-pass elements (not at the factor level), i.e., all element factors, will be reviewed in addition to the factor (s) that failed the must-pass requirement. The look back period is from the date of the implementation of the Corrective Action Plan up to the one month prior to the focused audit. In addition, any Delegate that receives non-compliance in the credentialing portion of the audit is subject to further action up to termination of their IEHP contract. All CAPs

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submitted to IEHP must meet the Corrective Action Plan Requirements noted in Policy 25D3, "Quality Management - Corrective Action Plan Requirements."

- P. Focused audits may occur between annual audits in the following circumstances:
1. Deficiencies noted as a result of the annual audit, as applicable;
  2. Review of documents submitted to IEHP indicates potentially significant changes to the Delegate program; and
  3. Any other circumstance or quality issue identified that in the judgment of IEHP, requires a focused audit.
- Q. If the Delegate is unable to meet the requirements at the second focused re-audit, IEHP may do one (1) of the following:
1. Immediately freeze the Delegate to new Member enrollment, as applicable;
  2. Send a thirty (30) day breach of contract notice with specific cure requirements;
  3. Rescind delegated status of Delegate, as applicable;
  4. Terminate the IEHP contract with the Delegate; or
  5. Not renew the contract.
- R. Delegates who wish to appeal the results of the Delegation Oversight Audit must do so in writing within thirty (30) calendar days of receiving their results to the Provider Delegation Manager. Delegates must cite reasons for their appeal, including disputed items or deficiencies.
- S. Delegates who consistently fail to meet IEHP standards, as confirmed through annual and/or focused audits or other oversight activities, are subject to actions up to and including rescission of delegated functions, non-renewal of the IEHP contract or termination of the IPA participation in the IEHP network.

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INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	July 1, 2012
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION AND OVERSIGHT

### A. Delegation Oversight

#### 3. Corrective Action Plan Requirements

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#### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice Providers.

#### **POLICY:**

- A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State, Federal laws, National Committee for Quality Assurance (NCQA) accreditation (if applicable), and contractual and reporting requirements.<sup>1,2</sup>
- B. IEHP's Delegation Oversight (DO) department is responsible for the oversight, monitoring and tracking of all assessments and Corrective Action Plans (CAPs).
- C. The CAP process is the first level of action taken by IEHP to remediate identified performance deficiencies identified through the auditing and monitoring of Delegates.
- D. Delegates who fail to achieve established threshold requirements for any delegated function for (2) consecutive months will be issued a CAP or Immediate Corrective Action Plan (ICAP).
- E. IEHP may issue a CAP for a decline in performance or identified risk in any given month. CAPs are required to remediate deficiencies identified during monthly monitoring and auditing activities, focused and/or clinical audits, and the annual Delegation Oversight Audits (DOA).

#### **DEFINITION:**

- A. Delegate- A medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medicare eligible IEHP Member. Corrective Action Plan (CAP) is a written statement identifying the deficiency, root cause and description of the detailed plan of action that is developed to achieve targeted outcomes to correct the deficiency, and the operational results of that action which ensure the deficient practices are not repeated. For deficiencies that required long term corrective action or a period of longer than thirty (30) calendar days to remedy or operationalize, the Delegate must demonstrate it has taken remedial action and is making progress toward achieving acceptable level of compliance. The CAP must include the date when full compliance is expected to be achieved.

#### **PROCEDURES:**

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<sup>1</sup> Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, "Subcontractual Relationships and Delegation"

<sup>2</sup> Title 42 Code of Federal Regulations (CFR) §438.230

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## 25. DELEGATION AND OVERSIGHT

### A. Delegation Oversight

#### 3. Corrective Action Plan Requirements

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#### **Delegation Oversight Audit CAP**

- A. IEHP monitors Delegate compliance with requirements set forth by IEHP, Centers for Medicare and Medicaid Services (CMS) and Department of Health Care Services (DHCS) through its annual DOA. The DOA includes oversight for QM, UM, Credentialing, Compliance, and Care Management. See Policy 25A2, “Delegation Oversight – Audit.” Scoring categories for each section of the DOA are as follows:
1. Full Compliance 90-100%
  2. Non - Compliance <90%
- B. All Delegates with scores less than 100% may be required to submit a CAP to remedy any deficiencies noted on the audit tool.
1. The Delegates must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies for each section.
  2. A CAP is considered complete only if all deficiencies from each section are present and submitted together. These sections are as follows:
    - a. QM;
    - b. UM;
    - c. Medi-Cal Addendum;
    - d. Compliance;
    - e. HIPAA Security;
    - f. Credentialing & Recredentialing; and
    - g. Care Management.
  3. The Delegates are responsible for coordination of its CAP response with each of its internal departments responsible for addressing audit deficiencies.
  4. IEHP does not accept CAPs for DOA and deficiencies when received in individual sections. These are returned to the Delegates and considered delinquent until a complete and all-inclusive CAP is received.
  5. Each section of the CAP response must be clearly identified with supporting documentation attached and clearly labeled.
  6. The CAP must be submitted to IEHP within thirty (30) calendar days of written notification by IEHP of the audit results. Information shall include:
    - a. The DOA score received for each section;
    - b. A list of the deficiencies identified by IEHP;

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## 25. DELEGATION AND OVERSIGHT

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- c. Root cause analysis for the deficiency;
  - d. How the deficiency is corrected along with supporting documentation, including policies and procedures, training agenda, material and sign-in sheets when applicable;
  - e. Completion dates for each of the corrective actions;
  - f. Identification of the person responsible for completing the corrective action; and
  - g. Follow-up or monitoring plan to ensure that the corrective action plan is successful.
7. Upon receipt of the initial CAP, IEHP reviews the CAP and either approves or denies the CAP in writing within thirty (30) calendar days of receipt.
  8. If an IPA submits a CAP that is in full-compliance (above 90%) with no specific identified risk and all prior deficiencies addressed, then the audit is considered complete and will be accepted .
  9. If the CAP is denied:
    - a. IEHP will communicate all remaining deficiencies to the Delegates, with a written request for a second CAP.
    - b. Delegates requiring a second CAP may be frozen to new Member assignment until a CAP is received and approved.
    - c. The Delegates are required to resubmit a second CAP within fifteen (15) calendar days to IEHP.
  10. Upon receipt of the second CAP by IEHP:
    - a. If the second CAP is approved, the CAP process is closed. If applicable, the Delegates are then re-opened to new Member assignment.
    - b. If the second CAP is denied, the Delegates may be placed in a contract cure process that gives the Delegates thirty (30) calendar days to adequately correct the deficiencies.
- C. Delegates wishing to appeal the results of the initial DOA must do so in writing to IEHP's Director of Delegation Oversight or designee within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.
- D. After receiving a written appeal, the Director of Delegation Oversight or designee responds to the appealing Delegates in writing, noting the status of the appeal. Once an appeal is received, all additional documentation submitted by the Delegates is reviewed and, if appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.

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## 25. DELEGATION AND OVERSIGHT

- A. Delegation Oversight
    - 3. Corrective Action Plan Requirements
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### Other Oversight Activities or Focused and/or Clinical Audits

- A. Other QM monitoring activities that could result in CAPs include but are not limited to:
  - 1. Monthly, Quarterly, Semi-Annual and Annual report submissions;
  - 2. UM, CM and Claims focused file audits;
  - 3. Grievance and Appeal audits;
  - 4. Compliance audits;
  - 5. HIPAA Security audits;
  - 6. Twenty-four (24) hour access studies;
  - 7. Language competency audits;
  - 8. Clinical audits (including asthma, diabetes, etc.);
  - 9. Specific quality studies;
  - 10. Focused audits;
  - 11. Pharmacy audits;
  - 12. Audits determined necessary by the Delegation Oversight Committee;
  - 13. Follow up audits; and /or
  - 14. Universe and Log Data Quality and Validation Audits.
  
- B. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures.
  
- C. IEHP may issue a CAP for a decline in performance or identified risk in any given month.
  - 1. Delegated Entities are evaluated and monitored for performance on an ongoing basis through the various sources, to include but not limited to:
    - a. Pre-Delegation Audits
    - b. Annual Audits
    - c. Focused Audits
    - d. Clinical Audits
    - e. Delegate Reporting
  
- D. Within thirty (30) calendar days of the audit or study, the Delegates receive written notification of the results including any required CAPs or sanctions. The written notification



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includes a cover letter and a completed audit tool (when applicable) noting any deficiencies found during the audit. Identified deficiencies will include requests for standard CAP and/or Immediate CAP (ICAP) (See Attachment “DOA CAP Response Form” in Section 25). The cover letter defines the timeframes for corrective action, and any other pertinent information.

1. The Delegates must submit a complete and comprehensive CAP response to IEHP that adequately addresses all deficiencies for each section within the CAP/ICAP.
2. The Delegates are responsible for coordination of their CAP response with each of its internal departments responsible for addressing audit deficiencies.
3. IEHP does not accept CAPs for multiple deficiencies when received in individual sections. These are returned to the Delegates and considered delinquent until a complete and all-inclusive CAP is received.
4. Each section of the CAP response must be clearly identified with supporting documentation attached and clearly labeled.
5. The ICAP form findings must be submitted to IEHP within seventy-two (72) hours of the issuance of the written notification. The standard CAP form must be submitted within thirty (30) calendar days of written notification by IEHP of the audit results.
  - a. The Audit or Study score received for each section;
  - b. A listing of the deficiencies as identified by IEHP;
  - c. CAPs must identify the root cause analysis for the deficiency;
  - d. CAPs must specifically state how the deficiency is corrected along with supporting documentation, including policies and procedures, training agenda, training materials, and sign in sheets when applicable;
  - e. Completion dates for each of the corrective actions;
  - f. Identification and signature of the person responsible for completing the corrective action; and
  - g. Follow-up or monitoring plan to ensure that the corrective action plan is successful.
6. If the CAP is incomplete:
  - a. IEHP will communicate all remaining deficiencies to the Delegates with a written request for an updated CAP including request for additional documentation and/ or any other documents as part of the CAP response.
  - b. For standard CAP findings, the Delegates are required to resubmit an updated CAP response within fifteen (15) calendar days to IEHP. For ICAP findings, the Delegate is required to submit an CAP response within (72) hours to IEHP.

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7. If the CAP is considered complete:
  - a. IEHP sends notification to the Delegate of the accepted CAP.
  - b. An accepted CAP may remain open to allow monitoring for sustained improvement.
- E. Delegates can appeal the results of any oversight activity, specialized study, audit and any required CAPs or sanctions to IEHP within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.
- F. After receiving a written appeal, IEHP's Director of Delegation Oversight or Delegation Oversight Manager responds to the appealing Delegates in writing, noting the status of the appeal. Once an appeal is received, all additional documentation submitted by the Delegates is reviewed and, if appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.

#### **Failure to submit a CAP**

- A. Failure to submit CAPs may result in one of the following activities, depending on the nature of the audit or study and the seriousness of the deficiency:
  1. Delegates are frozen to new Member assignment;
  2. Financial Sanction;
  3. Request for cure under contract compliance;
  4. Requirement to subcontract out the deficient activities within Management Services Organization (MSO) or Delegates;
  5. De-delegation of specified functions;
  6. Contract non-renewal; or
  7. Contract termination.
  8. Upon receipt of the Corrective Action Plan, IEHPs will review for compliance and:
    - a. May elect to keep the CAP open while the Delegates performance is monitored for sustained improvements; or
    - b. Complete a validation audit following the implementation of the audit (as needed).

#### **Failure to Implement Corrective Action Plan**

- A. Failure to demonstrate CAP implementation and sustained improvement as outlined in the Corrective Action Plan may result in further action including:
  1. Delegates are frozen to new Member assignment;
  2. Financial Sanction;

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3. Request for cure under contract compliance;
4. Requirement to subcontract out the deficient activities within Management Services Organization (MSO) or Delegates;
5. De-delegation of specified functions;
6. Contract non-renewal; or
7. Contract termination.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	January 1, 2001
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 1. Credentialing Policies

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##### **APPLIES TO:**

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

##### **POLICY:**

- A. IEHP and Delegates adhere to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing and recredentialing process, including the confidentiality of Practitioner information obtained during the credentialing process. Department of Health Care Services (DHCS) can modify these requirements at any time and is required to notify the Centers for Medicare & Medicaid Services (CMS) within ninety (90) days prior of any such changes.
- B. Delegates must have a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to its Members.<sup>1</sup>
- C. Delegates' policies and procedures describe how primary source information is received, dated and stored; how modified information is tracked and dated from its initial verification; the staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate; the security controls in place to protect the information from unauthorized modification; and how the organization audits the processes and procedures.

##### **PURPOSE:**

- A. IEHP promulgates credentialing and recredentialing decision guidelines for Practitioners directly contracted with IEHP and Practitioners credentialed and contracted by IEHP's Delegates to perform these activities. IPAs are expected to use these guidelines for recommended education and/or training for PCPs and Specialists, patient age ranges for Practitioners, hospital arrangements, and recommendations for review of malpractice or other adverse history when making credentialing and recredentialing decisions.
- B. IEHP delegates all credentialing and recredentialing functions to Delegates that meet IEHP's requirements for delegation of credentialing. The Delegate must demonstrate a rigorous process to select and evaluate Practitioners.
- C. Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. Breeze, National Practitioner Data Bank (NPDB) etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from a National Committee for Quality Assurance (NCQA) approved

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<sup>1</sup> Title 42 Code of Federal Regulations (CFR), Part 455, Subpart E

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## 25. DELEGATION AND OVERSIGHT

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and appropriate state-licensing agency.

#### **DEFINITION:**

- A. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.
- B. PSV Documentation Methodology: The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.
- C. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification and include what was verified verbally.
- D. Verification Time Limit (VTL) - NCQA counts back from the decision date to the verification date to assess timeliness of verification.
- E. Written Verification - Requires a letter or documented review of cumulative reports. The Delegated IPA must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.
- F. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.
  - 1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight.
    - a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
    - b. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered delegation.

#### **PROCEDURES:**

- A. Delegates' policies and procedures must include the Practitioner Credentialing Guidelines that

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## 25. DELEGATION AND OVERSIGHT

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specify the following:<sup>2</sup>

1. The types of Practitioners it credentials and recredentials. Credentialing requirements apply to:<sup>3</sup>
  - a. Practitioners who are licensed, certified or registered by the State of California to practice independently (without direction or supervision)
  - b. Practitioners who have an independent relationship with the organization.
    - 1) An independent relationship exists when the organization directs its Member to see a specific practitioner or group of Practitioners, including all Practitioners whom Member can select as Primary Care Provider (PCP).
  - c. Practitioners who provide care to Members under the organization's medical benefits.
  - d. The criteria listed above apply to Practitioners in the following settings:
    - 1) Individual or group practices
    - 2) Facilities
    - 3) Telemedicine
  - e. Delegates are required to contract with and credential all their Practitioners defined as PCPs, Specialists, Non-Physician Practitioners, and Physician Admitters, including employed Physicians participating on the Provider panel and published in external directories who provide care to Members. At minimum, the Credentialing policies and procedures include the following types of Practitioners and describes which Providers the Delegate credentials:
    - 1) Doctor of Medicine (M.D.)
    - 2) Doctor of Osteopathic Medicine (D.O.)
    - 3) Doctor of Podiatric Medicine (D.P.M.)
    - 4) Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), who provide medical services only
    - 5) Occupational Therapists (O.T.)
    - 6) Physical Therapy (P.T.)
    - 7) Physician Assistants (P.A.) or Physician Assistants Certified (P.A.-C)

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<sup>2</sup> 42 CFR § 422.204

<sup>3</sup> National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 1, Element A, Factor 1

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- 8) Certified Nurse Midwives (C.N.M.)<sup>4</sup>
  - 9) Nurse Practitioners (N.P.)
  - 10) Speech Pathologists (S.P.)
  - 11) Audiologists (Au.)
  - 12) Registered Dieticians (R.D.) and Nutritionists
  - 13) Psychiatrists (M.D.)
  - 14) Licensed Marriage and Family Therapists (L.M.F.T.)
  - 15) Licensed Clinical Social Workers (L.C.S.W.)
  - 16) Psychologists (Ph.D., Psy.D.)
  - 17) Doctor of Chiropractic (D.C.)
  - 18) Licensed Midwives (L.M.)<sup>5</sup>
- f. Practitioners who do not need to be Credentialed:
- 1) Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the Hospital or another inpatient setting.
  - 2) Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility.
  - 3) Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) Functions.
  - 4) Covering Practitioners (e.g., locum tenens).
    - Locum tenens who do not have an independent relationship with the organization are outside NCQA’s scope of credentialing.
  - 5) Practitioners who do not provide care for members in a treatment setting (e.g. board certified consultants).
  - 6) Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.
  - 7) IEHP does not require Delegated IPAs to credential Practitioners that are Hospital based and do not see Members on a referral basis.

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<sup>4</sup> Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022 supersedes APL 16-017 and APL 15-017, “Provision of Certified Midwife and Alternative Birth Center Facility Services

<sup>5</sup> Ibid.

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- g. IEHP does not require Delegated IPAs to contract with the following Provider types. Services rendered by these Practitioners are covered by IEHP, however, must utilize the network contracted by IEHP. Therefore, credentialing and recredentialing of these Providers will be completed by IEHP.
- 1) Doctor of Chiropractic (D.C.)
  - 2) Licensed Acupuncturists (L.Ac.)
  - 3) Optometrists (O.D.)
  - 4) Other Behavioral Healthcare Practitioners
    - Addiction Medicine Specialists
    - Master Level Clinical Nurses
    - Licensed Clinical Social Workers
    - Marriage Family Therapists
    - Licensed Professional Clinical Counselors (L.P.C.C)<sup>6</sup>
2. Delegates' credentialing policies and procedures describe the sources the organization uses to verify credentialing information. The policy must describe the sources used to verify credentialing information of each of the following criterion listed below. All verification sources must be included in policy to ensure compliance with IEHP.<sup>7</sup>
- a. State license to Practice (Verification Time Limit (VTL): one hundred-eighty (180) calendar days prior to Credentialing decision date). Must be unencumbered, valid, current, and at the time of committee and remain valid and current throughout the Practitioner's participation with IEHP. Failure to maintain a valid and current license at all times, will result in an administrative termination of the Practitioner.

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

- 1) Medical Board of California (M.D.)
- 2) Osteopathic Medical Board of California (D.O.)
- 3) Board of Podiatric Medicine (D.P.M.)
- 4) Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C., L.P.C.C.)
- 5) Board of Psychology (Ph.D., Psy.D.)

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<sup>6</sup> Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3.

<sup>7</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 2



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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

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- 6) Dental Board of California (D.D.S., D.M.D.)
  - 7) California Board of Occupational Therapy (O.T.)
  - 8) California State Board of Optometry (O.D.)
  - 9) Physical Therapy Board of California (P.T.)
  - 10) Physician Assistant Committee (P.A., P.A.-C)
  - 11) California Board of Registered Nursing (C.N.M., N.P.)
  - 12) California Board of Chiropractic Examiners (D.C.)
  - 13) Speech-Language Pathology & Audiology Board (S.P., Au)
  - 14) Acupuncture Board (L.Ac.)
- b. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate verified through one (1) of the following sources:
- 1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision;
  - 2) IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA Number and NPI number will be documented in the Practitioner's file.
  - 3) If a Practitioner does not have a DEA or CDS certificate, the delegate must have a documented process to require an explanation why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner's patients who need prescriptions requiring DEA certification.
- c. Education and Training (VTL: Prior to the Credentialing Decision) IEHP may use any of the following to verify education and training:
- 1) The primary source from the Medical School.
  - 2) The state licensing agency or specialty board or registry, if the state agency and specialty board, respectively, perform primary source verification. IEHP:
    - Obtains written confirmation of primary source verification from the primary source, at least annually; or
    - Provides a printed, dated screenshot of the state licensing agency's or specialty board, or registry website displaying the statement that it performs

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primary source verification of Practitioner education and training information; or

- Provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution; or
  - National Student Clearinghouse may be considered an agent of the medical or professional school if the school has a contract with the Clearinghouse to provide verification services.
    - IEHP must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.
- 3) Sealed transcripts if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program.
- 4) Below are acceptable sources for Physicians (M.D., D.O.) to verify graduation from Medical School:
- AMA Physician Master File.
  - American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

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

- Primary source from the institution where the postgraduate medical training was completed.
  - AMA Physician Master File.
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - FCVS for closed residency programs.
    - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.
- 5) Below is the acceptable source for Nurse Practitioners with a Behavioral Health (BH) designation, to verify training in Psych/Mental Health.

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- The status must be recognized and verified through the BreZe Online services website or directly with the licensing board via phone or mail
- d. Board Certification (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). Below are the acceptable sources to verify board certification:
- 1) For all Practitioner types
    - The primary source (appropriate specialty board).
    - The state licensing agency if the primary source verifies board certification.
  - 2) For Physicians (M.D., D.O.)
    - ABMS or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
      - The ABMS “Is your Doctor Board Certified,” accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
    - AMA Physician Master File.
    - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
    - Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards perform primary source verification of completion of education and training.
  - 3) For other health care professionals
    - Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.
  - 4) For Podiatrists (D.P.M.)
    - American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
    - The American Board of Podiatric Medicine.
    - American Board of Multiple Specialties in Podiatry.
  - 5) For Nurse Practitioners (N.P.)
    - American Association of Nurse Practitioners (AANP).
    - American Nurses Credentialing Center (ANCC).

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## 25. DELEGATION AND OVERSIGHT

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- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
  - Pediatric Nursing Certification Board (PNCB).
  - American Association of Critical-Care Nurses (AACN).
- 6) For Physician Assistants (P.A.-C).
- National Commission of Certification of P.A.'s (NCCPA).
- 7) For Certified Nurse Midwives (C.N.M.).
- American Midwifery Certification Board (AMCB).
- 8) For Psychologists (Ph.D., Psy.D.).
- American Board of Professional Psychology (ABPP).
- e. Work history (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date) IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.
- f. Malpractice Claim History. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the Practitioner. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). IEHP will obtain confirmation of the past seven (7) years of malpractice settlements through one of the following sources:
- 1) Malpractice Insurance Carrier;
  - 2) National Practitioner Data Bank Query; or
  - 3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.
- g. Current Malpractice Insurance Coverage: IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) or written verification from the insurance carrier directly, be obtained in conjunction of collecting information on the application. (VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner's participation with IEHP).
- 1) For Practitioners with federal tort coverage, (e.g. Health Resources & Services Administration (HRSA)), the Practitioner must submit:
    - A copy of the face sheet or a federal tort letter as an addendum to the application. The face sheet or the federal tort letter must include the:

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- Insurance effective and expiration dates (future effective dates are acceptable)
    - A practitioner roster that lists the practitioners covered under the federal tort coverage.
  - h. Hospital Admitting Privileges: IEHP must verify that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating Hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be confirmed with the Hospital, in writing, via approved website or verbally.
    - 1) If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in “good standing.”
    - 2) If the Practitioner does not have clinical privileges, the IEHP must have a written statement delineating the inpatient coverage arrangement documented in the Provider’s file. (See Policy 5B, “Hospital Privileges”).
    - 3) Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have Hospital privileges and documentation in the file is not required for these types of Practitioners.
    - 4) Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Nurse Midwives (NM)) may not have Hospital privileges. However, if they provide the IEHP their Hospital privileges, IEHP will be responsible for verifying if those privileges are active and ensure they are in good standing.
    - 5) Specialists (MDs, DOs and DPMs) may not have Hospital privileges. Documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).
  - i. State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).
    - 1) Verification sources for sanctions or limitations on licensure include:
      - Chiropractors: State Board of Chiropractic Examiners CIN-BAD, NPDB.
      - Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
      - Physicians: Appropriate state board agencies, FSMB, NPDB.
      - Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.

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- Non-Physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.
  - For delegates using the Continuous Query (formerly Proactive Disclosure Service (PDS))
    - Evidence of current enrollment must be provided.
    - Report must be reviewed within one hundred eighty (180) calendar days of the initial credentialing decision.
    - Evidence of review must be documented in the file or on checklist.
- j. Medicare/Medicaid Sanctions. Verification Sources for Medicare/Medicaid Sanctions:
- 1) OIG must be the one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS.<sup>8</sup>
  - 2) The Medi-Cal Suspended and Ineligible list must be one (1) of the verification source for Medicaid sanctions, to ensure compliance with DHCS.<sup>9</sup>
  - 3) NPDB
  - 4) FSMB
  - 5) FEHB Program Department Record, published by the Office of Personnel Management, OIG.
  - 6) List of Excluded Individuals and Entities (maintained by OIG).
  - 7) Medicare Exclusions Database.
  - 8) State Medicaid Agency or intermediary and the Medicare intermediary.
  - 9) For delegate's using the Continuous Query (formerly Proactive Disclosure Service (PDS))
- k. NPI Number: Practitioners must hold and maintain a valid and active individual National Provider Identification Number (NPI) that can be verified through the National Plan & Provider Enumeration System (NPPES) website.
- 1) Group NPI Numbers may be requested by IEHP, in addition to the mandatory individual NPI number.<sup>10</sup>
3. Delegates' policies require credentialing of Practitioners before they provide care to Members. IEHP does not allow provisional credentialing. Policies must define the criteria required to reach a credentialing decision and must be designed to assess the Practitioner's ability to deliver care. This criterion is used to determine which

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<sup>8</sup> DHCS APL 19-004"

<sup>9</sup> Ibid.

<sup>10</sup> DHCS APL 19-004

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Practitioners may participate in its network, which may include, but are not limited to:<sup>11</sup>

a. Verification of Credentials

- 1) A current and valid, unencumbered license to practice medicine in California, at the time of Credentialing decision.
- 2) Current and valid DEA registered in California, applies to Practitioners who are required to write prescriptions
  - If the Practitioner designates another Practitioner to write all prescriptions on their behalf, while their DEA is still pending, the Practitioner must provide the following information for the designated Physician to ensure compliance with NCQA:
  - Practitioner Name
  - NPI (IEHP requirement)
    - Used as a unique identifier for the prescribing practitioner
  - DEA Number (IEHP requirement)
    - Used to validate that the DEA is current, active and registered in California.
- 3) Education and Training. IEHP specific specialty requirements: Medical Doctors (M.D.) and Doctor of Osteopathic (D.O.) must meet the education and training requirements set forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) and additional criterion set by IEHP and noted below, if applicable. All IEHP specific specialty requirements are subject for review by the IEHP Medical Director or Chief Medical Officer (CMO). Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

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

- If the Practitioner is not board certified in the subspecialty in which he/she is applying, there must be evidence of verification of residency and training in the subspecialty (e.g. Fellowship in Cardiology, Rheumatology, Pediatric Endocrinology, etc.), as relevant to the credentialed specialty, and meet the training requirements as set forth by ABMS or AOA.
- Practitioners who do not meet graduate medical training requirements as set forth by ABMS or AOA for the Provider's requested subspecialty, will be subject to review by the IEHP Credentialing Subcommittee for review.

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<sup>11</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 3

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Further review may be completed by the IEHP Peer Review Subcommittee.

- Effective January 1, 2017, IEHP Credentialing guidelines require Providers to meet the internship and residency requirements to be a Pediatric, Internal Medicine, Family Practice, or Public Health and General Preventive Medicine Provider in order to be credentialed as a Primary Care Provider in IEHP's network.
- Existing Providers who do not meet this requirement are grandfathered into the network, however if the Provider chooses to terminate, the Provider may not reapply or be reinstated as a Primary Care Provider.
- IEHP designated specialty requirements:
  - Bariatric Surgery requirements effective January 1, 2019. Meet the education and training requirements for General Surgery; and one of the following criteria:
    - Completion of an accredited bariatric surgery fellowship;
    - Documentation of didactic training in bariatric surgery (IEHP recommends the American Society for Metabolic and Bariatric Surgery Course). This information will be verified through:
      - ✚ Bariatric training certificate and/or supporting letter from supervising bariatric surgeon, which will be verified by Credentialing. Supporting letter will include the minimum criteria:
        - ❖ Supervising bariatric surgeon qualifications;
        - ❖ Supervising bariatric surgeon relationship with applicant;
        - ❖ Duration of relationship of supervising bariatric surgeon with applicant; and
        - ❖ Assessment of applicant's competency to perform bariatric surgery by supervising bariatric surgeon.
    - Attestation of bariatric surgery case volume signed by applicant (See Attachment, "Bariatric Surgeon Case Volume Attestation" in Section 5) to indicate volume of the following:
      - ✚ Volume of applicant's proctored cases; and
      - ✚ Volume of cases where applicant was the primary surgeon.



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- ❖ IEHP requires a minimum of fifteen (15) cases where applicant was the primary surgeon.<sup>12</sup>
- Current or past “Regular or Senior Member” of American Society for Metabolic and Bariatric Surgery (ASMBS). Verification of membership will be obtained by the Credentialing Department.
- IEHP recommends applicant actively participates with the MBSAQIP (Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program) or an equivalent regional or national quality improvement program.
  - ✚ Supportive documentation of participation with program is to be submitted with Credentialing application and/or request.
- **Family Practice 1: Family Practice Providers with Obstetrics (OB) services**, must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:
  - Provide a copy of a signed agreement that states member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
    - ✚ The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted hospital linked with that IPA network.
- **Family Practice 2: Family Practice that includes full OB services and delivery** must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:
  - Have and maintain full delivery privileges at an IEHP contracted hospital.
  - Provide a written agreement for an available OB back up Provider is required.
    - ✚ The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP hospital linked with the Family Practice Provider; and
    - ✚ Provide a protocol for identifying and transferring high risk members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc).
- **Obstetrics/Gynecology (OB/GYN) Providers who would like to**

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<sup>12</sup> American Society for Metabolic and Bariatric Surgery Standard Manual, <https://www.facs.org/~media/files/quality%20programs/bariatric/mbsaqip%20standardsmanual.ashx>

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**participate as a Primary Care Provider only**, will provide outpatient well woman services only with no hospital or surgical privileges, must provide the following information for consideration:

- Documentation of primary care practice in the United States;
- Twenty-five (25) Continuing Medical Education (CME) units for most recent three (3) year period, of which must be in primary care related areas;
- Applicants must provide two (2) letters of recommendation from a physician coworker (i.e. Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months); and
  - ✚ The physician coworkers must hold an active board certification in a Primary Care Specialty (i.e. board certified in Internal Medicine, Family Practice or Pediatrics).
- In lieu of having full Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc), must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery. (See Attachment, “Patient Transfer Agreement” in Section 5).
  - ✚ The Agreement must include back-up physician’s full delivery privileges at IEHP network hospital, in the same network as the non-admitting OB Provider.
  - ✚ The OB Provider must be credentialed and contracted within the same network.

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

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

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- PCPs that have Member assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.
- Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, “IEHP Addendum E” in Section 5);
- Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years; and
- Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e., PCPs with work experience associated with the applicant in the preceding twenty-four (24) months). The Physician coworkers must hold an active board certification in Internal Medicine or Family Practice.
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- **Specialties not recognized by either board (ABMS or AOA) are subject to Medical Director, Chief Medical Officer Review.** Further review may be completed by the Credentialing Subcommittee or Peer Review Subcommittee, who will either approve or deny.
- **Urgent Care Providers** must:
  - Meet the education and training requirements set forth by ABMS or AOA for at least one (1) of the following Specialty boards:
    - ✚ American Board of Pediatrics
    - ✚ American Board of Family Practice
    - ✚ American Board of Internal Medicine
    - ✚ American Board of Obstetrics and Gynecology
    - ✚ American Board of Emergency Medicine
    - ✚ Osteopathic Board of Pediatrics
    - ✚ Osteopathic Board of Family Physicians
    - ✚ Osteopathic Board of Internal Medicine
    - ✚ Osteopathic Board of Obstetrics and Gynecology
    - ✚ Osteopathic Board of Emergency Medicine
  - If the Practitioner is board certified or eligible in a specialty and/or subspecialty recognized by the American Board of Medical Specialties or American Osteopathic Association not

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referenced above, then those Providers are subject to Medical Director, Chief Medical Officer Review. Further review may be completed by the Peer Review Subcommittee, who will either approve or deny. For their review and consideration, the following documents must be submitted:

- ❖ Provide evidence of twenty-five (25) CME units in Pediatric Primary Care completed within the last three (3) years if the Provider is requesting to treat Pediatric patients;
  - ❖ Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years if the Provider is requesting to treat adult patients; and
  - ❖ Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The physician coworkers must hold an active board certification in Pediatrics, Family Practice or Internal Medicine
- 4) Board Certification. IEHP does not require board certification; however IEHP must verify the certification status of the practitioners who state that they are board certified, to include that the board eligibility requirements are met.
- 5) Work History. IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the practitioner's application or Curriculum Vitae (CV). If the practitioner has less than five years of work history, the time frame starts at the initial licensure date.

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

- 6) Malpractice history. IEHP obtains confirmation of the past seven (7) years of malpractice settlements from the malpractice carrier or queries the National Practitioner Data Bank (NPDB). Appropriate Malpractice History: For Practitioners with a history of malpractice suits or decisions, the following criteria warrants full Credentialing Subcommittee Review of the history and should be applied in making credentialing and recredentialing decisions:
- Number of claims - any claims within the prior seven (7) years.
  - Results of cases - any settlements within the prior seven (7) years.

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- Trends in cases - Practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).
- 7) Hospital Admitting Privileges. Practitioner must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation(s) or admitting privileges at a participating hospital. Practitioners must have appropriate admitting privileges or arrangements with IEHP’s contracted Hospitals, if applicable See Policy 5B, “Hospital Privileges” and See Attachment, “Hospital Admitting Privileges Reference by Specialty” in Section 5).
- Providers are not required to maintain Hospital admitting privileges if they are only practicing at an Urgent Care or providing Telehealth Services only.
- 8) NPI: Must confirm Provider has an active Individual NPI with a Primary address that must be registered to an address in California.
- Group NPI may be submitted to IEHP in conjunction to the Individual NPI.
  - Telehealth Providers are not required to have an NPI registered with a primary address in California.
- 9) Grievance History
- Lower than average grievance rate
  - Absence of grievance trends
- 10) All PCP and Urgent Care Providers must meet the Facility Site Review (FSR)/Medical Record Review (MRR) Guidelines. See Policy MC06A, “Facility Site Review and Medical Records Review Survey Requirements and Monitoring.”<sup>13</sup>
- b. Sanction Information
- 1) State Sanctions, restrictions on licensure and limitations on scope of practice:
- Any actions, restrictions or limitations on scope of practice, are presented for review of and discussion to the Credentialing Subcommittee and/or Peer Review Subcommittee.
- 2) Medicare and Medicaid Sanctions
- Medi-Cal Suspended & Ineligible List Providers are deemed suspended and ineligible from Medi-Cal will be terminated or not be credentialed and contracted with for Medi-Cal line of business. IEHP does not allow Medi-

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<sup>13</sup> Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3

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Cal Suspended & Ineligible List Providers to participate in the IEHP network.

- Providers Excluded/Sanctioned by Medicare or Medicaid (OIG). IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report). Providers identified on the OIG report, will not be credentialed or contacted, and terminated from our network if they are existing Providers.<sup>14</sup>
- Medicare Opt-Out Providers who are identified on the Medicare Opt-Out will not be contracted for Medicare line of business. IEHP does not allow Medicare Opt-Out Providers to participate in Medicare line(s) business.
- Preclusions List, Providers identified on the preclusions list will be terminated or not be credentialed and contracted with.<sup>15</sup>

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

1) Attestation to:

- Reasons for inability to perform the essential functions of the position;
- Lack of present illegal drug use;
- History of loss of license and felony convictions;
- History of loss or limitation of privileges or disciplinary actions;
- Current Malpractice Insurance coverage; and
- Malpractice Insurance Coverage: Must have current and adequate malpractice insurance coverage that meets the following criteria:
  - Minimum \$1 million per claim/\$3 million per aggregate.
  - Coverage for the specialty the Provider is being credentialed and contracted for.
  - Coverage for all locations the Provider will be treating IEHP patients.<sup>16</sup>
- Current and signed attestation confirming the correctness and completeness of the application.

2) Release of Information used for primary source verification.

3) Addendum A

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<sup>14</sup> DHCS APL 19-004

<sup>15</sup> Centers for Medicare & Medicaid Services, "Preclusion List Requirements", 11/02/2018

<sup>16</sup> NCQA, 2022 HP Standards and Guidelines, CR1, Element C, Factor 5

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- Practitioner Type
  - Practice Type
  - Name(s) of any employed Advanced Practice Practitioners (e.g. NPs, Nurse Midwives, or PAs)
  - Age Limitations
  - Practitioner Office Hours
  - Practitioner’s written plan for continuity of care if they do not have Hospital privileges
  - Languages spoken by Physician
  - Languages spoken by staff
- 4) Addendum B, used for Professional Liability Action explanation(s).
- 5) Addendum C, used to confirm Practitioner’s status as a:
- Certified Workers Compensation Provider
  - Reservist
- 6) Addendum D, Notice to Practitioners of Credentialing Rights/Responsibilities
- 7) Addendum E, applicable to General Practice and Obstetrics/Gynecology providers who are PCP’s.
- 8) Verification of Qualifications for HIV/AIDS Physician Specialist form (See Attachment, “Verification of Qualifications for HIV/AIDS Physician Specialist”, in Section 5) required for Practitioners who would like to be designated as an HIV/AIDS Specialist.
- 9) Behavioral Health (Area(s) of Expertise Form. To ensure Practitioners are listed with the types of services they offer, this form is required for all Practitioners with a Behavioral Health Affiliation/Designation, to include but are not limited to:
- Psychiatrists
  - Psychologists
  - Addiction Medicine Specialists
  - Master Level Clinical Nurses
  - Licensed Clinical Social Workers
  - Licensed Marriage Family Therapists

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- License Professional Clinical Counselors NPs with a Behavioral Health (BH) designation
  - PAs with a BH designation.
- 10) Transgender Questionnaire (See Attachment, “Transgender Questionnaire” in Section 5) are required for all Practitioners who are or would like to be designated as a Transgender Competent Provider. At minimum, the Practitioner must meet and provide evidence of the following for consideration:
- Demonstrate ten (10) Continuing Medical Education (CME) hours within the last three (3) years,
  - Certification through WPATH
  - Must provide evidence of the following annual staff training on transgender care, that includes:
    - Agenda
    - Sign in sheet
    - Policies and Procedures
- 11) Licensed Midwife Attestation: Plan for Consultation, Emergency Transfer, & Transport (See Attachment, “Licensed Midwife Attestation”, in Section 5) required for all Licensed Midwife practitioners.
- IEHP requires the backup Licensed Physician, engaged in active clinical obstetrical practice and with whom the Licensed Midwife consults when there are significant deviations from the normal, in either mother or infant, is an active Obstetrics/Gynecology practitioner within the IEHP network.
- 12) Attachment I: Statement of Agreement by Supervising Provider. IEHP requires a completed Attachment I: Statement of Agreement by Supervising Provider, for all Advanced Practitioner and Supervising Physician arrangements, to ensure arrangements are documented appropriately, which will be collected at the time of credentialing, recredentialing and upon relationship change.
- If these arrangements are clearly described on the Delegation of Services Agreement, Practice Agreement, or Standardized Procedures, those documents may be used in lieu of submitting an Attachment I form.
- 13) Practitioner offices who employ Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) must ensure written arrangements are in place between the Advanced Practice Practitioner and the practice where they treat IEHP members. These documents must be readily available to IEHP upon request. (See Policy 6F, “Facility Site Review – Non-Physician Practitioner Requirements”).



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- IEHP requires all Advanced Practice Practitioners to practice at the same site as their Supervising Physician.
- PAs with a Behavioral Health Designation must be supervised by a licensed Physician who specializes in Psychiatry.

The following written arrangements must be provided to IEHP upon request for:

- PAs must provide one (1) of the following:
  - Delegation of Services Agreement and Supervising Physician Form (See Attachment, “Delegation of Services Agreement and Supervising Physician Form” in Section 5).<sup>17</sup> This agreement must:
    - Define specific services identified in practice protocols or specifically authorized by the supervising Physician., and
    - Both the Physician and PA must attest to, date and sign the document.
    - An original or copy must be readily accessible at all practice sites in which the PA works;
  - Practice Agreement, effective January 1, 2020,<sup>18</sup> the writing, developed through collaboration among one or more Physicians and Surgeons and one or more PAs, that defines the medical services the PA is authorized to perform<sup>19</sup> and that grants approval for Physicians and Surgeons on the staff of an organized health care system to supervise one or more PAs in the organized health care system. Any reference to a Delegation of Services Agreement relating to PAs in any other law shall have the same meaning as a practice agreement. The Practice Agreement must include provisions that address the following:<sup>20</sup>
    - The types of medical services a PA is authorized to perform.
    - Policies and procedures to ensure adequate supervision of the PA, including, but not limited to, appropriate communication, availability, consultations, and referrals between a Physician and Surgeon and the PA in the provision of medical services.
    - The methods for the continuing evaluation of the competency and qualifications of the PA.

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<sup>17</sup> Title 16 California Code of Regulations (CCR) § 1399.540(b)

<sup>18</sup> Senate Bill 697

<sup>19</sup> Business & Professions Code § 3502

<sup>20</sup> Bus. & Prof. Code § 3502.3

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- The furnishing or ordering of drugs or devices by a PA.<sup>21</sup>
- Any additional provisions agreed to by the PA and Physician and Surgeon.
- A practice agreement shall be signed by both of the following:
  - The PA.
  - One or more Physicians and Surgeons or a Physician and Surgeon who is authorized to approve the practice agreement on behalf of the staff of the Physicians and Surgeons on the staff of an organized health care system.
- A delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.
- A practice agreement may designate a PA as an agent of a supervising Physician and Surgeon.
- Nothing in this section shall be construed to require approval of a practice agreement by the board.
  - Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California, a practice agreement may authorize a PA to do any of the following:
    - Order durable medical equipment, subject to any limitations<sup>22</sup> or the practice agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.<sup>23</sup>
    - For individuals receiving home health services or personal care services, after consultation with a supervising Physician and Surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.
    - After performance of a physical examination by the PA under the supervision of a Physician and surgeon consistent with this chapter, certify disability of the Unemployment Insurance Code. The Employment Development Department

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<sup>21</sup> Bus. & Prof Code § 3502.1

<sup>22</sup> Bus. & Prof Code § 3502

<sup>23</sup> Bus. & Prof Code § 3502.3 (1)

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shall implement this paragraph on or before January 1, 2017.<sup>24</sup>

- NPs and CNMs are required to have Standardized Procedures. Standardized Procedures must be on-site site specific and:
    - To meet the requirements, reference textbooks and other written sources, which must include:<sup>25</sup>
      - (i) Book (specify edition) or article title, page numbers and sections.
    - NP and/or CNM must be practicing at a site assigned to their supervising Physician; and
    - Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the documents must include:
      - Table of Contents of the Standardized Procedures used, between the NP and/or CNM and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
      - Evidence that the Standards of Care established by the sources were reviewed and authorized by the NP, Physician and administrator in the practice setting (i.e., signature page that includes all parties involved).
  - Standardized Procedures written using the Practice Agreement or PAs Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.<sup>26,27,28</sup>
- d. Adverse History Guidelines: IEHP must carefully review the oversight process for the Delegates' review of all Practitioners with evidence of adverse history are presented to Credentialing Committee for review and documented in the meeting minutes, that may include, but is not limited to Providers who have:
- 1) Restrictions on licensure
  - 2) Restrictions on DEA
  - 3) Loss of Clinical privileges or negative privilege actions
  - 4) Sanction Other negative actions may include, but are not limited to:

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<sup>24</sup> California Code, Unemployment Insurance Code (UIC) § 2708

<sup>25</sup> 16 CCR § 1474 (3)

<sup>26</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 3

<sup>27</sup> Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3

<sup>28</sup> Title 16, California Code of Regulations (CCR) § 1474 (3)

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- Use of illegal drugs
- Criminal history
- Engaged in any unprofessional conduct or unacceptable business practices
- Higher than average grievance rate or trend in grievances

#### e. Provider Network

- 1) Advanced Practice Practitioners are allowed to increase only one (1) supervising PCP's enrollment capacity per location with a maximum of two (2) unique locations allowed.
- 2) Advanced Practice Practitioners must practice at a site assigned to their supervising Physician.
- 3) Practice Parameter expansion(s) or reduction(s). Providers are required to submit a request that includes a detailed explanation or complete a Provider Privilege Adjustment Request Form (See Attached, "Provider Privilege Adjustment Request Form"), when requesting a change in practice parameters such as an expansion or reduction in Member age range or specialty care privileges (i.e. addition of specialty). All Practice Parameter expansions and reductions are subject for review by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.
  - IEHP will consider all relevant information including practice site demographics, Provider training, experience and practice capacity issues before granting any such change. At a minimum, Provider's written request must include:
    - Documentation of any relevant training (e.g., Continuing Medical Education, post graduate/residency training, etc.); and
    - Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.)
- 4) Patient age ranges for PCP must be specifically delineated as part of the Delegated credentialing process. The age range for DualChoice line of business are Ages 21 and above.

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

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 1. Credentialing Policies

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

4. Delegates' policies must define the process used and the criteria required to reach credentialing decisions that are designed to assess the Practitioner's ability to deliver care. At a minimum:<sup>29</sup>
  - a. The Credentialing Committee must receive and review the credentials of the Practitioners who do not meet the Delegates established criteria.
  - b. Policy must identify what is considered acceptable to be determined as a clean file, if the Delegate utilized a clean file process.
  - c. If retrospective review by IEHPs Credentialing Department reveals that a Practitioner approved by a Delegate does not meet the above requirements, IEHP can submit the Practitioner to IEHPs Peer Review Subcommittee for review.
5. Delegates may designate to their Medical Director the authority to determine and sign off on a credentialing and recredentialing file that meets the Delegate standards as complete, clean, and approved. Delegates may assign an associate medical director or other qualified medical staff member as the designated medical director if the individual has equal qualifications as the medical director and is responsible for credentialing, as applicable. The Delegate's Credentialing Committee must review the credentials of all Practitioners being credentialed or recredentialed who do not meet the Delegates established criteria, and to provide advice and expertise for credentialing decisions.<sup>30</sup>
  - a. If the Medical Director or equally qualified Practitioner signs off on clean files, the sign off date is the Committee date.
  - b. If the Delegate decides not to use the Medical Director or equally qualified Practitioner, the Delegate can continue to send "clean files" to the Credentialing Committee.
6. Delegates' policies must describe the process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.<sup>31,32</sup>
  - a. Policies must explicitly state that credentialing and recredentialing decisions are not based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient in which the Practitioner specializes and describe the steps for monitoring or preventing discriminatory practices during the credentialing/recredentialing processes.
  - b. Delegates procedures for monitoring and preventing discriminatory credentialing

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<sup>29</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 4

<sup>30</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 5

<sup>31</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 6

<sup>32</sup> 42 CFR § 422.205

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 1. Credentialing Policies

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decisions may include but are not limited to:

- 1) Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination;
- 2) Maintaining and heterogeneous Credentialing Committee membership and requiring those responsible for credentialing decisions to sign an affirmative statement to make decisions in a non-discriminatory manner.
- 3) Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes. Policy must indicate that monitoring is to be conducted at least annually. Examples of monitoring discriminatory practices:
  - Having a process for performing periodic audits of credentialing files (in-process, denied and approved files)
  - Having a process for performing annual audits of Practitioner complaints about possible discrimination. (Can be reviewed and discussed during quarterly or semi-annual review of complaints)
- 4) Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes. Examples for preventing discriminatory practices:
  - Maintaining a heterogeneous credentialing committee and requiring those responsible for credentialing decisions to sign a statement affirming that they do not discriminate.
  - Timeframe for prevention: None. Committee members can attest annually or at each meeting.
7. Delegates' policies and procedures must describe the process for notifying Practitioners when credentialing information obtained from other sources varies substantially from that provided. A statement that Practitioners are notified of discrepancies does not meet the requirement.<sup>33</sup>
8. Delegates' policies and procedures must describe the process for notifying Practitioners the credentialing and recredentialing decisions within sixty (60) calendar days of the Committee's decision.<sup>34</sup>
9. Delegates' policies must describe the medical director or other designated Practitioner's overall responsibility and participation in the credentialing process.<sup>35</sup>
10. Delegates' policies and procedures must clearly state the information obtained in the credentialing process is confidential and describe the process to ensure confidentiality of the information collected during the credentialing process. The Delegates' mechanisms

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<sup>33</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 7

<sup>34</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 8

<sup>35</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 9

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 1. Credentialing Policies

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in effect to ensure confidentiality of all information obtained in the credentialing process, except as otherwise provided by law, may include, but is not limited to:<sup>36</sup>

- a. Confidentiality statements are signed by Committees and Credentialing staff;
- b. Practitioner files are maintained in locked file cabinets are only accessible by authorized personnel, if applicable; and
- c. Security for database systems is maintained through passwords or other means to limit access to Practitioner information to authorized staff only.

11. Delegates' policies and procedures describe the Delegates' process for ensuring that information provided to IEHP for Member materials and Practitioner directories is consistent with the information obtained during the credentialing and recredentialing process. At minimum, policy should demonstrate that the information collected during the credentialing and recredentialing process and requests received in between cycles, is entered, maintained, and submitted to IEHP by the Credentialing Department to ensure consistency.<sup>37</sup>

- B. Delegates' policies and procedures describe how the following three (3) factors are met and how the Practitioners are notified (e.g. application, contact, Provider manual, other information distributed to Practitioners, website, letter to Practitioners):<sup>38</sup>

1. Review information submitted to support their credentialing application
  - a. Policies should allow for review of information obtained from outside sources (e.g. malpractice insurance carriers, state licensing boards) to support their credentialing application. Delegates are not required to make available:
    - 1) References.
    - 2) Recommendations.
    - 3) Peer-Review protected information.
2. Delegate notifies Practitioners of their right to correct erroneous information (submitted by another source) and must clearly state:
  - a. The time frame for making corrections.
  - b. The format for submitting corrections.
  - c. Where corrections must be submitted.

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

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<sup>36</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 10

<sup>37</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 11

<sup>38</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element B, Factor 1-3

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 1. Credentialing Policies

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

3. Delegates notifies Practitioners of:
  - a. Their right to be informed of the status of their application, upon request.
  - b. The information it is allowed to share with Practitioners.
  - c. Its process for responding to requests for application status.
- C. Delegates credentialing process, both paper and electronic, must describe:
  1. How primary source verification information is received, dated and stored.
  2. How modified information is tracked and dated from its initial verification.
    - a. The policy must clearly state how it tracks:
      - 1) When the information was modified
      - 2) How the information was modified
      - 3) Staff who made the modification
      - 4) Why the information was modified
  3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.
    - a. The delegates' policies and procedures identify the:
      - 1) Level of staff who are authorized to access, modify and delete information
      - 2) Circumstances when modification or deletion is appropriate
  4. The security controls in place to protect the information from unauthorized modification.
    - a. Policies and procedures describe the process for:
      - 1) Limiting physical access to the credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources.
      - 2) Preventing unauthorized access, changes to and release of credentialing information.
      - 3) Password-protecting electronic systems, including user requirements to:
        - Use strong passwords
        - Avoid writing down passwords
        - Use different passwords for different accounts
        - Change passwords periodically
        - Changing or withdrawing passwords, including alerting appropriate staff



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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 1. Credentialing Policies

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who oversee computer security to:

- Change passwords when appropriate
  - Disable or remove passwords of employees who leave the organization
  - If the Delegate contracts with an external entity to outsource storage of credentialing information, the contract describes how the contracted entity ensures the security of the stored information.
    - Contract will require review if outsourcing
5. How the organization audits the processes and procedures in factors 1-4.
- a. The policies and procedures must describe the audit process for identifying and assessing risks and ensuring the specified policies and procedures are followed. The description includes:
    - 1) The audit methodology used, including sampling, the individuals involved in the audit and audit frequency.
    - 2) The oversight of the department responsible for the audit.<sup>39</sup>
- D. At least annually, Delegates must demonstrate that it monitors compliance with its CR controls, by:
- 1. Identifying all modifications to credentialing and recredentialing information that did not meet the organizations policies and procedures for modifications.
  - 2. Analyzing all instances of modifications that did not meet the organization’s policies and procedures for modifications, by conducting qualitative and quantitative analysis of all modification that did not meet its policies and procedures.
  - 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters.
- E. Delegates’ recredentialing policies and procedures require information from quality improvement activities and Member complaints in the recredentialing decision making process.<sup>40,41</sup>
- F. Delegates’ policies and procedures must ensure that it only contracts with Physicians who have not opted out.
- 1. Medicare Opt-Out Providers who are identified on the Medicare Opt-Out will not be contracted for Medicare line of business. IEHP does not allow Medicare Opt-Out Providers to participate in the IEHP network for Medicare lines of business.<sup>42</sup>

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<sup>39</sup> NCQA, 2022 HP Standards and Guidelines, CR 1, Element C, Factors 1-5

<sup>40</sup> Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.3

<sup>41</sup> DHCS APL 19-004

<sup>42</sup> Medicare Managed Care Manual, Chapter 6 “Relationships with Providers”, Chapter 6 § 60.2

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 1. Credentialing Policies

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- G. Delegates must have policies and procedures that prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report).
1. Providers identified on the OIG report, will not be credentialed or contacted, and terminated from our network if they are existing Providers.<sup>43</sup>
- H. Delegates must have policies and procedures that they do not contract with Practitioners who are precluded from receiving payment for Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries.
1. IEHP does not allow Practitioners identified on the preclusions list to participate in the IEHP network.

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<sup>43</sup> DHCS APL 19-004

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## **25. DELEGATION AND OVERSIGHT**

### **B. Credentialing Standards**

#### **2. Credentialing Committee**

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#### **APPLIES TO:**

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

#### **POLICY:**

- A. Delegates Credentialing Committee must use participating Practitioners to provide expert advice and expertise for credentialing decisions.
- B. In accordance with National Committee for Quality Assurance (NCQA) guidelines, Delegates Credentialing Committee must review credentials for Practitioners who do not meet established thresholds.
  - 1. Assessment of Timeliness - IEHP uses the Credentialing Committee or medical director decision date to assess timeliness in the file review elements, even if a review board or governing body reviews decisions made by the Credentialing Committee or Medical Director.
  - 2. Providing care to Members - IEHP does not permit Practitioners to provide care to its Members before they are credentialed.
- C. Delegates Credentialing Committee ensures files that meet established criteria are submitted to the Credentialing Committee for review or has a process for a medical director review and approval of clean files.

#### **PURPOSE:**

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

#### **DEFINITION:**

- A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.
  - 1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, Managed Service Organization (MSO) etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.
    - a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
    - b. If information is gathered from a company website and the Delegate staff is pulling

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 2. Credentialing Committee

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

- B. Clean files: Credentialing files that meet the organization’s criteria for participation and are not required to be sent to the credentialing committee for review.<sup>1</sup>
- C. Credentials Committee Minutes: A document from a peer review committee which includes thorough discussion of credentialing files, decisions/recommendations, and follow-up of issues.
- D. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g. evaluation of a physician’s credentials and practice by another physician).<sup>2</sup>
- E. Timeliness: A term used when auditing file elements to confirm they are within one-hundred eighty (180) calendar days of the credentials committee decision.

#### **PROCEDURES:**

- A. Participating Practitioners are external to the organization and are part of the organization’s network, as noted by NCQA.<sup>3</sup>
  - 1. The Credentialing Committee is a peer-review body with members from the range of Practitioners participating in the organizations network that makes recommendations regarding credentialing decisions.

Delegates may have separate review bodies for each Practitioner type (e.g., Physician, Oral Surgeon, Psychologist), specialty or multidisciplinary committee, with representation from various specialties.

If the Delegate is part of a regional or national organization, a regional or national Credentialing Committee that meets the criterion may serve as the peer review committee for the local organization.

At a minimum, the policy and procedures must include:

- a. The Credentialing Committee is comprised of a range of participating Practitioners that includes multi-disciplinary representation with the ability to seek the advice of participating Practitioners outside of the Committee, at the Committee’s discretion, when applicable.
  - 1) Representation includes a range of participating Practitioners in the Delegates

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<sup>1</sup> National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, Glossary

<sup>2</sup> NCQA, 2022 HP Standards and Guidelines, Glossary

<sup>3</sup> NCQA, 2022 Health Plan Standards and Guidelines, CR 2, Element A, Factor 1

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 2. Credentialing Committee

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network;

- 2) If the Credentialing Committee is comprised of Primary Care Providers (PCPs) only, the policy must state that Specialists are consulted, when necessary and appropriate. Evidence may include, but is not limited to:
  - There is evidence through their Committee minutes that a Specialist was consulted, when applicable; and
  - There is a listing that indicates what Specialists were used (if applicable).
- 3) Quorum requirements of Committee (minimum of three (3));
  - Meetings should include a quorum of Practitioners for each meeting.
- 4) Identity of voting Members;
- 5) Identity of who has authority to make final credentialing decisions and the relationship to the Governing Board (if applicable);
- 6) Frequency of Committee meeting (at minimum, quarterly);
- 7) Process to document, review and approve delegate credentialing policies and procedures by the Committee on an annual basis;<sup>4</sup>
- 8) Committee's opportunity to review documentation, criteria and credentials of all Practitioners being credentialed or recredentialed prior to rendering a recommendation; and
- 9) All primary source information obtained and reviewed in the credentialing or recredentialing process must be no more than one hundred eighty (180) days old at the time of the Committee decision.

B. Delegates Credentialing Committee policies must describe how the Credentialing Committee receives and reviews the credentials of Practitioners who do not meet the Delegates criteria for participation in the network. The Credentialing Committee must give thoughtful consideration of the credentialing information. IEHP will review Credentialing Committee meeting minutes from three (3) different meetings within the look-back period. If the required meeting minutes are not available for review, IEHP will review the meeting minutes that are available within the look-back period. Delegates must provide evidence of the following:<sup>5</sup>

1. The Credentialing Committee reviewed credentials for Practitioners who do not meet the Delegate's criteria for participation in the network;
2. The Credentialing Committee's discussion must be documented within its meeting minutes; and

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<sup>4</sup> NCQA, 2022 HP Standards and Guidelines, CR 2, Element A, Factor 3

<sup>5</sup> NCQA, 2022 HP Standards and Guidelines, CR 2, Element A, Factor 2

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 2. Credentialing Committee

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3. Credentialing Committee meetings and decision-making take place in the form of real-time virtual meetings (e.g. through video conferencing or WebEx conferment with audio).
  - a. All meetings, including ad hoc, may not be conducted only through email.
  - b. Meetings should include a quorum of Practitioners for each meeting, as established in the Delegates policy.
  - c. Minutes should be signed by the Credentialing Committee Chairperson and dated within one (1) month or by the date of the next meeting.
  - d. Ad hoc Credentialing Committee meeting minutes must be documented at the time of the ad hoc meeting and must be presented at the next formal meeting.
- C. For files that meet the Delegates credentialing criteria, the delegate must:<sup>6</sup>
  1. Submit all Practitioner files to the Credentialing Committee for review; or
  2. Has a process for medical director or quality physician review and approve clean files.
    - a. Evidence of review is a handwritten signature, handwritten initials, or unique electronic identifier, if the organization has appropriate controls for ensuring that only the designated medical director or qualified physician can enter the electronic signature.
    - b. An individual signature is not required in each Practitioner file if there is one report with a signature that lists all required credentials for all Practitioners with clean files.
  3. If the Delegate presents all files (including clean files) to the Credentialing Committee, this factor is met.

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<sup>6</sup> NCQA, 2022 HP Standards and Guidelines, CR 2, Element A, Factor 3

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 3. Credentialing Verifications

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##### **APPLIES TO:**

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

##### **POLICY:**

- A. Delegate verifies that the following are within the prescribed time limits: License to Practice, Drug Enforcement Administration (DEA), education and training, board certification, work history and malpractice history.
- B. Delegate verifies state sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions.
- C. Delegate ensures applications for credentialing and recredentialing include reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitation of privileges or disciplinary actions, current malpractice insurance coverage, and a current and signed attestation confirm the correctness and completeness of the application.
- D. Delegate verifies that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating Hospital.
- E. Delegate monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out.
- F. Delegate includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process.
- G. Delegate confirms all Practitioners maintain an active individual National Provider Identifier (NPI) number registered through the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) and must be registered to an address in the State of California.
- H. Delegate ensures all Primary Care Provider's (PCP) and Urgent Care's (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring").
- I. Delegates must provide IEHP with Social Security Numbers for all new and existing practitioners participating providers, to ensure all Practitioners are included in IEHP's screening of the Death Master File.

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 3. Credentialing Verifications

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- J. Delegates monitors its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List.
- K. Delegates must ensure all Practitioners are within the appropriate age range guidelines, as appropriate.
- L. Delegates must submit appropriate documentation to expand or limit their practice parameters for IEHP review and approval.
- M. Delegates must ensure and obtain the appropriate documentation for all Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Nurse Midwives (NMs) between the Mid-Level and Supervising Physician, provide them to IEHP, and ensure these documents are readily available upon request. (See Policy 6F, “Non-Physician Practitioner Requirements”).

#### **PURPOSE:**

- A. IEHP must ensure Delegates conducts timely verification of information to ensure that Practitioners have the legal authority and relevant training and experience to provide quality care.
- B. Pencils are not an acceptable writing instrument for credentialing documentation.
- C. Each file contains evidence of verification, defined by NCQA as “Appropriate documentation.” IEHP documents verification in the credentialing files using any of the following methods or a combination:
  - 1. Credentialing documents signed (or initialed) and dated by the verifier.
  - 2. A checklist that includes for each verification:
    - a. The source used.
    - b. The date of verification.
    - c. The signature or initials of the person who verified the information.
    - d. The report date, if applicable.
  - 3. A checklist with a single signature and a date for all the verifications that has a statement confirming that the signatory verified all of the credentials on that date and that includes for each verification.
    - a. The source used.
    - b. The report date, if applicable.
    - c. If the checklist does not include checklist requirements listed above appropriate



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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 3. Credentialing Verifications

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credentialing information must be included.

- D. Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. BreZE, National Practitioner Data Bank (NPDB), etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from an NCQA approved and appropriate state-licensing agency.
- E. PSV Documentation Methodology. The Delegate may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.
- F. Delegates may use web crawlers to verify credentialing information from approved sources. A “web crawler” is software that retrieves information directly from a website; in this case, the state licensing or certification agency (i.e. the primary source). Delegates must provide documentation that the web crawler collects information from approved sources, and documents that staff reviewed the credentialing information.

#### **DEFINITION:**

- A. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.
- B. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification, and include what was verified verbally.
- C. Verification Time Limit (VTL): National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification.
  - 1. For web queries, the data source data – e.g. release date or as of date is used to assess timeliness of verification.
- D. Written Verification - Requires a letter or documented review of cumulative reports. The Independent Practice Association (IPA) must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.
- E. NPPEs – CMS National Plan and Provider Enumeration System.
- F. CMS Preclusions List – List of prescribers and individuals or entities who fall within any of the following categories:

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 3. Credentialing Verifications

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1. Currently revoked from Medicare:
  2. Under an active re-enrollment bar; or
  3. CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.
- G. Death Master File (DMF) contains information about persons who had Social Security numbers and whose deaths were reported to the Social Security Administration from 1962 to the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.
- H. Delegate: If IEHP gives another Delegate (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.
1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.
    - a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
    - b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.
- I. Types of Signatures:
1. Wet signature - created when a person physically marks a document.
  2. Faxed signature – the “copy” or “duplication” of your signature (no matter the method, system or medium you choose) is referred to as a facsimile signature.
  3. Digital signature - type of electronic signature that encrypts documents with digital codes that particularly difficult to duplicate. It includes a certificate of authority, such as a Windows certificate, to ensure the validity of the signatory (the signature’s author and owner).
  4. Electronic signature - symbols or other data in digital form attached to an electronically transmitted document as verification of the sender’s intent to sign the document.
  5. Scanned signature - a written signature that’s been scanned into an electronic format, like a PDF.
  6. Photocopied signature - a signature reproduced provided that the copy must be of an original document containing an original handwritten signature.

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 3. Credentialing Verifications

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7. Signature stamp - is an implement personalized with an individual's name for a quick and easy authorization of documents. These stamps can come customized with just a signature or can include both a signature and printed name.

#### **PROCEDURES:**

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

1. A current and valid license to practice in California (Verification Time Limit (VTL): one hundred-eighty (180) calendar days prior to Credentialing decision date).
  - a. Must be valid, current, and unencumbered at the time of committee and remain valid and current throughout the Practitioner's participation with IEHP.
    - 1) All Practitioners must be licensed by the State of California by the appropriate state licensing agency. Delegates must verify licensure directly from the state licensing or certification agency (or its website). The following licensures may be verified through BreEZe Online services online or directly with the licensing board via phone or mail:
      - Medical Board of California (M.D.)
      - Osteopathic Medical Board of California (D.O.)
      - Board of Podiatric Medicine (D.P.M.)
      - Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
      - Board of Psychology (Ph.D., Psy.D.)
      - Dental Board of California (D.D.S., D.M.D.)
      - California Board of Occupational Therapy (O.T.)
      - California State Board of Optometry (O.D.)
      - Physical Therapy Board of California (P.T.)
      - Physician Assistant Committee (P.A., P.A.-C)
      - California Board of Registered Nursing (C.N.M., N.P.)
      - California Board of Chiropractic Examiners (D.C.)
      - Speech-Language Pathology & Audiology Board (S.P., Au)
      - Acupuncture Board (L.Ac.)
    - 2) Failure to maintain a valid and current license at all times, will result in an

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administrative termination of the Practitioner.<sup>1</sup>

2. A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate. Delegates must verify that the practitioner's DEA or CDS certificate is valid and current in each state where the practitioner provides care to members. The DEA or CDS Certificate:
  - a. Must be valid and current at the time of committee and remain valid and current throughout the Practitioner's participation with IEHP registered with an address in the State of California.
  - b. Verification may be in the form of:
    - 1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision; or
  - c. Any Practitioner with a DEA with an "EXEMPT" Fee or status, the DEA is only valid at the exempting institution and any affiliate Hospital or Clinic rotations within the scope of training. The Delegate must confirm the Practitioner's practice and exempting institutions relationship and document their findings in the Provider file, if the address on the DEA does not match the Providers practice location. If a Practitioner is practicing outside of the exempting institution and/or its affiliates, the Practitioner must obtain a "Paid" status DEA.
  - d. Delegates may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, if the Delegate has a documented process for allowing a Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioners name, DEA number and NPI number will be documented in the Practitioners file.
  - e. If a Practitioner does not have a DEA or CDS certificate, the Delegate must have a documented process to require an explanation why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner's patients who need prescriptions requiring DEA certification.
    - 1) For credentialing files where verification of DEA or CDS is before June 1, 2020, and a practitioner who is DEA- or CDS- eligible does not have a DEA or CDS certificate, NCQA accepts either the verification process required in the 2020 standards or the applicable prior year's standards, which state "If a qualified

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<sup>1</sup> National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 3, Element A, Factor 1

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practitioner does not have a valid DEA or CDS certificate, the organization notes this in the credentialing file and arranges for another practitioner to fill prescriptions.”

- Practitioner’s statement. I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management, example provided by NCQA.
  - f. Failure to maintain an active DEA, may result in an administrative termination of the Practitioner.<sup>2</sup>
3. Education and training (VTL: Prior to the Credentialing Decision) All Practitioners must have completed appropriate education and training for practice in the U.S. or a residency program recognized by NCQA, in the designated specialty or subspecialty they request to be credentialed and contracted. The Delegate verifies the highest of the following three (3) levels of education and training obtained by the Practitioner, as appropriate. i.e., Board Certification, Residency or Graduation from medical or professional school. An expired board certification may be used for verification of education/training.

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

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

- a. The primary source from the Medical School.
- b. The state licensing agency or specialty board or registry if the state agency and specialty board, respectively, perform primary source verification. The Delegate:
  - 1) Obtains written confirmation of written primary source verification from the primary source, at least annually, or
  - 2) Provides a printed, dated screenshot of the state licensing agency’s or specialty board or registry website displaying the statement that it performs primary source verification of Practitioner education and training information, or
  - 3) Provides evidence of a state statute requiring the licensing agency, specialty or registry to obtain verification of education and training directly from the institution.

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<sup>2</sup> NCQA, 2022 HP Standards and Guidelines, CR 3, Element A, Factor 2

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- 4) National Student Clearinghouse may be considered an agent of the medical or professional school if the school has a contract with the Clearinghouse to provide verification services.
  - Delegates must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.
- c. Sealed transcripts if the Delegate provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program.
- d. Below are acceptable sources for physicians (M.D., D.O.) to verify graduation from Medical School:
  - 1) American Medical Association (AMA) Physician Master File.
  - 2) American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - 3) Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

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

- 1) Primary source from the institution where the postgraduate medical training was completed.
  - 2) AMA Physician Master File.
  - 3) AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - 4) Federation Credentials Verification Service (FCVS) for closed residency programs.
    - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.<sup>3</sup>
4. Board certification status, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date).
    - a. The Delegate verifies current certification status of Practitioners who state that they are board certified.

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<sup>3</sup> NCQA, 2022 HP Standards and Guidelines, CR 3, Element A, Factor 3

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- 1) The Delegate must document the expiration date of the board certification within the credential file.
  - If a Practitioner has a “lifetime” certification status and there is no expiration date for certification, the Delegate verifies that the board certification is current and documents the date of verification.
- 2) If board certification has expired it may be used as verification of education and training.
- 3) Verification must be performed through a letter directly from the board or an online query of the appropriate board as long as the board states that they verify education and training with primary sources, is an acceptable source by NCQA, and indicate that this information is correct. Below are the acceptable sources to verify board certification:
  - For all Practitioner types
    - The primary source (appropriate specialty board).
    - The state licensing agency if the primary source verifies board certification.
  - For Physicians (M.D., D.O.)
    - American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
      - The ABMS “Is your Doctor Board Certified,” accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
    - AMA Physician Master File.
    - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
    - Boards in the United States that are not members of the ABMS or AOA if the Delegate documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.
  - For other health care professionals
    - Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.

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- For Podiatrists (D.P.M.)
    - American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
    - The American Board of Podiatric Medicine.
    - American Board of Multiple Specialties in Podiatry.
  - For Nurse Practitioners (N.P.)
    - American Association of Nurse Practitioners (AANP).
    - American Nurses Credentialing Center (ANCC).
    - National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
    - Pediatric Nursing Certification Board (PNCB).
    - American Association of Critical-Care Nurses (AACN).
  - For Physician Assistants (P.A.-C.)
    - National Commission of Certification of P.A.'s (NCCPA).
  - For Certified Nurse Midwives (C.N.M.).
    - American Midwifery Certification Board (AMCB).
  - For Psychologists (Ph.D., Psy.D.).
    - American Board of Professional Psychology (ABPP).
5. Work history (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date) The Delegate must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.
- a. The Delegate must document review of work history on the application, CV, or checklist that includes the signature or initials of staff who reviewed work history and the date of review. Documentation of work history must meet the following:
- 1) Must include the beginning and ending month and year for each work experience.
  - 2) The month and year do not need to be provided if the Practitioner has had continuous employment at the same site for five (5) years or more. The year to year documentation at that site meets the intent.
  - 3) If the Practitioner completed education and went to straight into practice, this will be counted as continuous work history.



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- 4) If the Practitioner has practiced fewer than five (5) years from the date of credentialing. The work history starts at the time of initial licensure.
  - 5) The Delegate must review for any gaps in work history. If a work history gap of six (6) months to one (1) year is identified, the Delegate must obtain an explanation from the Practitioner. Verification may be obtained verbally or in writing or in writing for gaps of six (6) months to one (1) year.
  - 6) Any gap in work history that exceeds one (1) year must be clarified in writing from the Practitioner. The explanation of the gap needs to be sufficient to ascertain that the gap did not occur as a result of adverse and/or reportable situations, occurrences or activities.<sup>4</sup>
6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date)
    - a. The Delegate must obtain confirmation of the past seven (7) years of malpractice settlements through one of the following sources:
      - 1) Malpractice Insurance Carrier
      - 2) National Practitioner Data Bank Query
      - 3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.
    - b. A minimum the seven (7) years claim history must be reviewed for initial credentialing and all claim history activities after the previous credentialing decision date, will be reviewed for recredentialing.
    - c. The seven (7) year period may include residency and fellowship years. The Delegate is not required to obtain confirmation from the carrier for Practitioners who had a hospital insurance policy during a residency and fellowship.<sup>5</sup>
- B. Delegate verifies the following sanction information for credentialing:
1. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).
    - a. Verification sources for sanctions or limitations on licensure include:
      - 1) Chiropractors: State Board of Chiropractic Examiners, Chiropractic Information Network/Board Action Databank (CIN-BAD), or NPDB.

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<sup>4</sup> NCQA, 2022 HP Standards and Guidelines, CR 3, Element A, Factor 5

<sup>5</sup> NCQA, 2022 HP Standards and Guidelines, CR 3, Element A, Factor 6

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- 2) Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
  - 3) Physicians: Appropriate state board agencies, Federation of State Medical Boards (FSMB), NPDB.
  - 4) Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.
  - 5) Non-physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.
  - 6) For Delegate's using the Continuous Query (formerly Proactive Disclosure Service (PDS))
    - Evidence of current enrollment must be provided.
    - Report must be reviewed within one hundred eighty (180) calendar days of the initial credentialing decision.
    - Evidence of review must be documented in the file or on checklist.
2. Medicare and Medicaid sanctions. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).
- a. Verification Sources for Medicare/Medicaid Sanctions:
    - 1) State Medicaid Agency or intermediary and the Medicare intermediary.
    - 2) Medicare intermediary
    - 3) List of Excluded Individuals and Entities (maintained by OIG).
      - OIG must be one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS.
        - Date of query and staff initials must be evident on a checklist or the OIG page must be in the file.
    - 4) Medicare Exclusions Database.
    - 5) The Federal Employees Health Benefits (FEHB) Program Department Record, published by the Office of Personnel Management, OIG.
    - 6) AMA Physician Master File
    - 7) NPDB
      - For Delegate's using the Continuous Query (formerly Proactive Disclosure Service (PDS)). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the credentialing decision and show evidence

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the practitioner was enrolled in the alert services at the time of the cited report. Evidence must be documented in the file or on checklist.

8) FSMB

9) The Medi-Cal Suspended and Ineligible list must be one (1) of the verification source for Medicaid sanctions, to ensure compliance with Department of Health Care Services (DHCS).<sup>6</sup>

- Date of query and staff initials must be evidence on a checklist, or the report page must be in the file.

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

1. Reasons for inability to perform the essential functions of the position.<sup>7</sup>
2. Lack of present illegal drug use.
  - a. Delegate's application may use alternative language or general language that may not be exclusive to present use or only illegal stances.<sup>8</sup>
3. History of loss of license and felony convictions.
  - a. At initial credentialing, the Practitioner must attest to any loss of license or felony convictions since their initial licensure.
  - b. At recredentialing, the Practitioners may attest to any loss of licensure or felony convictions since their last credentialing cycle.<sup>9</sup>
4. History of loss or limitation of privileges or disciplinary actions.
  - a. At initial credentialing, the Practitioner must attest to any loss or limitation of privileges since their initial licensure.
  - b. At recredentialing, the Practitioners may attest to any loss or limitation of privileges since their last credentialing cycle.<sup>10</sup>
5. Current malpractice insurance coverage. IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) be obtained in conjunction of collecting information on the application.

(VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner's participation with IEHP).

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<sup>7</sup> NCQA, 2022 HP Standards and Guidelines, CR 3, Element C, Factor 1

<sup>8</sup> NCQA, 2022 HP Standards and Guidelines, CR 3, Element C, Factor 2

<sup>9</sup> NCQA, 2022 HP Standards and Guidelines, CR 3, Element C, Factor 3

<sup>10</sup> NCQA, 2022 HP Standards and Guidelines, CR 3, Element C, Factor 4

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- a. All Practitioners must have current and adequate malpractice insurance coverage that is current and:
  - 1) Meets IEHP’s standard of \$1 million/\$3 million, as well as the IPAs standards. Professional Liability Insurance coverage and amounts of coverage must be verified with the insurance carrier or through the Practitioner via a copy of the policy and the signed attestation completed by the Practitioner. The copy of the Practitioner’s certificate must be initialed, and date stamped to show receipt prior to the credentialing decision and to show it was effective at the time of the credentialing decision.
  - 2) Must include coverage for the specialty the Practitioner is being credentialed for and for all locations the Practitioner will be treating IEHP patients.
    - If the specialty coverage and/or the locations are not identified on the malpractice insurance certificate, the coverage must be verified with the insurance carrier and documented in the Practitioner’s file.
  - 3) For Practitioners with federal tort coverage, (e.g. Health Resources & Services Administration (HRSA)), the Practitioner must submit:
    - A copy of the face sheet or federal tort letter as an addendum to the application. The face sheet or federal tort letter must include the:
      - Insurance effective and expiration dates (future effective dates are acceptable)
    - A roster that lists all practitioner covered under the federal tort coverage.
  - 4) There must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee approval date.
    - Failure to maintain current malpractice coverage for the specialty the Provider is being credentialed for and for all locations the Practitioner will be treating IEHP patients, will result in an administrative termination of the Practitioner.<sup>11</sup>
6. Current and signed attestation confirm the correctness and completeness of the application. Attestation must be:
  - a. Signed and dated within the timeframe and must include all elements to be compliant.
    - 1) The one hundred-eighty (180) calendar-day time frame is based on the date the Practitioner signed the application.
      - If the signature or attestation exceeds one hundred-eighty (180) calendar-days the Practitioner must only attest that the information on the application

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<sup>11</sup> NCQA, 2022 HP Standards and Guidelines, CR 3, Element C, Factor 5

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- remains correct and complete, be re-signing and re-dating the attestation. Practitioner does not need to complete another application.
- b. Signed with a full signature, if the attestation needs to be re-signed by the Practitioner; dating and initialing is not acceptable.
    - 1) Faxed, digital, electronic, scanned or photocopies signatures are accepted. Signature stamps are not acceptable. (See Definitions, “Types of Signatures”)
  - c. If the attestation is not signed and/or dated, within the appropriate time frame, all application elements are non-compliant (except current malpractice coverage since IEHP requires a face sheet is obtained).
    - 1) If a question is answered incorrectly, Delegate is responsible for notifying the Practitioner to have them review the question.
      - If the Provider chooses to change their response, the Provider may initial and date next to the change.
      - If the Provider chooses not to change their response, the Delegate will document their attempt to have the Practitioner review their response and that the provide chose not to change their response.
    - d. When reviewing the Council for Affordable Quality Healthcare (CAQH) application, NCQA accepts the last attestation date generated by this system as the date when the practitioner signed and dated the application to attest to its completeness and correctness.
- D. Delegate verifies that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current Hospital affiliation or admitting privileges at a participating Hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be:
1. Confirmed with the Hospital, in writing, via approved website or verbally, and must include:
    - a. The date of appointment;
    - b. Scope of privileges, restrictions (if any i.e. restricted, unrestricted) and recommendations.
    - c. Confirmation Provider has admitting privileges in the specialty the Provider is credentialed and contracted for.
    - d. If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in “good standing.”

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- e. Practitioner must meet the requirements for Hospital Privileges as required by IEHP. (See Policy 5B, “Hospital Privileges”), i.e. if an admitter or hospitalist arrangement is used, a written agreement that meets IEHP admitter requirements, confirming coverage for all inpatient work covering the entire age range of the Practitioner must be included in the Practitioner’s credentialing file.
  - 1) These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider profile, admitter report or attachment.
  - 2) If the Provider utilizes an admitter or hospitalist arrangement, the Delegate must document these arrangements in the Provider file, to include when the Provider was notified. Documentation must include:
    - The date the Practitioner was notified
    - Name(s) of the admitter and/or hospitalist, admitting on behalf of the Provider
    - Name(s) of the Hospital, affiliated with the inpatient coverage arrangements
2. If the Practitioner does not have clinical privileges, the Delegate must have a written statement delineating the inpatient coverage arrangement. (See Policy 5B, “Hospital Privileges”). For Specialties that are required to have clinical privileges or admitting privileges at a Participating hospital, See Attachment, “Hospital Admitting Privileges Reference by Specialty”.
3. Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have Hospital privileges and documentation in the file is not required for these types of Practitioners. (See Attachment, “Hospital Admitting Privileges Reference by Specialty” in Section 5).
4. Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Nurse Midwives (NM)) may not have Hospital privileges. However, if they provide the Delegate their Hospital privileges, Delegate will be responsible for verifying if those privileges are active and ensure they are in good standing.
5. Specialists (MDs, DOs and DPMs) may not have Hospital privileges, documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).
  - a. These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider profile, admitter report or attachment.
    - 1) These arrangements are subject to IEHP review and approval.
    - 2) IEHP may request for inpatient coverage arrangements for the Practitioner, if IEHP identified that specialty as a specialty that requires Hospital admitting arrangements.

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6. Certified Nurse Midwives (CNMs) may provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services only after they are fully credentialed and approved by the IPA or IEHP directly. CNM Providers must meet the following criteria:
  - a. In lieu of having full hospital delivery privileges, provide a written agreement with an Obstetrician (OB) Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed.
    - The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the CNM Provider.
    - The OB Provider must be credentialed and contracted within the same practice and network.
7. Family Practice including outpatient Obstetrics (OB) services (FP-1) must provide a copy of a signed agreement that states:
  - a. Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk members with a contracted and credentialed OB.
    - 1) The OB must be contracted and credentialed by the same network as the Family Practice Provider and must hold admitting privileges to the IEHP Hospital linked with that IPA network.
8. Family Practice including full Obstetrics services and delivery (FP-2). Providers that fulfill these requirements may be referred to and see Obstetrician/Gynecologist (OB/GYN) Members within the same IPA as the referring Physician, and must have:
  - a. Full delivery privileges at an IEHP network Hospital; and
    - 1) Provide a written agreement for an available OB back up Provider is required. The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and
    - 2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).
9. Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Provider only, will provide outpatient well woman services only with no Hospital or surgical privileges, must provide the following information for consideration:
  - a. In lieu of obtaining or maintaining full Hospital delivery privileges, the Practitioners must provide a written agreement with OB that includes:
    - 1) A protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.).

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- 2) Must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery.
  - 3) The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.
    - The OB Provider must be credentialed and contracted within the same network.
  10. Licensed Midwife (LM) practitioners are required to have a backup Licensed Physician, engaged in active clinical obstetrical practice and with whom the Licensed Midwife consults when there are significant deviations from the normal, in either mother or infant. Therefore, LMs must complete a Licensed Midwife Attestation: Plan for Consultation, Emergency Transfer, & Transport (See Attachment, "Licensed Midwife Attestation", in Section 5) required for all Licensed Midwife Practitioners.
    - a. IEHP requires the backup Licensed Physician is an active Obstetrics/Gynecology Practitioner within the IEHP network.
  11. Urgent Care Providers are not required to maintain Hospital privileges if they are exclusively practicing at an Urgent Care.<sup>12,13,14</sup>
- E. Delegate monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out. Delegate is responsible for:
1. Reviewing and obtaining the information via hard copies or electronic from <https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z>.
    - a. Certain healthcare Provider categories cannot opt-out of Medicare. These include Chiropractors, physical therapists and occupational therapists in independent practice.<sup>15</sup>
  2. If Delegate employs their Practitioners, the initial credentialing and recredentialing review of employed Practitioners must include a review of the Medicare Opt-Out Report in all files credentialed.
  3. The following are acceptable ways to verify review of the Opt-Out report:
    - a. Checklist/Verification: Must have the following to be compliant:
      - 1) Staff initials/signature;
      - 2) Run date from CMS.gov Opt-Out Reports; and

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<sup>12</sup> Medicare Managed Care Manual, Relationships with Providers", Section 60.3

<sup>13</sup> Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, "Provider Credentialing/Rec credentialing and Screening/Enrollment

<sup>14</sup> California Code of Regulations (CCR) § 1300.51(d)(H)(iii)

<sup>15</sup> Medicare Managed Care Manual, Relationships with Providers", Section 60.2



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- 3) Indicate whether or not the practitioner is listed on the report.
- b. Pages of the CMS.gov listing report showing where the providers name would have been listed in alpha order. Must have the following to be compliant:
  - 1) Staff initials/signature;
  - 2) Run date from CMS.gov Opt-Out Reports; and
  - 3) Indicate whether or not the Practitioner is listed on the report.
- F. Delegate includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process. (Verification Time Limit: Last recredentialing cycle to present).
  1. Quality activities include, but are not limited to:
    - a. Adverse events
    - b. Medical record review
    - c. Data from Quality Improvement Activities
    - d. Performance Information, may include but is not limited to:
      - 1) Utilization Management Data
      - 2) Enrollee satisfaction surveys
      - 3) Other activities of the Delegate
    - e. Not all quality activities need to be present
  2. Grievance/complaints<sup>16,17</sup>
- G. Delegate ensures all Practitioners hold and maintain a valid and active National Provider Identifier (NPI) Practitioners individual NPI number, and the information provided must be:
  1. Verified through the NPPES website;
  2. Active while in the IEHP network;
  3. Current at all times (i.e. Primary Practice Address must be registered to an address within California).
    - a. Telehealth Providers are not required to have an NPI registered to an address within California.

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<sup>16</sup> Medicare Managed Care Manual, Relationships with Providers”, Section 60.3

<sup>17</sup> DHCS APL 19-004

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 3. Credentialing Verifications

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4. Practitioners that have a group NPI number may submit that information to IEHP, in addition to the mandatory individual NPI number.<sup>18</sup>
- H. Delegate ensures all Primary Care Provider's (PCP) and Urgent Care's (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring"). All PCPs and UCs must pass an IEHP facility on-site review at the time of initials credentialing and every three (3) years thereafter, for Medi-Cal Programs.<sup>19</sup>
  1. Delegates are not delegated to perform on-site visits on behalf of IEHP; however, their policies and procedures must ensure they notify their Practitioners of IEHP's requirements and they remain compliant while they continue participation in IEHP's network. This would apply to, but not limited to:
    - a. Prior to participating in the IEHP network as a PCP or an Urgent Care provider; or
    - b. When a Practitioner relocates.
- I. Delegates must obtain and provide IEHP with Social Security Numbers for all new and existing Practitioners participating providers, to ensure all Practitioners are included in IEHP's screening of the Social Security Administration's Death Master File (SSADMF).
  1. All Delegated IPA Provider submissions for participation in the IEHP network, the Delegate must include the Provider's full Social Security Number (SSN).
    - a. Submissions without SSN will be ceased and not processed by IEHP.
  2. Delegated IPAs with existing Providers without SSNs will be notified. The Delegated IPAs are required to provide all missing SSNs to IEHP.
    - a. Delegated IPAs who do not provide the requested information will be placed on a Corrective Action Plan (CAP), until all missing SSNs are submitted.
  3. If a Practitioner confirms that his/her SSN is correctly stated on the Social Security Administration's Death Master File (SSADMF), but is clearly not deceased, the Delegate must request for:
    - a. A copy of the Social Security Card;
    - b. A photo ID;
    - c. A signed attestation from the Practitioner confirming they are who they say they are; and
    - d. The Provider to contact the Social Security Administration's Death Master File (SSADMF) to correct the issue.

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<sup>18</sup> DHCS APL 19-004

<sup>19</sup> Medicare Managed Care Manual, Relationships with Providers", Section 60.3

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 3. Credentialing Verifications

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4. If a Practitioners' SSN is correctly stated but the name and Date of Birth (DOB) does not, the Delegate must request for:
  - a. A copy of the Social Security Card;
  - b. A photo ID;
  - c. A signed attestation from the Practitioner confirming they are who they say they are; and
  - d. The Provider to contact the Social Security Administration's Death Master File (SSADMF) to correct the issue.<sup>20</sup>
- J. Delegates monitors its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List (See Policy 25B5, "Ongoing Monitoring and Interventions").
- K. Delegates must ensure all Practitioners are within the appropriate age range guidelines, as appropriate. IEHP DualChoice Member age ranges are ages 21 and above.
  1. Specialists Member age ranges are specific to the specialty involved, training, and education of the Physician.
  2. Non-Physician Practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Opticians, Optometrists (OD), Chiropractors (DC), Dieticians and Nutritionists are as applicable to the training and certification of the non-physician Practitioner.
- L. Delegates must submit appropriate documentation to expand or limit their practice parameters for IEHP review and approval. Practitioners may practice outside of scope with approval from IEHP, by undergoing the Provide Privilege Adjustment process in this policy.
  1. Primary Care Providers age range expansions.
    - a. For PCP's who have Pediatric age ranges assigned and would like to expand their age range to reflect all ages, will be processed with a secondary specialty of General Practice, must provide the following information for review and consideration:
      - 1) Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, "IEHP Addendum E" in Section 5);
      - 2) Provide evidence of twenty-five (25) Continuing Medical Education (CME) units in Adult Primary Care completed within the last three (3) years;
      - 3) Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e., Primary Care Providers with work experience associated with the

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<sup>20</sup> DHCS APL 19-004

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 3. Credentialing Verifications

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applicant in the preceding twenty-four (24) months). The Physician coworkers must hold an active board certification in Internal Medicine or Family Practice;

- 4) Malpractice coverage for the age range provider is requesting for that covers all locations the Provider will be treating IEHP Members; and
- 5) Pass a Medical Record Chart Audit for Adult Members

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<b>Chief Approval:</b> <i>Signature on File</i>	<b>Original Effective Date:</b>	January 1, 2020
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 4. Recredentialing Cycle Length

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#### **APPLIES TO:**

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

#### **POLICY:**

- A. Delegates are responsible for formally recredentialing their contracted Practitioners (i.e., Primary Care Providers (PCPs), Non-Physician Practitioners, Specialists, and Admitting Physicians) at least every thirty-six (36) months from their last credentialing decision date and submit specific updates to IEHP. (See Policy 25B10 “Credentialing Standards – Credentialing Quality Oversight of Delegates”)<sup>1,2</sup>

#### **PURPOSE:**

- A. To describe the guidelines for Delegates recredentialing and ensures recredentialing is conducted in a timely manner.<sup>3</sup>

#### **DEFINITION:**

- A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.
1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.
    - a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
    - b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

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<sup>1</sup> National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 4, Element A

<sup>2</sup> Title 42 Code of Federal Regulations (CFR) § 422.204(b)(2)(ii)

<sup>3</sup> Medicare Managed Care Manual, “Relationships with Providers”, Section 60.3

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 4. Recredentialing Cycle Length

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##### **PROCEDURES:<sup>4</sup>**

- A. The length of the recredentialing cycle is within the required thirty-six (36) month time frame and is a must-pass element for NCQA. Files that fail to meet the thirty-six (36) month time frame will be scored non-compliant “0”, which will result in a Corrective Action Plan from the Delegate. All recredentialing files must contain the Credentialing Committee decision date.
1. The thirty-six (36) month recredentialing cycle begins on the date of the previous credentialing decision. The thirty-six (36) month cycle is counted to the month, not to the day.
    - a. If a recredentialing file selected during the Credentialing Delegation Oversight audit, has not gone through the recredentialing cycle or Committee and it is not compliant for recredentialing, it will not be included in the file review.
      - 1) The entire Delegate roster will be reviewed for recredentialing timeliness, not just those processed within the last twelve (12) months.
        - IEHP will document in comments the total number of Practitioners that appear on the spreadsheet that have not been recredentialled within the last thirty-six (36) months, which will result in a Corrective Action Plan from the Delegate.
      - b. If Delegate determines that there was a system wide problem with its initial credentialing process, and as a result implemented corrective action through early recredentialing may present evidence of such actions to the health plan during the audit.
        - 1) If a file was recredentialing early to correct a deficiency, the file will be scored non-compliant for cycle length, with comments.
      - c. A recredentialing file that was placed into the initial credentialing file pull due to being out of timeframe will not be included in the initial credentialing files. The file will be included in the universe of recredentialing files.
      - d. A recredentialing file that is past due cannot be terminated and then reinstated before or within thirty (30) calendar days and processed as an initial file.
        - 1) The past due file must be recredentialled as soon as possible instead of being terminated.

B. Delegates may extend a Practitioner’s recredentialing cycle time frame (beyond thirty-six (36) months) if the Practitioner is on active military leave, maternity/medical leave or a sabbatical. Upon the Practitioners return, Delegates must:

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<sup>4</sup> NCQA, 2022 HP Standards and Guidelines, CR 4, Element A

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 4. Recredentialing Cycle Length

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1. Verify that the Practitioner has a valid license to practice before the Practitioner resumes seeing patients.
  2. Within sixty (60) calendar days of when the Practitioner resumes practice, the Delegate must complete the recredentialing cycle. Delegates must document this and recredentials the Practitioner within sixty (60) calendar days of the Practitioners return to practice.
    - a. If there is a termination of thirty (30) calendar days, the Delegate can initially credential the Practitioner before rejoining the Delegates network.
- C. Delegates failure to recredential within thirty-six (36) months. The Delegate will be scored down if it missed the thirty-six (36) month timeframe for recredentialing a Practitioner but did not terminate the Practitioner.
1. If the Delegate does not have the necessary information for recredentialing, the Delegate must:
    - a. Inform the Practitioner that this information is needed at least thirty (30) calendar days before the recredentialing deadline and that without this information, the Practitioner will be administratively terminated.
      - 1) The Delegate must include this notification in the Practitioner’s credentialing file.
      - 2) If the practitioner is subsequently terminated for lack of information, the termination notice must be in the Practitioner’s file.
  2. Delegates may recredential the Practitioner within thirty (30) calendar days of missing the deadline.
    - a. If recredentialing is not completed within thirty (30) calendar days, Delegates must initial credential the Practitioner.
  3. If the Delegates terminates a Practitioner for administrative reasons (e.g. the Practitioner failed to provide complete credentialing information) and not for quality reasons, it may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial credentialing.
    - a. Delegates must perform initial credentialing if reinstatement is more than thirty (30) calendar days after termination.

<b>INLAND EMPIRE HEALTH PLAN</b>		
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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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##### **APPLIES TO:**

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

##### **POLICY:**

- A. Delegate must develop and implement policies and procedures for ongoing monitoring of Practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against Practitioners when it identifies occurrences of poor quality.<sup>1</sup>
- B. Delegate maintains a documented process for monitoring whether network Providers have opted out of participating in the Medicare Program, may not participate in Medicare lines of business.<sup>2,3</sup>
- C. Delegate will verify that their contracted Providers have not been terminated as Medi-Cal Providers or have not been placed on the Suspended and Ineligible Provider List.<sup>4</sup>
- D. Delegated maintains a documented process for monitoring whether its Practitioners are included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List, to ensure compliance with the Medicare Program Final Rule.<sup>5</sup>
- E. IEHP maintains a documented process for monitoring Practitioners identified on the Restricted Provider Database, for Practitioners directly credentialed with IEHP and those credentialed through a Delegated Network.<sup>6</sup>
- F. IEHP maintains a documented process that includes the System for Award Management (SAM) in their list of database checks, for Practitioners directly credentialed with IEHP and those credentialed through a Delegated Network.<sup>7</sup>
- G. Delegates that subscribe to a sanctions alert service must have a documented process and evidence for the screening and notification process.
- H. Delegate is responsible for notifying IEHP of any findings and the actions decided by the Credentialing Committee regarding the Practitioners identified through the ongoing

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<sup>1</sup> National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 5, Element A, Factors 1-5

<sup>2</sup> Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks," § 60.2

<sup>3</sup> Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019 "Provider Credentialing/Recredentialing and Screening/Enrollment"

<sup>4</sup> Ibid.

<sup>5</sup> Centers for Medicare & Medicaid Services (CMS), Policy CMS-4182 Final Rule

<sup>6</sup> DHCS APL 19-004

<sup>7</sup> Ibid.



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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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monitoring of sanctions, complaints, and quality issues between recredentialing cycles.

- I. Delegate must have a process to verify and maintain Practitioner licensing status, DEA or CDS certificate, etc., and remedies if the license or certification expires or status changes during the Practitioner's participation with IEHP regardless of its outside the recredentialing cycle.
- J. Delegates must report Social Security Numbers for all new and existing Practitioners to IEHP, to ensure all Practitioners are included in IEHP's screening of the Social Security Administration's Death Master File (SSADMF).<sup>8</sup>

#### **PURPOSE:**

- A. Delegate identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.<sup>9</sup>

#### **DEFINITIONS:**

- A. Adverse event – An injury that occurs while a Member is receiving healthcare service from a Practitioner.<sup>10</sup>
- B. Death Master File (DMF) contains information about persons who had Social Security Numbers and whose deaths were reported to the Social Security Administration from 1962 to the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.
- C. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.
  1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, Management Service Organization (MSO) etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight.
    - a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
    - b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

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<sup>8</sup> DHCS APL 19-004

<sup>9</sup> NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 1-5

<sup>10</sup> NCQA, 2022 HP Standards and Guidelines, Glossary

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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- D. NPDB Continuous Query generates individual alerts from NCQA-recognized sources reporting an action.
- E. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g., evaluation of a physician's credentials and practice by another physician).<sup>11</sup>
- F. Quality of care: The degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.<sup>12</sup>

#### **PROCEDURES:**

- A. Delegates include in their policy and procedures and provide evidence of ongoing monitoring and makes appropriate interventions by:
  - 1. Delegate collects and reviews information from the following sources for Medicare and Medicaid sanctions. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance.
    - a. Delegates must use the List of Excluded Individuals and Entities (maintained by OIG) as the verification source for Medicare Sanctions, and review the report on a monthly basis, within thirty (30) calendar days of its release.<sup>13,14</sup>
      - 1) Delegate may develop a tracking log to include the report run date, review date, initials of person reviewing report, the list reviewed, and the web link used; or
      - 2) Delegate can print the entire list. The report must be dated and initialed
        - Practitioners identified on the Health & Human Services (HHS)-Office of Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.
          - Members will be reassigned to new Practitioners.
          - The Provider will be presented to Peer Review Subcommittee as an administrative termination, for further review and discussion. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings to include any additional prior quality of care issues and Member complaints for the Provider.

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<sup>11</sup> Ibid.

<sup>12</sup> NCQA, 2022 HP Standards and Guidelines, Glossary.

<sup>13</sup> NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 5

<sup>14</sup> NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 1-2

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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2. Delegate collects and reviews information from any of the following sources for reviewing sanctions or limitations on licensure. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance.<sup>15</sup>
  - a. Physicians. Sanction and limitation on licensure verifications must be verified through:
    - 1) BreEZe Online services online or directly with the licensing board via phone or mail:
      - Medical Board of California (M.D.)
      - Osteopathic Medical Board of California (D.O.)
    - 2) Federation of State Medical Boards (FSMB)
    - 3) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:
      - Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
      - Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
        - Documentation can be kept electronically or via an electronic or paper/log checklist.
  - b. Chiropractors. Sanction and limitation on licensure verifications must be verified through:
    - 1) BreEZe Online services online or directly with the licensing board via phone or mail:
      - California Board of Chiropractic Examiners (D.C.)
    - 2) Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD)
    - 3) National Practitioner Data Bank (NPDB) . For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a

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<sup>15</sup> NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 2

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:

- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
  - Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
    - Documentation can be kept electronically or via an electronic or paper/log checklist.
- c. Oral Surgeons. Sanction and limitation on licensure verifications must be verified through:
- 1) BreEZe Online services online or directly with the licensing board via phone or mail:
    - Dental Board of California (D.D.S., D.M.D.)
  - 2) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:
    - Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
    - Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
      - Documentation can be kept electronically or via an electronic or paper/log checklist.
- d. Podiatrists. Sanction and limitation on licensure verifications must be verified through:
- 1) BreEZe Online services online or directly with the licensing board via phone or mail:
    - Board of Podiatric Medicine (D.P.M.)
  - 2) Federation of Podiatric Medical Board (FPMB)
  - 3) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
  - Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
    - Documentation can be kept electronically or via an electronic or paper/log checklist.
- e. Nonphysician healthcare Practitioners. Sanction and limitation on licensure verifications must be verified through:
- 1) BreEZe Online services online or directly with the licensing board via phone or mail:
    - Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
    - Board of Psychology (Ph.D., Psy.D.)
    - California Board of Occupational Therapy (O.T.)
    - California State Board of Optometry (O.D.)
    - Physical Therapy Board of California (P.T.)
    - Physician Assistant Committee (P.A., P.A.-C)
    - California Board of Registered Nursing (C.N.M., N.P.)
    - Speech-Language Pathology & Audiology Board (S.P., Au)
    - Acupuncture Board (L.Ac.)<sup>16</sup>
  - 2) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:
    - Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
    - Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
      - Documentation can be kept electronically or via an electronic or paper/log checklist.

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<sup>16</sup> NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 2

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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3. Policies for collecting and reviewing complaints must state Delegate:<sup>17</sup>
  - a. Investigates Practitioner-specific Member complaints upon their receipt and evaluates the Practitioner's history of complaints, if applicable.
  - b. Evaluates the history of complaints for all Practitioner's history of complaints at least every six (6) months.
  - c. Quality or collecting and reviewing complaints are not delegated and complaints are forwarded to the Health Plans, as applicable.
  - d. Policy and evidence may be found in the Quality Department.
4. Policies for collecting and reviewing information from identified adverse events Delegate must state:<sup>18</sup>
  - a. Monitoring for adverse events occurs every six (6) months.
  - b. Quality/collecting and reviewing adverse events are not delegated and events are forwarded to the Health Plans, as applicable.
  - c. Policy and evidence may be found in the Quality Department.
5. Policies for implementing appropriate interventions when it identifies instances of poor quality related for factors 1-4 may be found in the Quality Department. Delegate must have a process to determine if there is evidence of poor quality that could affect the health and safety of its Members and implement the appropriate policy based on action/intervention.<sup>19</sup>
  - a. At minimum, Providers identified through ongoing monitoring for licensure actions, sanctions, adverse history, grievances and/or complaints, must be fully discussed and reviewed by the Credentialing Committee. The reason for review must be considered and documented in the meeting minutes.
    - 1) Interventions can be identified in one of the following:
      - Committee minutes
      - Practitioner files
      - Delegate file binders
  - b. If IEHP believes that a Member's health or safety may be at risk due to adverse events or quality concerns, IEHP may take one of the following actions:
    - 1) Refer the Practitioner to the next IEHP Peer Review Subcommittee meeting for

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<sup>17</sup> NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 3

<sup>18</sup> NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 4.

<sup>19</sup> NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 5

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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direction;

- 2) Immediately suspend the Practitioner from participation with IEHP with referral to the next IEHP Peer Review Subcommittee meeting; or
  - 3) Any other action as appropriate, given the circumstances and severity of the situation.
- B. Delegates maintains a documented process for monitoring whether network physicians have opted out of participating in the Medicare Program using one of the CMS.gov Opt-Out sites.
1. Delegate must review the Opt-Out Report from one of the CMS.gov sites on a quarterly basis, within thirty (30) days of its release.
    - a. The report must be dated and initialed
    - b. A checklist may be used to document the date of the electronic file download. The checklist must contain:
      - 1) The date of the download and signature of the Delegate personnel who verified it.
      - 2) Delegates must review quarterly Opt-Out reports even if they employ their Practitioners.
- C. Delegates must use the Medi-Cal Suspended & Ineligible List, published monthly by the Department of Health Care Services (DHCS), as the verification source for Medicaid Sanctions. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance. Delegate must review the Suspended & Ineligible List on a monthly basis, within thirty (30) days of its release.
1. Delegate may develop a tracking log to include the report run date, review date, initials of person reviewing report, the list reviewed, and the web link used;
  2. Delegate may print the parts of the list that are applicable; or
  3. Delegate can print the entire list
    - a. The report must be dated and initialed
      - 1) All Members assigned to suspended Practitioners will be reassigned to new Practitioners.
      - 2) The Suspended Practitioner will be presented to the Peer Review Subcommittee as an administrative termination and for further review, discussion.
        - Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings to include any additional prior

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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quality of care issues and Member complaints for the Provider.<sup>20</sup>

- D. Delegated maintains a documented process for monitoring whether its Practitioners are included in the CMS Preclusions List, to ensure compliance with the Medicare Program Final Rule. In order for Providers (including entities) to receive payment from Medicare Plan (Part C and D), they must not be included in the CMS Preclusions List. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance.<sup>21</sup>
1. On a monthly basis, IEHP will share updates of the Preclusions List on the Secure File Transfer Portal (SFTP), as it will be made available by CMS approximately every thirty (30) days, around the first (1<sup>st</sup>) business day of each month.
    - a. Delegates are required to screen their Provider network against the Preclusions List monthly, within thirty (30) days of its release.
    - b. Notify IEHP within two (2) business days if an exact match is found for:
      - 1) National Practitioner Identification (NPI)
      - 2) Employer Identification Number (EIN), specific to entities
- E. IEHP maintains a documented process for monitoring practitioners identified on the Restricted Provider Database (RPD).<sup>22</sup> IEHPs Credentialing Analyst will obtain the Restricted Provider Database report monthly, by the 5<sup>th</sup> of each month, for practitioners directly credentialed with IEHP and those credentialed through a Delegated Network.
1. Providers identified on the RPD will be presented to Peer Review Subcommittee for review and discussion. The following actions will be required to ensure compliance with DHCS guidelines:
    - a. Payment Suspension: Providers are placed under a payment suspension while under investigation based upon a credible allegation of fraud.
      - 1) IEHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services will be withheld; or
        - If IEHP chooses to continue the contractual relationship with providers who are placed on payment suspensions, IEHP must allow out-of-network access to members currently assigned to the provider by approving the request.
      - 2) IEHP may choose to terminate the contract by submitting appropriate documentation.<sup>23</sup>

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<sup>20</sup> Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019 “Provider Credentialing/Rec credentialing and Screening/Enrollment”

<sup>21</sup> Centers for Medicare & Medicaid Services (CMS), Policy CMS-4182 Final Rule

<sup>22</sup> DHCS APL 19-004

<sup>23</sup> DHCS APL 21-003 Supersedes APL 16-001 “Medi-Cal Network Provider and Subcontractor Terminations”



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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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- b. Temporary Suspension: Providers placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.
  - 1) IEHP must terminate the contract and submit appropriate documentation.<sup>24</sup>
- F. IEHP maintains a documented process that includes the System for Award Management (SAM) in their list of database checks. IEHP uses OIG Compliance Now as the vendor to collect data and alert services, to include but is not limited to the System for Award Management (SAM) in their scope of review.
  1. The OIG LEIE includes all healthcare providers and suppliers that are excluded from participation in federal health care programs, including those health care providers and suppliers that might also be on the SAM (previously EPLS). In addition to health care providers (that are also included on the OIG LEIE) the EPLS includes non-health care contracts<sup>25</sup>, which are out of scope for the practitioners undergoing the Credentialing process.
- G. Delegates that subscribe to a sanctions alert service must have evidence of its subscription to the sanctions alert service during the look back period. Delegates using an outside company or sanctions alert service (i.e. OIG Compliance Now, Streamline Verify) for ongoing monitoring or data collection and alert services, must:
  1. Have evidence of its subscription to the sanctions alert service during the look back period.
  2. Provide a documented process and evidence that includes, but is not limited to:
    - a. How the list of Providers is compiled and provided to the company for screening
    - b. List of sanctions screened by outside company, (can be found in an attachment or contract with entity)
    - c. How the Outside company notifies Delegate of their findings
    - d. Screening is reviewed within thirty (30) calendar days of their release
    - e. If no reports were received for ongoing monitoring, Delegate must document or note that no reports were received during the monthly look-back period.
    - f. Documentation can be kept electronically or via electronic or paper log/checklist.
      - 1) A spreadsheet/tracking log may be used as documentation for compliance. Delegate must include:
        - Name of board/entity
        - Date of query

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<sup>24</sup> Ibid.

<sup>25</sup> Medicare Managed Care Manual, Chapter 21 “OIG/GSA Exclusion”, Section 50.6.8

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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- Date of report
  - Signature(s)/initials of Delegate personnel who reviewed it.
- 2) If the reporting entity does not publish sanction information on a set schedule, the delegates:
    - Documents that the reporting entity does not release information on a set schedule.
    - Queries for this information for at least six (6) months.
  - 3) If the reporting entity does not release sanction information reports, the delegate must conduct individual queries of credentialed Practitioners every twelve (12) to eighteen (18) months after the last credentialing cycle.
- d. Delegates that subscribe to a sanctions alert service reviews the information within thirty (30) calendar days of a new alert. The delegate must:
- 2) Show evidence of its subscription to the sanctions alert service during the look-back period and reviews the information within thirty (30) calendar days of a new release.
- H. IEHP notifies Delegates of any adverse actions it becomes aware of through sources other than the Delegate. In addition, IEHP shares with all Delegates the results of performing monitoring through quality improvement studies, Member complaints and Member satisfaction surveys, as applicable. IEHP reviews the history of each Delegate's credentialed and approved Practitioners. Delegate is responsible for notifying IEHP of:
1. Any findings and the actions decided by the Credentialing Committee within thirty (30) days of the decision, to include, but not limited to:
    - a. Date(s) of the Credentialing Committee the Practitioner was reviewed;
    - b. Date of the Credentialing Committee decision;
    - c. Delegate's Plan of action for the Practitioner;
    - d. Frequency of monitoring (if applicable); and
    - e. Any follow-ups scheduled
  - 1) All Practitioners identified through the ongoing monitoring will be presented to IEHP's Peer Review Subcommittee for review and decision.
    - IEHP reserves the right to approve, deny, terminate or otherwise limit Practitioner participation in the IEHP network for any reason including up to quality issues.
      - If a Provider is denied participation due to quality of care and an 805 was filed with the appropriate licensing agency and the National

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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Practitioner Data Bank (NPDB) than the Provider is not eligible to reapply.

- For administrative terminations or denials, he/she may reapply after one (1) year.
  - Practitioners can appeal adverse decisions by the IEHP Peer Review Subcommittee as delineated in IEHP’s Peer Review Process and Level I Review and Level II Appeal (See Attachments, “IEHP Peer Review Level I and Credentialing Appeal” and “IEHP Peer Review Process and Level II Appeal” in Section 5).
2. Any of the following occurs with one of their contracted Practitioners:
    - a. The surrendering, revocation or suspension of a license;
    - b. The surrendering, revocation or suspension of DEA registration;
    - c. A change in hospital staff status or hospital clinical privileges, including any restrictions or limitations;
    - d. A change in hospital admitting arrangements for Practitioners without IEHP affiliated hospital privileges;
    - e. Loss of malpractice insurance; and
    - f. The notification must include the IPA’s proposed action and/or resolution.
  3. Delegates are required to notify IEHP in writing within thirty (30) days of its knowledge, if any of the following occurs with one of their contracted Practitioners:
    - a. Any filing pursuant to Business and Professions Code Sections § 805, 805.01 or 809;
    - b. Any filing with the NPDB; and
    - c. The notification must include the Delegate’s proposed action and/or resolution.
- I. Delegate must have a process to verify and maintain Practitioner licensing status, DEA or CDS certificate, etc., and remedies if the license or certification expires or status changes during the Practitioner’s participation with IEHP.
1. Delegate is responsible for notifying IEHP of any licensure and DEA changes within thirty (30) days of the change. The notification must include:
    - a. Date the Delegate was notified;
    - b. Type of change;
    - c. Effective date of the change;
    - d. Date of Credentialing Committee review, (if applicable);

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

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- e. Delegate's Plan of Action for the Practitioner;
  - f. Frequency of monitoring (if applicable); and
  - g. Any follow-ups scheduled.
- J. Delegates must report Social Security Numbers (SSN) for all new and existing Practitioners to IEHP, to ensure all Practitioners are included in IEHP's screening of the SSADMF.
- 1. All Delegates must provide the Social Security Numbers for their respective practitioners under the following:
    - a. Provider Profile Submission
    - b. Credentialing Activities Report
    - c. Upon request by IEHP. Applicable to all existing practitioners with missing SSN.
      - 1) Delegates who do not provide the requested information will be placed on a Corrective Action Plan (CAP) until all missing SSNs are submitted.
  - 2. If a Practitioner is identified on the SSADMF, and the practitioner:
    - a. Confirms that his/her SSN is correctly stated on the SSADMF, but is not deceased, IEHP will request for the following information from the practitioner:
      - 1) A copy of the Social Security Card.
      - 2) A Photo ID.
      - 3) A signed attestation (See attachment, "Death Master File Identity Attestation" in Section 5) from the Practitioner confirming their identity; and
      - 4) Request for the practitioner to contact the SSADMF to correct the issue.
    - b. Confirms their SSN is correctly stated but the name and Date of Birth (DOB) does not, IEHP will request for the following:
      - 1) A copy of the Social Security Card.
      - 2) A Photo ID.
      - 3) A signed attestation (See attachment, "Death Master File Identity Attestation" in Section 5) from the Practitioner confirming their identity; and
      - 4) Request for the practitioner to contact the SSADMF to correct the issue.
  - 3. Upon receipt of the required documents, the Credentialing designee will provide the attestation and supporting documentation to our Compliance Department for review and repository.<sup>26</sup>

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<sup>26</sup> DHCS APL 19-004

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 5. Ongoing Monitoring and Interventions

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<b>INLAND EMPIRE HEALTH PLAN</b>		
<b>Chief Approval:</b> <i>Signature on File</i>	<b>Original Effective Date:</b>	January 1, 2020
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION OVERSIGHT

### B. Credentialing Standards

#### 6. Notification to Authorities and Practitioner Appeal Rights

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##### **APPLIES TO:**

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

##### **POLICY:**

- A. Delegates policies and procedures must state how the organization reviews participation of Practitioners whose conduct could adversely affect Members' health or welfare, specify the range of actions that may be taken to improve Practitioner performance before termination, how the Delegate reports its actions to the appropriate authorities including state licensing agencies, the National Practitioner Data Bank (NPDB), and Inland Empire Health Plan (IEHP)<sup>1</sup>.and inform Practitioners of the appeal process.<sup>2</sup>
- B. Delegates policies and procedures regarding suspension or termination of a participating Physician require the Delegate to ensure that the majority of the hearing panel members are peers of the affected Physician.

##### **PURPOSE:**

- A. Delegates must use objective evidence and patient-care considerations when deciding on a course of action for dealing with a Practitioner who does not meet its quality standards.<sup>3</sup>
- B. Notification applies to Physicians and nonphysicians for suspensions and terminations for quality reasons.<sup>4</sup>
- C. Delegates must provide evidence that it followed its appeal process if it altered the conditions of a Practitioner's participation based on quality of care or service reasons.<sup>5</sup>
- D. Practitioners must appeal directly to their contracted IPA for adverse credentialing decisions rendered by the Delegated IPA.
- E. Reporting to appropriate authorities is not applicable in the following circumstances:
  - 1. If there are no instances of suspension, termination, restriction or revocation to report for quality reasons.

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<sup>1</sup> National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 6, Element A, Factor 1

<sup>2</sup> National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 6, Element A, Factor 2

<sup>3</sup> NCQA, 2023 HP Standards and Guidelines, CR 6, Element A, Factor 1-2

<sup>4</sup> Title 42 Code of Federal Regulations (CFR) § 422.202

<sup>5</sup> Ibid.

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## 25. DELEGATION OVERSIGHT

### B. Credentialing Standards

#### 6. Notification to Authorities and Practitioner Appeal Rights

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2. For automatic administrative terminations based on the Practitioners not meeting specific contractual obligations for participation in the network.
- F. All credentialing records and proceeds are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.<sup>6</sup>

#### **DEFINITION:**<sup>7</sup>

- A. “Agency” means the relevant state licensing agency having regulatory jurisdiction over the licentiates.
1. The Medical Board of California is the agency for the following Practitioner types:
    - a. Physicians and Surgeons (MDs)
    - b. Doctors of Podiatric Medicine (DPMs)
    - c. Licensed Midwives (LMs)
    - d. Physician Assistants (PAs)
- B. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.
1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.
    - a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
- C. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.
- D. “Denial or termination of staff privileges, membership, or employment” includes failure or refusal to renew a contract or to renew, extend or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.
- E. “Licentiate” means a Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, or physician’s assistant. Licentiate also includes a person authorized

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<sup>6</sup> California Evidence Code § 1157

<sup>7</sup> Business and Professions Code § 805

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#### 6. Notification to Authorities and Practitioner Appeal Rights

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to practice medicine pursuant to California Code, Business and Professions Code Section 2113 or 2168.

- F. “Medical disciplinary cause or reason” means that aspect of a licentiate’s competence or professional conduct that is reasonably likely to be detrimental to the patient’s safety or to the delivery of patient care.
- G. “Peer” is an appropriately trained and licensed Physician in a practice similar to that of the affected Physician.
- H. “Staff privileges” means any arrangements under which a licentiate can to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

#### **PROCEDURES:**

##### A. Delegates has policies and procedures for:

- 1. The range of actions available to the Delegate, that:
  - a. Specify that the Delegate reviews participation of Practitioners whose conduct could adversely affect Members’ health or welfare.
  - b. Specify the range of actions available to the Delegate, that they may take to improve the Practitioner performance before termination<sup>8</sup>, to include, but not limited to:
    - 1) Profiling
    - 2) Corrective actions(s)
    - 3) Monitoring
    - 4) Medical Record Audit
  - c. Specify that the Delegate reports its actions to the appropriate authorities. Appropriate authorities include, but are not limited to:
    - 1) Appropriate Licensing Board<sup>9</sup>
      - Medical Board of California 805 and 805.01 reports or the appropriate licensing board must be filed fifteen (15) days after a recommendation or final determination. The following types of providers require 805 and

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<sup>8</sup> NCQA, 20223 HP Standards and Guidelines, CR 6, Element A, Factor 1

<sup>9</sup> Bus. and Prof. Code § 805



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## 25. DELEGATION OVERSIGHT

### B. Credentialing Standards

#### 6. Notification to Authorities and Practitioner Appeal Rights

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805.01 reporting:

- Medical Doctors (MD)
- Dentists (DDS)
- Osteopaths (DO)
- Podiatrists (DPM)
- Marriage Family Therapists (MFT)
- Licensed Clinical Social Workers (LCSW)
- Psychologists (PsyD, PhD)
- Physician Assistants
- Nurse Practitioners (NP) effective 01/01/2021 (AB 890)

#### 2) National Practitioner Data Bank (NPDB)

2. Making the appeal process known to Practitioners. The Delegates policies and procedures must give the Practitioners the right to appeal and must include the following steps within the appeal process:<sup>10</sup>
  - a. Provide written notification when a professional review action has been brought against a Practitioner, including reasons for the action.
  - b. Allow Practitioners to request a hearing/appeal and the timing for submitting the request.
  - c. Policy must state that the Delegate cannot have an attorney, if the Practitioner does not have attorney representation, to ensure compliance with CA Business & Professions Code 809.3(c).<sup>11</sup>
3. Practitioner appeal process where the Delegate informs the affected Practitioner of its appeal process and includes the following information in process and notification.<sup>12</sup>
  - a. Providing written notification indicating that:
    - 1) A professional review action has been brought against the Practitioner;
    - 2) Reasons for the action; and
    - 3) A summary of the appeal rights and process, which can be made known to the Practitioner through an attachment, addendum, policy, contract or manual.

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<sup>10</sup> NCQA, 2023 HP Standards and Guidelines, CR 6, Element A, Factor 2

<sup>11</sup> California Code, Business and Professions Code (BPC) § 809.3(c)

<sup>12</sup> NCQA, 2023 HP Standards and Guidelines, CR 6, Element A, Factor 2

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## 25. DELEGATION OVERSIGHT

### B. Credentialing Standards

#### 6. Notification to Authorities and Practitioner Appeal Rights

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- b. Allowing the Practitioner to request a hearing and the specific time period for submitting the request.
  - c. Allowing at least thirty (30) days after the notification for the Practitioner to request a hearing.
  - d. Allowing the Practitioner to be represented by an attorney or another person of the Practitioner's choice.
  - e. Appointing a hearing officer or a panel of individuals to review the appeal.
  - f. Providing written notification of the appeal decision that contains specific reasons for the decision.
4. Delegates must have policies and procedures that describe when and how reporting occurs, to whom incidents are reported and what specific incidents are reportable. The policy must address what is expected of the Delegates staff and outline accountability so that staff understand their responsibilities in order to perform their functions correctly. When the Delegate decides to suspend or terminate a Practitioner's contract, there must be procedures notifying the appropriate authorities (including state agencies, as appropriate) of the action, that includes, but is not limited to:
- a. 805 Reports.<sup>13</sup>
    - 1) Delegate is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason.
      - If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a Physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.
      - If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of podiatric medicine, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension
    - 2) If an 805 is reported, it shall include the following information:
      - The name of the licentiate involved;
      - The license number of the licentiate involved;
      - A description of the facts and circumstances of the medical disciplinary cause or reason; and

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<sup>13</sup> Bus. and Prof. Code § 805

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## 25. DELEGATION OVERSIGHT

### B. Credentialing Standards

#### 6. Notification to Authorities and Practitioner Appeal Rights

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- Any other relevant information deemed appropriate by the reporter.
- 3) Delegates must file an 805 report with the relevant agency within fifteen (15) days after the effective date on which any of the following occur as a result of an action of a peer review body:
- A licentiate's application for staff privileges or membership is denied or rejected for medical disciplinary cause or reason.
  - A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
  - Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reason.
- 4) If a licentiate takes any action listed above, after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the chief of a staff or a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within fifteen (15) days after the licentiate takes the action.<sup>14</sup>
- Resigns or takes a leave of absence from membership, staff privileges or employment.
  - Withdraws or abandons his or her application for staff privileges or membership.
  - Withdraws or abandons his or her request for renewal of staff privileges or membership.
- b. 805.01 Reports<sup>15</sup>
- 1) Delegate must file an 805.01 within fifteen (15) days after a peer review body makes a final decision or recommendation of termination, suspension or restriction of staff privileges, membership or employment due to an

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<sup>14</sup> Bus. & Prof. Code § 805

<sup>15</sup> California Code, Business and Professions Code (BPC) § 805.01

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## 25. DELEGATION OVERSIGHT

### B. Credentialing Standards

#### 6. Notification to Authorities and Practitioner Appeal Rights

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investigation, for at least one (1) of the following reasons:

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

c. National Practitioner Data Bank (NPDB)

- 1) Reports must be submitted to the NPDB within thirty (30) days of the action.<sup>16</sup>

d. Health Plan Reporting

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

B. Delegates policies and procedures regarding suspension or termination of a participating physician require the Delegate to ensure that the majority of the hearing panel members are peers of the affected Physician.<sup>17</sup>

1. A Peer is an appropriately trained and licensed Physician in a practice similar to that of the affected Physician.
2. Panel members do not have to possess identical specialty training.
3. Policies and procedures do not always have to state the word “majority”, but at least 51% of the members must be peers.

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<sup>16</sup> 45 CFR § 60

<sup>17</sup> Medicare Managed Care Manual, Chapter 6, “Suspension, Termination, or Nonrenewal for Physician Contract,” Section 60.4

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## 25. DELEGATION OVERSIGHT

### B. Credentialing Standards

#### 6. Notification to Authorities and Practitioner Appeal Rights

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<b>INLAND EMPIRE HEALTH PLAN</b>		
<b>Chief Approval:</b> <i>Signature on File</i>	<b>Original Effective Date:</b>	January 1, 2020
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 7. Assessment of Organizational Providers

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##### **APPLIES TO:**

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

##### **POLICY:**

- A. Delegate has written policies and procedures for the initial and ongoing assessment of Providers who contract with the Delegate to provide medical services to Members as designated in the IEHP Division of Financial Responsibility (DOFR) Matrix. Delegates must assess all health care delivery providers before contracting with a provider, and for at least every thirty-six (36) months thereafter. Delegates must confirm the provider is in good standing with state and federal regulatory bodies; confirms the provider has been reviewed and approved by an accrediting body; and conducts an onsite quality assessment if the provider is not accredited.<sup>1</sup>
- B. IEHP delegates to IPAs that meet IEHP delegation requirements for credentialing, the responsibility for the initial and on-going assessment of subcontracted Providers that render services to Members and the delegate is responsible for claims payment for those Health Care Delivery Organization Providers. IEHP retains oversight responsibilities for all subcontracted Providers. The Provider types included in the medical assessment include, but are not limited to: Hospitals,<sup>2</sup> Home Health Agencies,<sup>3</sup> Skilled Nursing Facilities,<sup>4</sup> Free-Standing Surgical Centers,<sup>5</sup> Clinical Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Providers of End-stage Renal Disease Services, Hospice, Outpatient Diabetics Self-Management Training Providers, Portable X-ray Supplier, Outpatient Physical Therapy Providers, Speech Pathology Providers, Rural Health Clinics and Federally Qualified Health Centers.
- C. Delegates are not responsible for the claim's payment for behavioral healthcare facilities, therefore are not required to include them in their scope. IEHP includes behavioral healthcare facilities, providing mental health or substance abuse services in an inpatient setting in their scope of providers. Residential Treatment Facilities and Ambulatory Behavioral Health Facilities are not covered by this policy as these are not a covered IEHP benefit.<sup>6</sup>

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<sup>1</sup> National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 7, Element A, Factors 1-3

<sup>2</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 1

<sup>3</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 2

<sup>4</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 3

<sup>5</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 4

<sup>6</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element C, Factors 1-3

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 7. Assessment of Organizational Providers

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##### **PURPOSE:**

- A. Delegate evaluates the quality of organizational Providers with which it contracts.
- B. IEHP directly contracts with IPAs and Hospitals (Providers). In turn, Providers subcontract with Health Care Delivery Organizational Providers (subcontracted Providers) to provide services to Members as designated in the Division of Financial Responsibility (DOFR) Matrix outlined in IEHP's Capitated Agreements with the Hospitals and IPAs.
- C. All Providers must adhere to all procedural and reporting requirements under state and federal laws and comply with the most recent NCQA, state and regulatory guidelines for subcontracted organizational Providers, as well as IEHP requirements.
- D. Delegated Providers that subcontract with Ancillary and organizational Providers are responsible for ensuring that their subcontracted Providers meet IEHP's requirements as stated herein and in Policy 5A7, "Credentialing Standards - Assessment of Organizational Providers", IEHP audits Delegate's compliance with IEHP requirements on an annual basis, using the IEHP Delegation Oversight Audit Tool beginning with a pre-contractual assessment, in accordance with Policy 25A1, "Delegation Oversight - Delegated Activities." Delegated IPAs are subject to corrective action as defined in Policy 25A3, "Delegation Oversight - Corrective Action Plan Requirements."
- E. IEHP reserves the right to perform facility site audits when quality of care issues arise and to deny contracted or subcontracted Providers participation in the IEHP network if IEHP requirements for participation are not met.
- F. Contracted and/or subcontracted Provider's failure to meet IEHP's requirements may result in adverse action up to and including non-renewal or termination of the delegated entity contract or IEHP contract

##### **DEFINITION:**

- A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.
  - 1. Sub-delegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Sub-delegate. The Delegate will be responsible for sub-delegation oversight.
    - a. Ongoing monitoring or data collection and alert service are NOT seen as delegation.
    - b. If information is gathered from a company website and the Delegate staff is pulling

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

- B. Free-Standing facility: An outpatient center that is separate from a Hospital or other inpatient facility and whose primary focus is providing immediate or short-term medical services on an outpatient basis.<sup>7</sup>
- C. Organizational Provider (OP): refers to facilities providing services to Members and where Members are directed for services rather than being directed to a specific Practitioner. This element applies to all OPs with which the organization contracts (e.g., Telemedicine Providers, Urgent Care Centers).<sup>8</sup>
- D. Organizational Provider Credentialing: Credentialing of facilities including hospitals, home health agencies, skilled nursing facilities & rehabilitation facilities, etc.

#### **PROCEDURES:**

- A. Delegate has written policies and procedures for the initial and ongoing assessment of Providers who contract with the Delegate, to provide medical services to Members as designated on the IEHP Division of Financial Responsibility (DOFR) Matrix. Delegates' policies for assessing a health care delivery provider specifies that before it contracts with a Provider, and at least every thirty-six (36) months thereafter:<sup>9</sup>
  - 1. Must specify sources used to confirm that Providers are in good standing with state and federal requirements, that include, but are not limited to:<sup>10</sup>
    - a. State (Department of Health Care Services) regulatory body. Licensure must be maintained throughout the duration of the subcontractors' participation in the IEHP network.
      - 1) Copies of Credentials (e.g., A copy of the license and expiration date) from the provider. The Health Care Delivery Organization Provider is responsible for providing IEHP with copies of its renewed license and accreditation within sixty (60) days following the expiration of the license and accreditation.
        - Accreditation and licensure must be maintained throughout the duration of the subcontractors' participation in the IEHP network. A current and unencumbered license; must also be appropriately licensed and no other negative license actions that may impact participation

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<sup>7</sup> NCQA, 2023 HP Standards and Guidelines, Glossary

<sup>8</sup> National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 7, Element A

<sup>9</sup> California Welfare and Institutions Code (Welf. & Inst. Code), § 14043.6 and 14123

<sup>10</sup> NCQA, 2023 HP Plan Standards and Guidelines, CR 7, Element A, Factor 1



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- Physician-owned clinics are not required to be licensed by DHCS, but they must be accredited by an agency approved by the Medical Board. (If the physician-owned clinic is appropriately accredited, they would be compliant with the Knox-Keene Act of Title 28);<sup>11</sup>
- 2) If a state license is not issued by the Department of Health Care Services, the facility should have a business license or certificate of occupancy.
- b. Federal Regulatory Bodies. Delegates must ensure Providers have no sanctions that may impact participation. Delegates must ensure review of the:
  - 1) Department of Health & Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities List (LEIE). Review of OIG or Medicare/Medicaid Sanctions must be completed and documented on the spreadsheet or the file. The monthly review of the OIG report as part of the “Ongoing Monitoring” qualifies as compliant for this section if the facilities are included on the OIG Report.<sup>12</sup>
    - IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners or entities found on OIG Reports).<sup>13,14</sup>
      - CMS’ Medicare Exclusion Database (MED) is the source that is used to populate the LEIE list. IEHP will use the LEIE to verify if practitioners are identified on the MED.<sup>15</sup>
    - 2) CMS signed participating agreement letter, if applicable.<sup>16</sup>
    - 3) An attestation from a Provider to the organization regarding the Providers regulatory status is not acceptable.
  - c. The Organizational Providers must maintain accreditation and license status in good standing and/or current at all times during their participation in the IEHP network.<sup>17</sup>
- 2. Delegates may accept an accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the Provider, as evidence that the Provider has been reviewed and approved by an accrediting body. Accreditation and licensure must be

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<sup>11</sup> Knox-Keene Health Care Service Plan Act of Title 28

<sup>12</sup> Medicare Managed Care Manual, Chapter 6 “Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks,” § 60.2

<sup>13</sup> DHCS APL19-004

<sup>14</sup> DHCS APL 21-003

<sup>15</sup> Ibid.

<sup>16</sup> Medicare Managed Care Manual, Chapter 6, “Institutional Provider and Supplier Certification”, Section 70

<sup>17</sup> National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 7, Element A, Factor 1

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maintained throughout the duration of the subcontractors' participation in the IEHP network

Delegate's policies must state which accrediting bodies it accepts for each type of provider. IEHP recognizes the following accreditations by Organizational Provider type:

- a. Hospitals.
  - 1) The Joint Commission (TJC)
  - 2) Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the American Osteopathic Association (AOA), it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)
  - 3) Det Norske Veritas National Integrated Accreditation of Healthcare Organization (DNVNHAIHO)
  - 4) Center for Improvement in Healthcare Quality (CIHQ)
- b. Home Health Agencies
  - 1) The Joint Commission (TJC)
  - 2) Community Health Accreditation Program (CHAP)
  - 3) Accreditation Commission for Health Care Inc (ACHC)
- c. Skilled Nursing Facilities
  - 1) The Joint Commission (TJC)
  - 2) Commission on Accreditation or Rehabilitation Facilities (CARF)
  - 3) Continuing Care Accreditation Commission (CCAC)
- d. Free-Standing Surgical Centers
  - 1) The Joint Commission (TJC)
  - 2) American Association for Accreditation for Ambulatory Surgical Facilities (AAAASF)
  - 3) Accreditation Association for Ambulatory Health Care (AAAHC)
  - 4) Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)

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- 5) The Institute for Medical Quality's (IMQ's) (CMS approved accrediting body verified by IEHP)<sup>18</sup>
- e. Behavioral Health Providers (Intensive Programs and Inpatient Treatment Programs)
  - 1) The Joint Commission (TJC)
  - 2) Commission on Accreditation or Rehabilitation Facilities (CARF)
  - 3) Healthcare Facilities Accreditation Program (HFAP)
  - 4) Council on Accreditation (COA)
- f. Hospice
  - 1) The Joint Commission (TJC)
  - 2) Community Health Accreditation Program (CHAP)
  - 3) Accreditation Commission for Healthcare INC (ACHC) (CMS approved accrediting body verified by IEHP)
- g. Clinical Laboratories
  - 1) The Joint Commission (TJC)
  - 2) Clinical Laboratory Association Improvement (CLIA) Certificate or CLIA Waiver
  - 3) Commission on Office Laboratory Accreditation (COLA)
  - 4) College of American Pathology (CAP)
- h. Comprehensive Outpatient Rehabilitation Facilities
  - 1) The Joint Commission (TJC)
  - 2) Commission on Accreditation or Rehabilitation Facilities (CARF)
- i. Outpatient Physical Therapy Providers
  - 1) American Association for Accreditation of Ambulatory Surgical Services (AAAASF)
  - 2) If no Accreditation, must be certified by Medicare (Must have Medicare Part A)
- j. Outpatient Speech Pathology Providers
  - 1) American Association for Accreditation of Ambulatory Surgical Services (AAAASF)
  - 2) If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

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<sup>18</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 2

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- k. Providers of End-stage Renal Disease Services (Dialysis)
    - 1) The Joint Commission (TJC)
    - 2) If no Accreditation, must be certified by Medicare
  - l. Birth Centers
    - 1) Commission for the Accreditation of Birth Centers (CABC)
  - m. Congregate Living Health Facility
    - 1) The Joint Commission (TJC)
  - n. Outpatient diabetes self-management training Providers
    - 1) American Association of Diabetes educators (AADE)
    - 2) Indian Health Service (IHS)
  - o. Portable X-Ray Supplier
    - 1) Federal Drug Administration (FDA) Certification
  - p. Rural Health Clinics
    - 1) The Joint Commission (TJC)
    - 2) American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
    - 3) If no Accreditation, must be certified by Medicare
  - q. Federally Qualified Health Centers
    - 1) The Joint Commission (TJC)
    - 2) If no Accreditation, must be certified by Medicare
3. An onsite quality assessment must be conducted if the Provider is not accredited. Delegate policy must specify the onsite quality assessment criteria for each type of non-accredited provider includes, but is not limited to:
- a. Onsite quality assessment criteria for each type of Provider.
  - b. A process ensuring that the Providers credential their Practitioners.
  - c. Delegates policy may specify it only contracts with accredited Providers to meet this requirement.
  - d. A CMS or state quality review in lieu or a site visit under the following circumstances (if the Delegate chooses to substitute the site visit with a with a CMS or state quality review), if it meets the following requirements:
    - 1) The CMS or state review is no more than three (3) years old.

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- If the CMS or state review is older than three (3) years, the organization conducts its own onsite quality review.
  - 2) Delegate obtains a survey report or letter from CMS or the state, from either the Provider or the agency, stating that the facility was reviewed and passed inspection.
    - The report meets the Delegates quality assessment criteria or standards.
  - 3) The Delegate is not required to conduct a site visit if the state or CMS has not conducted a site review of the Provider and the Provider is in a rural area, as defined by the U.S. Census Bureau. (<https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html>).<sup>19,20</sup>
- B. Delegates’ policies and procedures must state which organizational Providers types are contracted and the Delegate is responsible for the initial and ongoing assessment of medical providers, which includes, but is not limited to:
1. Hospitals<sup>21</sup>
  2. Home Health Agencies<sup>22</sup>
  3. Skilled Nursing Facilities (SNFs)<sup>23</sup>
  4. Free-Standing Surgical Centers<sup>24</sup>
  5. Clinical Laboratories in its assessment
  6. Hospices
  7. Comprehensive Outpatient Rehabilitation Facilities (CORF)
  8. Outpatient Physical Therapy Providers (only applies to institutional facilities who take Medicare Part A. Does not apply to independently licensed Physical Therapists (PTs)).
  9. End-Stage Renal Disease Services Providers
  10. Outpatient Diabetes Self-Management Training Providers
  11. Portable X-Ray Suppliers
  12. Rural Health Clinics (RHC)<sup>25</sup>

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<sup>19</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 32

<sup>20</sup> Medicare Managed Care Manual, Chapter 6, “Institutional Provider and Supplier Certification”, Section 70

<sup>21</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 1

<sup>22</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 2

<sup>23</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 3

<sup>24</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 4

<sup>25</sup> Medicare Managed Care Manual, Chapter 6 “Institutional Provider and Supplier Certification”, Section 70

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13. Federally Qualified Health Centers (FQHC)<sup>26</sup>
  14. If Delegate policies and procedures address all Provider types, the Delegate will not need to specify which types they do not contract with.<sup>27</sup>
- C. IEHP’s delegation arrangements with Delegates “carves out” behavioral healthcare services, therefore, Delegates are not responsible for the initial and ongoing assessment for behavioral healthcare facilities providing mental health or substance abuse services in an inpatient setting. Residential Treatment Facilities and Ambulatory Behavioral Health Facilities are not covered in this policy, as these are not a covered IEHP benefit.<sup>28,29</sup>
- D. Delegates must assess contracted medical health care Providers, Organizational Providers, against the requirements and within the time frame. Delegates may: <sup>30</sup>
1. Use a comprehensive spreadsheet or log showing credentialing of Medical organizational Providers, to calculate compliance and completion of the File Review.
  2. Delegates must have a tracking mechanism for ensuring that licenses and certificates are current and reviews are compliant with the thirty-six (36) month timeframe.
- E. Delegates are not responsible for the assessment of Behavioral Healthcare Facilities. IEHP is responsible for the initial and ongoing assessment of Behavioral Health Facilities providing mental health or substance abuse services in an inpatient setting.<sup>31</sup>
1. Behavioral Health Facilities providing mental health or substances abuse services in Residential and Ambulatory settings are not covered as an IEHP benefit, therefore IEHP is not responsible for the initial and ongoing assessment.
- F. IEHP has documentation of assessment of free-standing surgical centers to ensure that if the organizational provider is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program. The following sources are included in the assessment of non-accredited free-standing surgical centers:<sup>32,33</sup>
1. Certification letter from Medicare stating the facility is certified.
    - a. If certification letter is not present, attestation in file or Medicare certification number will be noted on the spreadsheet; and
    - b. A CMS Survey, which include the certification number, is also present in the file.
  2. If a surgical center is associated with a TJC (The Joint Commission) American

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<sup>26</sup> Medicare Managed Care Manual, Chapter 6 “Institutional Provider and Supplier Certification”, Section 70

<sup>27</sup> NCQA, 2021 HP Standards and Guidelines, CR 7, Element B, Factor 1

<sup>28</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element C, Factor 1

<sup>29</sup> Medicare Managed Care Manual, Chapter 11, “Delegation requirements,” Section 110.2

<sup>30</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element D

<sup>31</sup> NCQA, 2021 HP Standards and Guidelines, CR 7, Element E

<sup>32</sup> Health and Safety Code § 1248.1

<sup>33</sup> NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 4

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Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), accreditation Association for Ambulatory Healthcare (AAAHC) accredited hospital or Healthcare Facilities Accreditation Program (HFAP), accrediting program approved by the American Osteopathic Association (AOA), then the assessment of the free-standing surgical center does not apply.

- G. Delegates must conduct Federal and Database checks during the provider's initial assessment and reassessment process, and monthly thereafter. Each provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the IEHP network.

1. Federal and State Database checks for the following databases are conducted by:

a. IEHP

- 1) Social Security Administration's Death Master File (SSADMF) applies to screening Practitioners against the (SSADMF); however Organizational Providers are not reviewed for individual practitioners, therefore the does not apply to the provider types referenced in this policy.
- 2) Restricted Provider Database. Contracting will obtain the Restricted Provider Database report monthly, by the 5<sup>th</sup> of each month. Providers identified on the RPD will be presented to Compliance for review and discussion. The following actions will be required to ensure compliance with DHCS guidelines:
  - Payment Suspension: Providers are placed under a payment suspension while under investigation based upon a credible allegation of fraud.
    - IEHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services will be withheld; or
    - If IEHP chooses to continue the contractual relationship with providers who are placed on payment suspensions, IEHP must allow out-of-network access to members currently assigned to the provider by approving the request.
      - IEHP may choose to terminate the contract by submitting appropriate documentation.<sup>34</sup>
  - Temporary Suspension: Providers placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.
    - IEHP must terminate the contract and submit appropriate documentation.<sup>35</sup>

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<sup>34</sup> DHCS APL 21-003"

<sup>35</sup> Ibid.

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##### b. Delegate

- 1) National Plan and Provider Enumeration System (NPPES). IEHP ensures the provider has an active and current Organization NPI.
- 2) List of Excluded Individuals/Entities (LEIE).
  - Practitioners identified on the HHS-Office of Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.<sup>36,37</sup>
    - Members will be reassigned to new Practitioners.
- 3) System for Award Management (SAM).
  - The OIG LEIE includes all healthcare providers and suppliers that are excluded from participation in federal health care programs, including those health care providers and suppliers that might also be on the SAM (previously EPLS). In addition to health care providers (that are also included on the OIG LEIE) the EPLS includes non-health care contracts.<sup>38</sup>
- 4) CMS' Medicare Exclusion Database (MED). The MED database is the source that is used to populate the LEIE list. Therefore, IEHP will use the LEIE to conduct their assessment of the MED database.
- 5) DHCS' Suspended and Ineligible Provider List.
  - Providers identified on the Medi-Cal Suspended and Ineligible List will be automatically terminated for all lines of business, without appeal rights.
    - All Members assigned to the suspended Provider will be reassigned to new Practitioners.<sup>39</sup>

H. Delegate has a documented process for informing IEHP's Compliance Department of any providers identified with a disciplinary action or on a exclusionary list. If during the contract period, the Delegate becomes aware of a change in the accreditation and/or CMS Site Survey, license, certification status, sanctions, fraudulent activity or other legal or remedial actions have been taken against any Provider, the Delegate must:<sup>40</sup>

1. Notify IEHP's Compliance Department by emailing [compliance@iehp.org](mailto:compliance@iehp.org) or fax (909)

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<sup>36</sup> Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks", § 60.2

<sup>37</sup> DHCS APL 19-004

<sup>38</sup> Medicare Managed Care Manual, Chapter 21, "OIG/GSA Exclusion", Section 50.6.8

<sup>39</sup> DHCS APL 19-004

<sup>40</sup> California Welfare and Institutions Code (Welf. & Inst. Code), 14043.6 and 14123



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477-8536 or via Compliance Hotline (866) 355-9038 within five (5) business days of discovering any of our Providers have been added to disciplinary or exclusionary lists.

- a. May report the termination of the contract to regulatory agencies as per contractual requirements and any services provided after the date of exclusion shall not be reimbursable or may be subject to recoupment.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on File</i>	<b>Original Effective Date:</b>	January 1, 2020
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 2023

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##### **APPLIES TO:**

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

##### **POLICY:**

- A. Delegates must ensure there is a delegation agreement in place for all sub-delegation arrangements in place.<sup>1</sup>
- B. For new delegation agreements initiated, Delegates must evaluate the sub-delegates capacity to meet National Committee for Quality Assurance (NCQA), State, and Federal regulatory requirements before delegation began.<sup>2</sup>
- C. For delegation arrangements in effect for twelve (12) months or longer, Delegates must conduct oversight reviews of the Delegate’s credentialing activities.<sup>3</sup>
- D. If there are any opportunities for improvement identified during the review of delegated credentialing activities, Delegates will identify, notify and follow-up with the sub-delegate to ensure the opportunities have been addressed.<sup>4</sup>

##### **PURPOSE:**

- A. IEHP remains responsible for credentialing and recredentialing its Practitioners, even if it delegates all or part of these activities. Delegates are required to monitor the credentialing and recredentialing status and performance of their contracted Practitioners on a continuous basis in compliance with IEHP requirements and current NCQA, State, and federal regulatory guidelines.<sup>5</sup>
- B. Delegates must verify that sub-delegates perform the functions discussed in Section 25, of the Provider Manual and in the Delegation Agreement between the Delegate and the sub-delegate.<sup>6</sup>
- C. IEHP and any regulatory oversight agency have the right, within two (2) working days advance notice to the Delegate, to examine the Delegates credentialing and recredentialing files or sites as needed to perform oversight of all Practitioners or to respond to a complaint

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<sup>1</sup> National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 8, Element A, Factors 1-6

<sup>2</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element B

<sup>3</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factors 1-6

<sup>4</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element D

<sup>5</sup> Ibid.

<sup>6</sup> Medicare Managed Care Manual, Chapter 11, “Delegation requirements,” Section 110.2

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or grievance.

- D. If a Management Services Organization (MSO) and an IPA are owned or under the same ownership, this is not considered delegation.
- E. If an IPA changes MSOs during the annual audit period, only the current agreement will be reviewed and scored.
- F. If a Delegate terminates a delegation arrangement during the annual audit period, only the termination date will be reviewed.
- G. Delegates who delegate to an NCQA accredited entity, the Delegate must audit for Medi-Cal and DMHC requirements. Acceptance of accreditation only will not meet compliance for the additional regulatory requirements.
- H. If the Delegate utilizes their sub-delegate for their specialty panel for HIV/AIDS Practitioners, the Delegate must include the Identification of HIV/AIDS Specialists in their annual oversight review.
- I. If the Delegate gives another organization the authority to perform certain functions on its behalf, this is considered delegation, e.g., Primary Source Verification of License, collection of the application, verification of Board Certification.
  - 1. Ongoing monitoring or data collection and alert services are NOT seen as delegation. IF the Delegate uses another organization for collecting data for ongoing monitoring or sanctions monitoring, and the Delegate then handles the review of information and intervention, it is not considered delegation.
  - 2. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered delegation.
- J. Delegates must provide IEHP all sub-delegation agreements and effective dates.

#### **DEFINITION:**

- A. Annual: A twelve (12) month period, within a two (2) month grace period, defined by NCQA.
- B. Audit Date: The date of the file review.
- C. Auto-Credit: Credit given to elements that have been audited by previous accrediting authority and meets industry compliance. Those elements will not be subjected to oversight.
- D. Credentials Verification Organization (CVO): An organization that conducts primary-source verification of Practitioner credentials for other organizations. AN organization may obtain the following certification under NCQA CVO status:
  - 1. Licensure
  - 2. DEA or CDS verification

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3. Education and Training
  4. Work History
  5. Malpractice History
  6. Medical Board Sanctions
  7. Medicare/Medicaid sanctions
  8. Processing application and Attestation content; and
  9. Ongoing Monitoring of Sanctions (licensure and Medicare/Medicaid)
- E. Delegation: An organization gives an entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate the responsibility of ensuring that the function is performed appropriately.
- F. Exit Interview: Auditor discussion of audit results with Delegate via phone, email or in person.
- G. Factor: A scored item in an element.
- H. Implementation Date: NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.
- I. Look-back period: Is the date range used for pulling files for a review.
- J. Management Services Organization (MSO): an entity that, under contract provides services such as a facility, equipment, staffing, contract negotiation, administration, and marketing.
- K. NCQA CR Accreditation: A provider organization that has achieved an NCQA accreditation in credentialing would receive auto-credit for certain standards of credentialing.
- L. NCQA CVO Certification: An organization that has been certified by NCQA to collect primary source verifications. An organization that has obtained this certification will still need to have a full file/policy review but does not need to evaluate on actual verification documentation but on the current and timely verification.
- M. NCQA Health Plan Accreditation: A health plan organization that has achieved NCQA accreditation and would receive auto-credit for credentialing. An organization that has obtained this accreditation will still need to have a file/policy review for CMS, or state requirements.
- N. Pre-Assessment: Evaluation of a potential delegate's credentialing program prior to executing a delegated agreement.
- O. Timeliness: A term used when auditing file elements to confirm they are within one-hundred eighty (180) calendar days of the credentials committee decision.
- P. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source

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Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Sub-delegation: Occurs when a group has delegated certain activities to in turn uses another entity to complete some of its delegated activities.
  - a. Using a vendor for ongoing monitoring of sanctions is not considered delegation by NCQA.
  - b. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered delegation.
  - c. Ongoing monitoring or data collection and alert services are NOT seen as delegation. If the organization uses another organization for collecting data for ongoing monitoring or sanction monitoring and the organization then handles the review of information and intervention, it is not considered delegation.

#### **PROCEDURES:**

- A. For all Credentialing delegation arrangements, Delegates must have a delegation agreement that describes all delegated Credentialing (CR), that includes:
  1. A mutual agreement that documents delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the Organization and the delegated entity. Dated and signed agreement between both parties must be evident.<sup>7</sup>
    - a. Effective date may be at the front of the delegation agreement.
    - b. If date is not in the front, the latest signatory date from both parties will be used as the effective date.
    - c. Other acceptable evidence of the mutually agreed-upon effective date may include, but is not limited to:
      - 1) A letter
      - 2) Meeting minutes
      - 3) Other form of communication between the organization and the Delegate that references the parties' agreement on the effective date of the activities.
        - Delegate must submit evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the Delegate's performance of delegated activities.
  2. The delegation agreement or addendum thereto or other binding communication between

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<sup>7</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 1

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the organization and the delegate specifies the CR activities:

- a. Performed by the delegate in detailed language.
  - b. Not delegated but retained by the organization.
    - 1) The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other CR functions not specified in this agreement as the Delegate’s responsibility).
  - c. If the Delegate sub-delegates an activity, the delegation agreement must specify which organization is responsible for oversight of the sub delegate.<sup>8</sup>
  - d. The delegation agreement(s) must have language that the delegate will adhere to state and federal regulations.
    - 1) This language is not required for Credentialing Verification Organization (CVO) Agreements.
3. Delegate must determine the method of reporting and the content of the reports, but the agreement specifies:
- a. The reporting is at least semi-annually for DualChoice line of business. Reporting examples include:<sup>9,10</sup>
    - 1) Lists of credentialed and recredentialed Practitioners.
    - 2) Committee meeting minutes.
    - 3) Facilities credentialed.
  - b. What information is reported by the Delegate about delegated activities.
  - c. How, and to whom, information is reported (i.e. joint meetings or to appropriate committees or individuals in the organization).
  - d. Delegate must receive regular reports from all sub-delegates, even NCQA accredited or NCQA Certified Delegates.
4. Delegates’ Delegation Agreement states the process for monitoring and evaluating the delegate’s performance.<sup>11</sup>
5. Delegate retains the right to approve, suspend and terminate Providers, who participate in the Delegates’ network.<sup>12</sup>
- a. This does not apply if the subdelegate does not have decision making authority.

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<sup>8</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 2

<sup>9</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 3

<sup>10</sup> Medi-Cal Exhibit A, Attachment 4 of Plan Contract – QI Activities)

<sup>11</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 4

<sup>12</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 5

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 8. Delegation of Credentialing

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- b. If the delegation agreement does not specify the right to approve language, the Delegate may provide alternate documentation through another communication between the Delegate and sub-delegate, for review for compliance.
  6. If the subdelegate fails to meet the terms of the agreement and, at a minimum, circumstances that result in revocation of the agreement.<sup>13</sup>
- B. For new delegation arrangements, the Delegate must evaluate the sub-delegates capacity to meet NCQA, State, and Federal regulatory requirements before delegation began.<sup>14</sup>
  1. Delegates may use an accredited Health Plan audit as the pre-delegation evaluation.
    - a. If Delegate uses a health plan audit, there must be evidence that the health plan audit was reviewed, e.g., Committee minutes, email approval or other methods indicating acceptance of review.
    - b. If Delegate changes Management Services Organizations (MSOs), the Delegate must evaluate the new MSO prior to contracting.
  2. For any amendments or newly delegated activities within the last twelve (12) months, the Delegate must have documentation, dated before the delegation began showing that it evaluated the subdelegate before implementing delegation.<sup>15</sup>
  3. If the pre-delegation evaluation was performed more than twelve (12) months prior to implementing delegation, the Delegate must conduct another pre-delegation evaluation.
  4. The Delegate must have a systematic method for conducting this evaluation, especially if more than one (1) delegation agreement is in effect. The following list are examples:<sup>16</sup>
    - a. Site Visit.
    - b. Written review of the subdelegate's understanding of the standards and the delegated tasks.
    - c. Staffing capabilities.
    - d. Performance records (e.g. Audit).
    - e. Exchange of documents and review.
    - f. Pre-delegation/Committee meetings.
    - g. Telephone consultation.
    - h. Virtual review.

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<sup>13</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 5

<sup>14</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 5

<sup>15</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element B, Factor 2

<sup>16</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element B, Factor 4

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

1. Annually review its Delegate’s credentialing policy and procedures.
  - a. Review for evidence that the Delegate’s staff or committee annually reviewed their subdelegate’s credentialing policies and procedures, e.g. audit tool, audit correspondence, audit summary documentation, committee minutes, and email approval, noted in their database or other methods.
  - b. A Delegate may use an accredited health plan audit as the annual evaluation.
    - 1) If Delegate uses a health plan audit, there must be evidence that the health plan audit was reviewed, e.g. Committee minutes, email approval or other methods indicating acceptance of review.
    - 2) For NCQA-Certified or Accredited Delegates, including certified CVOs:
      - Review evidence of annual review of policy and procedures for delegated functions, as applicable.<sup>17</sup>
2. Annually audits credentialing and recredentialing files against NCQA, State, and Federal regulatory standards for each year that delegation has been in effect.<sup>18</sup>
  - a. Review for evidence that the Delegate’s staff or committee annually reviewed their subdelegate’s credentialing policies and procedures, e.g. audit tool, audit correspondence, audit summary documentation, committee minutes, and email approval, noted in their database or other methods.
  - b. A Delegate may use an accredited health plan audit as the annual evaluation.
    - 1) If Delegate uses an accredited health plan audit, there must be evidence that the health plan audit was reviewed, e.g. Committee minutes, email approval or other methods indicating acceptance of review.
    - 2) If Delegate does not use an accredited health plan audit, the Delegate must audit per IEHP standards (See Attachment, “Credentialing DOA Audit Tool” in Section 25).
3. Annually evaluates delegate performance against NCQA, state and federal regulatory standards for delegated activities.<sup>19</sup>
  - a. The audit must include all pieces of the credentialing process (e.g., policies and procedures, ongoing monitoring, file audit, etc.).
4. Semi-annually evaluates regular reports, as specified in element A. Acceptable methods

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<sup>17</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 1

<sup>18</sup> NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 2

<sup>19</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 3



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of review include:<sup>20</sup>

- a. Assess the Quality or Credentialing Committee Minutes.
  - b. It is acceptable to only receive lists of credentialed and recredentialed Practitioners from NCQA-accredited or NCQA-certified Delegates.
  - c. Delegates that are not NCQA-accredited or NCQA-certified need to demonstrate that it collects credentialing data from the delegate, evaluates the data, and takes corrective action if needed and follow-up on deficiencies.
  - d. If no performance issues are identified, reporting could be limited to lists of credentialed and recredentialed Practitioners.
  - e. For MSOs, reviewing reporting numbers which can usually be found in the Quality Improvement Meeting Minutes.
5. Annually monitors the Delegate's system security controls to ensure that the Delegate monitors its compliance with the delegation agreement or with the Delegate's policies and procedures at least annually.<sup>21</sup>
- a. Delegates process for monitoring system security controls covers sub-delegates that store, create, modify, or use CR data on its behalf. If the organization contracts with such delegates, it:
    - 1) Has a process for annually monitoring the delegate's CR system security controls in place to protect data from unauthorized modification?
    - 2) Ensures that the Delegate annually monitors that it follows the delegation agreement or its own policies and procedures.
  - b. Delegate reviews all modifications made in all Delegates' CR systems during the look-back period that did not meet the modification criteria allowed by the delegation agreement or by the delegates' policies and procedures.
    - 1) If the Delegate's CR system does not allow modifications, the Delegate:
      - Describes the functionality of the system that ensures compliance with the established policy.
      - Provides documentation or evidence of advanced system control capabilities that automatically record dates and prevent modifications that do not meet modification criteria.
  - c. Auditing is allowed only if the Delegate or the sub-delegate does not use a CR system

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<sup>20</sup> NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 4

<sup>21</sup> NCQA, 2023 HP Standards and Guidelines, CR 1, Element C, Factors 1-5

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that can identify all noncompliant modifications.<sup>22</sup>

- 1) Documentation includes the staff roles or department involved in the audit.
- 2) Delegate or the sub-delegate identifies all CR system modifications, but may use sampling to identify potential noncompliant changes for the audit.
- 3) The Delegate uses one of the following methods to audit files:
  - Five (5) percent or fifty (50) of its files, whichever is less, to ensure that information is verified appropriately.
    - (a) At a minimum, the sample includes at least ten (10) credentialing files and ten (10) recredentialing files. If fewer than ten (10) Practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than the sample.
6. Delegate acts on all findings from Factor 5 for each delegate and implements a quarterly monitoring process until each sub-delegate demonstrates improvement for one finding over three (3) consecutive quarters.
  - a. Delegate identifies and documents all actions it has taken, or plans to take, to address all modifications that did not meet the delegation agreement or the Delegate's policies and procedures, if applicable. One action may be used to address more than one finding for each Delegate or across multiple delegates, if appropriate.
    - 1) Delegate implements a quarterly monitoring process for each Delegate to assess the effectiveness of its actions on all findings.
      - Delegate must continue to monitor each Delegate until the sub-delegate demonstrates improvement of at least one (1) finding over three (3) consecutive quarters.
      - If a sub-delegate did not demonstrate improvement of at least one (1) finding during the look-back period, it submits all quarterly monitoring reports demonstrating ongoing monitoring.
      - If the Delegate identified findings less than three (3) quarters before the survey submission date, it submits all monitoring information it has available.
- D. For delegation arrangements that have been in effect for more than twelve (12) months, at least in the past year, the organization identified and followed up on opportunities for improvement, if applicable.<sup>23</sup>
  1. Findings from the Delegates pre-delegation evaluation, annual evaluation, file audits or

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<sup>22</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 5

<sup>23</sup> NCQA, 2023 HP Standards and Guidelines, CR 8, Element D, Factor 1

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ongoing reports can be sources for identifying areas of improvement for which it takes actions.

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

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 9. Identification of HIV/AIDS Specialists

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##### **APPLIES TO:**

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

##### **POLICY:**

- A. Delegate has written policy and procedure describing the process that the Delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS specialist, according to California State Regulations on an annual basis.
- B. On an annual basis, the Delegate identifies and reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS, Specialist according to California State regulations.
- C. The list of identified qualifying Physicians is provided to the department responsible for authorizing standing referrals.

##### **DEFINITION:**

- A. AIDS – Acquired Immunodeficiency Syndrome.
- B. Category 1 continuing medical education:
  - 1. For Physicians, continuing medical education as qualifying for category 1 credit by the Medical Board of California;
  - 2. For Nurse Practitioners, continuing medical education contact hours recognized by the California Board of Registered Nursing;
  - 3. For Physician Assistants, continuing medical education units approved by the American Association of Physician Assistants.
- C. HIV – Human Immunodeficiency Virus.
- D. Delegate – If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.
  - 1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight.
    - a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

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#### 9. Identification of HIV/AIDS Specialists

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

#### **PROCEDURES:**

- A. Delegate has a written policy and procedure describing the process that the Delegate identifies and verifies the appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist. An HIV/AIDS Specialist is a Physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the State of California, who meets any one of the four (4) criterion below:<sup>1</sup>
  - 1. Is credentialed as an HIV specialist by the American Academy of HIV Medicine (AAHIVM);
  - 2. Is board certified, or has earned Certificate of Added Qualifications, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualifications, in the field of HIV medicine; or
  - 3. Is board certified in the field of Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:
    - a. In the immediately preceding twelve (12) months has clinical managed medical care to a minimum of twenty-five (25) patients who are infected with HIV; and
    - b. In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of category 1 continuous medical education (CME) in the prevention of HIV infection, combined with diagnosis, treatment, or both, of the HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year.
  - 4. Meets the following qualifications:
    - a. In the immediately preceding twenty-four (24) months has clinically managed medical care to a minimum of twenty (20) patients who are infected with HIV; and
    - b. Has completed any of the following:
      - 1) In the immediately preceding twelve (12) months has obtained board certification or recertification in the field of infectious disease from a member board of the American Board of Medical Specialties; or
      - 2) In the immediately preceding twelve (12) months has successfully completed a minimum of thirty (30) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment of both, of

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<sup>1</sup> Health and Safety Code § 1300.74.16

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HIV-infected patients.

- 3) In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competence Examination administered by the American Academy of HIV Medicine.
- B. Delegate identifies and reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS Specialist, on annual basis. Delegate must provide:
1. Evidence that the Delegate identifies HIV/AIDS Specialists on an annual basis, which may include, but not limited to the following:
    - a. Review current and previous year's survey/spreadsheet/credentialing attestation/logs.
      - 1) This does not require screening of all the Delegate's practitioners, only those who potentially may qualify and wish to be listed as HIV/AIDS Specialists.
    - b. The department responsible for standing referrals may conduct the annual survey, instead of the Credentialing Department; this would meet the intent of this requirement.
    - c. Annual screening must be completed within twelve (12) months of the prior' year's annual screening.
    - d. If the Delegate changes MSO's and does not have this evidence, they should identify/reconfirm HIV/AIDS specialist within sixty (60) days of the MSO change.
- C. The list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.<sup>2,3</sup>
1. Once the Delegate has determined which, if any, of its physicians qualify was HIV/AIDS Specialists under the above regulations, this list of qualifying practitioners is sent (e.g. e-mail, letter) or made available to the department responsible for authorizing standing referrals.
    - a. Distribution of findings must be communicated within thirty (30) days from the completion of the screening/survey assessment (e.g., The date of the last survey collected/signed is used to begin your calculation).
      - 1) A verbal statement that the list was provided to the appropriate department is not acceptable evidence of compliance.

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<sup>2</sup> Health & Saf. Code § 1300.74.16

<sup>3</sup> DHCS MMCD All Plan Letter 02001, Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program

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### B. Credentialing Standards

#### 9. Identification of HIV/AIDS Specialists

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- 2) If the list is available to the appropriate department electronically, it is not required to send the list. No evidence is required.
- b. If the survey revealed that there are no qualified contracted HIV/AIDS Specialists within the Delegate, communication regarding HIV/AIDS Specialists availability to the appropriate department (e.g. Utilization Management or Case Management) is all that is necessary.
- c. If the Delegate does not have any contracted HIV/AIDS Specialists, the Delegate will be scored compliant during the Credentialing Audit.
- d. If the annual screening was not conducted and a list was distributed with old information, the Delegate will be scored non-compliant during the Credentialing Audit.

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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##### **APPLIES TO:**

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

##### **POLICY:**

- A. Delegates must obtain approval of Practitioners seeking participation in the IEHP network, from the Delegates Credentialing Committee and/or Medical Director before submitting the Practitioner to IEHP, for review and approval. Delegates must confirm the Practitioners meet IEHPs criterion as specified in Policy 25B1, “Credentialing Standards – Credentialing Policies.”
- B. If a Practitioner is changing from one (1) IPA to another, the new IPA must submit the Providers documentation (as noted in Procedure A below) within sixty (60) calendar days of the effective date of the change.
- C. All Delegates are responsible for recredentialing and/or employed Practitioners within the thirty-six (36) months of the last credentialing decision, as required by National Committee for Quality Assurance (NCQA). Delegates are required to report their recredentialing activities to IEHP. Delegates must report recredentialing activities and terminations by the 15<sup>th</sup> of the following month.
- D. All Practitioner terminations and changes (i.e., Address, specialty, age limits, Supervising Physicians, TIN changes etc.) must be submitted to [providerupdates@ichop.org](mailto:providerupdates@ichop.org). All changes and terminations submitted through the Secure File Transfer Protocol (SFTP) server will not be processed.
- E. Delegates must provide IEHP with a status report of their specialty network on a semi-annual basis during Provider Directory review. Delegates that do not require their Providers to be listed in the Provider Directory submit specialty networks quarterly.
- F. IPAs are responsible for reviewing, maintaining and notifying IEHP of any changes to their Hospital admitting arrangements for each of their affiliated links.

##### **PURPOSE:**

- A. IEHP must receive reports from its Delegates at least semi-annually, however IEHP requires Delegates to submit reports based on the IPA Reporting Requirements Schedule (See Attachment, “IPA Reporting Requirements Schedule – IEHP DualChoice” in Section 25). At a minimum, Delegates must report its progress in conducting credentialing and recredentialing activities, and on performance-improvement activities, if applicable. Findings from the Delegates pre-delegation evaluation, annual evaluation, file audit or ongoing reports can be sources to identify areas of improvement for reporting. Areas could be related to NCQA



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## 25. DELEGATION AND OVERSIGHT

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#### 10. Credentialing Quality Oversight of Delegates

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credentialing standards or to IEHPs expectations.<sup>1</sup>

- B. In addition to IEHP’s quality oversight, IPAs are expected to monitor the performance of their credentialed Practitioners on a continuous basis and to review any performance issues as may be applicable during the recredentialing process obtained by the IPA, from other sources or IEHP.<sup>2</sup>

#### **DEFINITION:**

- A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.
1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.
    - a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
    - b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered sub-delegation.

#### **PROCEDURES:**

- A. Delegates must obtain approval of Practitioners seeking participation in the IEHP network, from the Delegates Credentialing Committee and/or Medical Director before submitting the Practitioner to IEHP, for review and approval.
1. All credentialing file information must be submitted to IEHP via the SFTP, into the Delegates assigned ‘Credentialing’ Folder.
    - a. Once the upload is complete, the Delegate must take a screenshot showing the files uploaded into the ‘Credentialing’ Folder. The Delegate will need to email Provider Delegation at [CredentialingProfileSubmission@iehp.org](mailto:CredentialingProfileSubmission@iehp.org) notifying IEHP when the credentialing files are posted.
      - 1) IEHP will then respond to the email with a confirmation that the credentialing files were located.

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<sup>1</sup> National Committee for Quality Assurance (NCQA), 2022 HP Standards and Guidelines, CR 8, Element A, Factor 3

<sup>2</sup> NCQA, 2022 HP Standards and Guidelines, CR 8, Element A, Factor 4

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### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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- Upon receipt of credentialing files into the Delegates SFTP ‘Credentialing’ folder, IEHP will begin the credentialing process. Submitted files will be forwarded to IEHP Credentialing for processing.
    - For all Primary Care Providers (PCPs), Obstetrics/Gynecology (OB/GYNs) and Urgent Care’s, once all credentialing information is received, IEHPs Credentialing Department will request for a facility site review with IEHPs Quality Management (QM) Department, in accordance to Policy 6A, “Site Review and Medical Record Review Survey Requirements and Monitoring.”
    - If a Practitioner’s submission packet is incomplete and/or missing supporting documentation, the Delegate is notified via email with the reason why that the process was terminated for the Practitioner. The Delegate must resubmit all documents again, to include missing information to IEHP for review and reconsideration.
  - Credentialing Files submitted through any other methods will be rejected and the Delegate will be directed to submit the files via the SFTP.
2. The Delegate must submit the following for review and consideration:
- a. Contract (1<sup>st</sup> and signature pages)
    - 1) To include any applicable addendums to show the Practitioners relationship or affiliation with that contract.
  - b. W-9 for all Tax Identification Numbers (TINs) used by the Practitioner.
  - c. Attachment I: Statement of Agreement by Supervising Provider is required for all Physician Extenders (Physician Assistants, Nurse Practitioners and Nurse Midwife’s to confirm the relationship between the Supervising Physician and Physician Extender(s). (See Attachment, “Attachment I - Statement of Agreement by Supervising Provider” in Section 5)
    - 1) If these arrangements are clearly described on the Delegation of Services Agreement, Practice Agreement, or Standardized Procedures, those documents may be used in lieu of submitting an Attachment I form.
  - d. Hospital Admitting arrangements must be noted on the profile or provided as an attachment at the time of submission, to include but not limited to alternate admitting arrangements.
    - 1) If the IPA provides an alternative arrangement, IEHP does not have on file the IPA will be required to submit those arrangements to ensure compliance with IEHP requirements. (See Policy 5B, “Hospital Privileges”)
  - e. Practitioner profile or spreadsheet that includes all the elements listed below,

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#### 10. Credentialing Quality Oversight of Delegates

otherwise, it will be rejected back to the Delegate with the reason for review and resubmission.

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
1.	✓	✓	✓	IPA Name
2.	✓	✓	✓	Line(s) of Business <ul style="list-style-type: none"> <li>Required if Delegate is participating in more than one (1) line of business</li> </ul>
3.	✓	✓	✓	Identifier as to whether the packet is Initial (I) or Recredentialing (R)
4.	✓	✓	✓	Identifier for Practitioner Type: <ul style="list-style-type: none"> <li>PCP</li> <li>Specialist; or</li> <li>Mid-Level Practitioner</li> </ul>
5.	✓	✓	✓	Practitioner Name as it's listed on License to Practice
6.	✓	✓	✓	Other Names used (Preferred)
7.	✓	✓	✓	Practitioner Specialty
8.	✓	✓	✓	Practice/Clinic Name(s)
9.	✓	✓	✓	Practitioner Address(es)
10.	✓	✓	✓	Practitioner Phone and Fax numbers
11.	✓	✓	✓	Practitioner Office Hours
12.	✓	✓	✓	Practitioner Date of Birth (D.O.B.)
13.	✓	✓	✓	Practitioner Social Security Number (S.S.N.)
14.	✓	✓	✓	Practitioner Gender
15.	✓	✓	✓	Practitioner Cultural Background (optional);
16.	✓	✓	✓	Practitioner Languages spoken
17.	✓	✓	✓	Practitioner Tax Identification Number(s)
18.	✓	✓	✓	Practitioner License Number and expiration date

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	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
19.	✓	✓	✓	Initial Committee Approval Date
20.	✓	✓	✓	Recredentialing Committee Approval Date (if applicable)
21.	✓	✓	✓	Drug Enforcement Administration (DEA) Number and expiration date (if applicable)
22.	✓	✓		DEA Arrangements if the Practitioner does not have a DEA Certificate (if applicable)
23.	✓	✓		Hospital Affiliations <ul style="list-style-type: none"> <li>• Hospital Name</li> <li>• Status</li> <li>• Type of Service provided - Specialty</li> </ul>
24.	✓	✓		Hospital Admitter arrangements <ul style="list-style-type: none"> <li>• Name of Hospital</li> <li>• Name of Admitter</li> </ul>
25.	✓	✓	✓	Malpractice Insurance Coverage <ul style="list-style-type: none"> <li>• Name of Insurance carrier</li> <li>• Policy number</li> <li>• Coverage per claim</li> <li>• Coverage per aggregate</li> <li>• Expiration date</li> </ul>
26.	✓	✓	✓	Board Certification <ul style="list-style-type: none"> <li>• Name of Board</li> <li>• Expiration date/re-verification date</li> <li>• Certification status</li> </ul>
27.	✓	✓	✓	Medical School <ul style="list-style-type: none"> <li>• Name of Institution</li> <li>• Graduation Date MM/YYYY</li> </ul>

## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
28.	✓	✓		Internship <ul style="list-style-type: none"> <li>• Institution Name</li> <li>• Specialty</li> <li>• Training Type</li> <li>• Start Date MM/DD/YYYY</li> <li>• End date MM/DD/YYYY</li> </ul>
29.	✓	✓		Residency, if applicable <ul style="list-style-type: none"> <li>• Institution Name</li> <li>• Specialty</li> <li>• Training Type</li> <li>• Start Date MM/DD/YYYY</li> <li>• End date MM/DD/YYYY</li> </ul>
30.	✓	✓		Fellowship, if applicable <ul style="list-style-type: none"> <li>• Institution Name</li> <li>• Specialty</li> <li>• Training Type</li> <li>• Start Date MM/DD/YYYY</li> <li>• End date MM/DD/YYYY</li> </ul>
31.	✓	✓	✓	Individual National Provider Identifier (NPI) Number
32.			✓	Name of Supervising Physician
33.	✓	✓	✓	Staff Languages spoken
34.	✓	✓	✓	Age limits

3. Upon receipt of the documentation, IEHPs Credentialing Department performs a quality review of each delegate’s credentialed and approved Practitioner to ensure compliance with IEHPs guidelines (See Policy 5A, “Credentialing Standards – Credentialing Policies”).
  - a. The Practitioner review includes, but is not limited to the following:
    - 1) Review of credentialed Practitioner specialty and relevant education, training, practice experience.
    - 2) Review of requested age range

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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- 3) Review of Hospital arrangements, if applicable
- 4) Review of adverse history;
  - History of negative license action;
  - History of negative privileges action;
  - History of Medicare or Medicaid sanctions; and
  - Other adverse history (including felony convictions, etc.).
- b. In cases where the IPA submitted credentialing information is consistent with IEHP guidelines, no adverse history is present, and the Practitioner has successfully passed IEHP's site review (if applicable), the PCPs, Specialists, and Mid-Levels are reviewed and signed off by Credentialing Department.
- c. In cases where either the Delegate(s) submitted credentialing information is inconsistent with IEHP guidelines or data, or there is evidence of significant adverse history, the Practitioner is forwarded to the IEHP Peer Review Subcommittee for further review.
  - 1) Delegates must provide a written plan of action for the respective practitioner that includes, but is not limited to:
    - The Credentialing Date the practitioner was presented to review and discussion.
    - The Credentialing Committee decision and/or outcome.
    - If the Delegate will conduct additional monitoring (i.e. grievances and complaints), if so, how frequent
    - If the Delegate issued a plan of action or requested any additional information for the practitioner.
  - 2) The Practitioner is forwarded to the Peer Review Subcommittee for review, discussion and decision. The IEHP Medical Director presents the Practitioner's credentialing file and any other necessary supporting documentation from the IPA, Practitioners, or IEHP to determine if potential quality of care issues for Members exists.
    - If the IEHP Peer Review Subcommittee determines that no potential quality of care concern exists, no further action or review is undertaken.
    - The IEHP Peer Review Subcommittee reviews all pertinent information necessary. The IEHP Peer Review Subcommittee determines if there is a potential quality of care concern or adverse event that exists. The Peer

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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Review Subcommittee may make recommendations to improve the performance of a Practitioner, that includes but is not limited to:

- Request for additional information from the Delegate, with review at next meeting.
  - Individual counseling by the Delegate or IEHP Medical Director.
  - Focused audits of Practitioner’s practice by IEHP Quality Management staff.
  - Continuing medical education or training.
  - Restriction of privileges, including age range restrictions or other limitations.
  - Termination of the Practitioner from the IEHP network; and
  - Any other action appropriate for the circumstances
- 3) Actions by the IEHP Peer Review Subcommittee that differ from the IPA Credentialing Committee decisions, including changes in privileges and termination are tracked by IEHP.
- The IEHP Medical Director reviews the tracking report, the credentialing files and any other supporting information as necessary.
  - After review, IEHP takes any of the following action(s) against the delegate:
    - No action;
    - Verbal or written request for additional information from the Delegate’s Medical Director;
    - Request an interim focused credentialing audit of the Delegate by IEHP staff; or
    - Any other action as appropriate, including revocation of delegated credentialing responsibilities.<sup>3</sup>

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

1. Failure to meet this timeframe will result in “freezing” the Provider to auto-assignment of Member or possible termination.
  - a. IPAs who have outstanding “Pend changes” will be placed on a Corrective Action Plan (CAP) until all documents are submitted.

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<sup>3</sup> NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 5

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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- C. All Delegates are responsible for recredentialing Practitioners within the thirty-six (36) months of the last credentialing decision, as required by NCQA as a Must-Pass Element.<sup>4</sup>
1. By the 5<sup>th</sup> of every month, IEHP will post the Delegates outstanding recredentialing report to the SFTP Server.
  2. Delegates are required to review these reports and ensure that the Providers identified on the report are submitted to IEHP with their new recredentialing dates by the dates specified on the IPA Reporting Requirements Schedule (See Attachment, “IPA Reporting Requirements Schedule – DualChoice” in Section 25).
    - a. These dates are used to conduct file selections for the Delegates Delegation Oversight Audit for Credentialing; and
    - b. Track the Delegates Recredentialing timeliness (Recredentialing cycle length)
  3. The Delegates failure to submit timely reports or failure to recredential practitioners within the thirty-six (36) month timeframe will be deemed non-compliant and will result in a corrective action plan.
  4. Delegates are required to report their credentialing and recredentialing activities, and terminations via excel format. (See Attachment, “Credentialing and Recredentialing Report”, in Section 25). Delegates must submit their report based on the IPA Reporting Requirements Schedule (See Attachment, “IPA Reporting Requirements Schedule – Dual-Choice” in Section 25).<sup>5</sup>
    - a. Credentialing Tab: IEHP will review and analyze the Practitioner list and their credentialing dates to ensure they are consistent with IEHPs data.
      - 1) The Credentialing Dates are used to capture the Delegation Oversight Audit file selection, based on the look-back period, to select files for the annual audit.
    - b. Recredentialing Tab: IEHP will review and analyze the Practitioner list and their credentialing and recredentialing dates to ensure they are consistent with IEHPs data.
      - 1) The recredentialing dates are used to capture the Delegation Oversight Audit file selection, based on the look-back period, to select files for the annual audit.
    - c. Termination Tab: IEHP will review and analyze the Practitioner list to ensure the practitioners identified are not active in the IEHP network.
      - 1) The Provider Network Department will be notified of all practitioners who are not terminated from IEHP.
        - Upon request, Delegates are required to submit supporting documentation regarding terminations, that includes but is not limited to:

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<sup>4</sup> NCQA, 2022 HP Standards and Guidelines, CR 4, Element A, Factor 1

<sup>5</sup> NCQA, 2022 HP Standards and Guidelines, CR 8, Element A, Factor 3



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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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- Reason for termination
  - Termination effective Date
  - Reassignment of Advanced Practice Practitioners
  - Member reassignment designations
- D. All Practitioner terminations and changes (i.e. Address, specialty, age limits, Supervising Physicians, Taxpayer Identification Number (TIN) changes etc.) must be submitted to [providerupdates@iehp.org](mailto:providerupdates@iehp.org). All changes and terminations submitted through the SFTP server will not be processed. (See Policy 18, “Provider Network”).
1. PCP relocations must pass a California Department of Health Care Services (DHCS) required FSR Survey and close CAPs prior to receiving assignment of members, within thirty (30) days upon relocation or the date IEHP discovers that the PCP site moved, and a minimum every three (3) years thereafter, unless it was determined that they be placed on annual review. (See Policy 6A, “Facility Site Review and Medical Record Survey Requirements and Monitoring”).<sup>6</sup>
  2. Changes in Specialty and age limits are considered practice parameter expansions and reductions and submit the required documentation in Policy 25B1, “Credentialing Standards - Credentialing Policies”).
  3. Advanced Practice Practitioners (PAs, NMs, and NPs) relocating or changing supervising Physicians, Delegates must provide a current copy of the following documents to ensure compliance with IEHP guidelines (See Policy 6F, “Non-Physician Practitioner Requirements”).
    - a. PAs must provide one (1) on the following:
      - 1) Delegation of Services Agreement and Supervising Physician Form (See Attachment, “Delegation of Services Agreement and Supervising Physician Form” in Section 5).<sup>7</sup> This agreement must:
        - Define specific services identified in practice protocols or specifically authorized by the supervising Physician., and
        - Both the Physician and PA must attest to, date and sign the document.
        - An original or copy must be readily accessible at all practice sites in which the PA works;
      - 2) Practice Agreement, effective January 1, 2020,<sup>8</sup> the writing, developed through

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<sup>6</sup> Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006 Supersedes Policy Letters 14-004 and 03-002 and All Plan Letter 03-007, “Site Reviews: Facility Site Review and Medical Record Review”

<sup>7</sup> Title 16 California Code of Regulations (CCR) § 1399.540(b)

<sup>8</sup> Senate Bill 697

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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collaboration among one or more physicians and surgeons and one or more physicians' assistants, that defines the medical services the PA is authorized to perform pursuant to Section 3502<sup>9</sup> and that grants approval for Physicians and Surgeons on the staff of an organized health care system to supervise one or more PAs in the organized health care system. Any reference to a Delegation of Services Agreement relating to PAs in any other law shall have the same meaning as a practice agreement. The Practice Agreement must include provisions that address the following:

- A practice agreement shall include provisions that address the following:<sup>10</sup>
  - The types of medical services a PA is authorized to perform.
  - Policies and procedures to ensure adequate supervision of the PA, including, but not limited to, appropriate communication, availability, consultations, and referrals between a Physician and Surgeon and the PA in the provision of medical services.
  - The methods for the continuing evaluation of the competency and qualifications of the PA.
  - The furnishing or ordering of drugs or devices by a PA.<sup>11</sup>
  - Any additional provisions agreed to by the physician assistant and Physician and Surgeon.
- A practice agreement shall be signed by both of the following:
  - The PA.
  - One or more Physicians and Surgeons or a Physician and Surgeon who is authorized to approve the practice agreement on behalf of the staff of the Physicians and Surgeons on the staff of an organized health care system.
- A delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.
- A practice agreement may designate a PA as an agent of a supervising physician and surgeon.
- Nothing in this section shall be construed to require approval of a practice agreement by the board.

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<sup>9</sup> Business and Professions Code § 3502

<sup>10</sup> Bus. and Prof. Code § 3502.3

<sup>11</sup> Bus. & Prof. Code § 3502.1

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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- Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California, a practice agreement may authorize a PA to do any of the following:
  - Order durable medical equipment, subject to any limitations set forth in Section 3502 or the practice agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.
  - For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.
  - After performance of a physical examination by the PA under the supervision of a physician and surgeon consistent with this chapter, certify disability pursuant to Section 2708 of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.
- b. NPs and CNMs may perform the following procedures if a standardized procedure is in place:
  - 1) To diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissue of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions.
  - 2) Standardized Procedures must be on-site site specific and<sup>12</sup>
    - Reference textbooks and other written sources to meet the requirements of Title 16, CCR § 1474 (3), must include:
      - Book (specify edition) or article title, page numbers and sections.
    - NP and/or NM must be practicing at a site assigned to their supervising physician; and
    - Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the Delegate must collect and submit to IEHP:
      - Table of Contents of the Standardized Procedures used, between the

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<sup>12</sup> Title 22 California Code of Regulations (CCR) § 1474 (3)

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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- NP and/or CNM and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
- Evidence that the Standards of Care established by the sources were reviewed and authorized by the NP, Physician and administrator in the practice setting (i.e., signature page that includes all parties involved).
  - Standardized Procedures written using the PAs Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.
4. Practitioner Terminations. Delegates must provide IEHP sixty (60) calendar days advance notice of any significant change in their network, including the termination of a Practitioner.<sup>13</sup>
- a. All Delegates are required to notify IEHP of any adverse actions against any of their contracted Practitioners.
- E. Delegates must provide IEHP with a status report of their specialty network on a semi-annual basis during Provider Directory review.<sup>14</sup>
1. On a semi-annual basis, IEHP provides Delegates with the Specialty and Extender Roster information via online verification reports on the Secure Provider Portal including admitter and ancillary Providers previously submitted by the Delegate to IEHP that identifies the Delegate's current Provider Network that includes:
    - a. Provider name
    - b. Address (Address, City, and ZIP)
    - c. Phone/Fax number
    - d. Specialty
  2. Delegates must indicate for each specialist listed, as applicable, the following:
    - a. "New Hospital Privileges" – provided to indicate the Practitioner is adding new privileges with an IEHP network Hospital. Indicate Name of Hospital and privileges (active, courtesy, etc.).
    - b. "New Hospital Link" – provided to indicate which network Hospital will be added to Practitioner.
    - c. "Information is correct" – provided to specify information is correct and no changes

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<sup>13</sup> Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Supersedes APL 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"

<sup>14</sup> NCQA, 2022 HP Standards and Guidelines, CR 8, Element A, Factor 3

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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are required.

- d. “Provider Term Date” – provided to indicate the Practitioner is no longer part of the IPA’s specialty network. Provide effective date of termination.
  - e. “Term This Site Only” – provided to indicate the Practitioner is no longer at this location only. Provide effective date of location closure. Provide IEHP additional details on a separate sheet, if further review is required (i.e. provider is relocating, this site is the providers only existing location with IEHP and needs to add a different location.”
  - f. “Updated information” – provided to specify new addresses, a typo, or any other changes to the information provided on the secure Provider Portal.
3. IEHP makes the indicated changes that will be reflected on the IPA’s roster.
    - a. Delegates are required to update all information online and advise of completion to their Provider Service Representative within thirty (30) days of receipt. The online verification reports are made available in IEHP’s secure portal.
- F. IPAs are responsible for reviewing, maintaining and notifying IEHP of any changes to their Hospital admitting arrangements for each of their affiliated links, through the following process:
1. The Delegation Oversight Analyst emails all Delegates on the 15<sup>th</sup> of each month for verification of all Admitter Arrangements to ensure accurate information is obtained.
  2. IPAs are responsible for the following:
    - a. Ensuring all providers listed with the correct Admitting Provider.
    - a. If there are changes, the IPAs are responsible for notifying the Provider of the changes and of their current admitter arrangements for each respective hospital
    - b. For the Admitting Providers, the IPA confirms admitting privileges to the Hospitals they are admitting to, are in place and in good standing.
      - 1) The IPA is responsible for providing a replacement. If not, the Provider will be terminated from the IPA’s network for not having Hospital admitting arrangements, and;
    - c. The IPA is responsible for reviewing the Specialist Providers and reconfirming their Hospital arrangements, to ensure that the Admitting Provider is:
      - 1) Within the same specialty;
      - 2) Cover the same age range;
      - 3) Within the same practice; and
      - 4) Active within the same IPA network as the referring Physician.

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## 25. DELEGATION AND OVERSIGHT

### B. Credentialing Standards

#### 10. Credentialing Quality Oversight of Delegates

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- d. Ensuring all Providers on the report are still active with the IPA.
  - e. Any changes from the IPAs must be submitted by the 25<sup>th</sup> of every month, via Secure File Transfer Protocol (SFTP) server.
    - 1) The IPAs failure to respond by the 25<sup>th</sup> of each respective month will result in non-compliance and may result in a corrective action plan on monthly delegation reporting.
- G. On the last day of the month all network Hospitals are emailed the final Admitter list for that month. It includes Admitter's name, phone number and fax number for each Provider who utilizes a Hospital Admitter.

<b>INLAND EMPIRE HEALTH PLAN</b>		
<b>Chief Approval:</b> <i>Signature on File</i>	<b>Original Effective Date:</b>	January 1, 2020
<b>Chief Title:</b> Chief Operating Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION AND OVERSIGHT

- C. Care Management -
    - 1. Delegation and Monitoring
- 

### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice Members.

### **POLICY:**

- A. IEHP delegates to its IPAs and their Provider network the responsibility of providing case management services and coordination of care for their assigned Members. This includes but is not limited to ensuring the coordination of medically necessary health care services delivered within and outside their network, provision of preventive services in accordance with established standards, continuity of care, health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
- B. IEHP maintains the responsibility of ensuring that Delegates continues to be, in compliance with all applicable State and federal laws, contractual and reporting requirements.
- C. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated care management activities.<sup>1</sup> Oversight includes monitoring the IPAs' care management activities monthly, quarterly, annually, and as frequently as needed.

### **PROCEDURES:**

#### **Delegated Responsibilities**

##### *Care Management Program*

- A. IPAs will develop a care management program that includes:
  - 1. Evidence used to develop the program;
  - 2. Process for identifying Members who are eligible for the program;
  - 3. Stratification levels for the care management program;
  - 4. Frequency of care management contact for each care management stratification level;
  - 5. Defined program goals;
  - 6. How the IPA will evaluate the effectiveness of their care management program; and
  - 7. A process to evaluate Member satisfaction with the IPAs care management program.
- B. All IEHP DualChoice Members are required to be enrolled in a care management program, unless they choose to opt-out. IPAs are required to have a process where they offer care management to all Members and reassess at least annually or when there is a change in

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<sup>1</sup> Title 28 California Code of Regulations (CCR) § 1300.70

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## 25. DELEGATION AND OVERSIGHT

### C. Care Management - 1. Delegation and Monitoring

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Member's condition.

- C. IPAs are responsible for coordinating care with Long-Term Services and Supports (LTSS) programs, which includes Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS), and Community-Based Adult Services (CBAS). This also includes coordinating care with county behavioral health clinics for Members who are receiving specialty mental health services.
- D. IPA Care Management (CM) staff must include non-restricted California licensed medical personnel including but not limited to Registered Nurses, Licensed Vocational Nurses, Licensed Clinical Social Workers or master's level Social Workers. Members must be assigned to CM staff with the appropriate experience and qualifications based on the Member's assigned risk level and individual needs.
- E. IPAs will maintain policies and procedures for how they support Members with complex conditions that include:
  - 1. Complex case management (CCM) criteria/triggers that are relevant to their Member population;
  - 2. The process to determine timeframes for re-contact or reassessment at least annually or more frequently as health status changes; and
  - 3. Other relevant details of the program.
- F. IPAs will establish the frequency of their care management interventions based on their written policies and care management program description, as well as the Member's identified goals, issues, barriers, and risks. IPA Care Manager interventions include:
  - 1. Ensuring continuity of care as appropriate;
  - 2. Focus on providing services in the least restrictive setting;
  - 3. Following up on Member referrals;
  - 4. Identifying the needs for LTSS services, appropriate community-based resources such as housing/utilities, meals etc.;
  - 5. Identifying the need for behavioral health services;
  - 6. Assisting with the coordination of care across all settings;
  - 7. Determining timeframes for re-contact or reassessment as stated in the IPA's program description and policies as well as determined by the health status of the Member;
  - 8. Ensuring the PCP and other Members of the care team are updated on the Member's health status; and



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## 25. DELEGATION AND OVERSIGHT

### C. Care Management - 1. Delegation and Monitoring

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9. For Members receiving specialty mental health services through the County Behavioral/Mental Health Departments:<sup>2</sup>
  - a. Communicating with county behavioral health clinics to discuss diagnoses (medical, behavioral, and social needs), review treatment plans, and/or coordinate mental health services provided by the county with other services such as medical, LTSS, CBAS, MSSP, IHSS, etc.; and
  - b. Communicating with the Member to discuss their behavioral health needs and services and how these services may be coordinated with other services such as medical, LTSS, CBAS, MSSP, IHSS, etc.
  - c. Communicating with IEHP, County BH Provider and PCP for review and approval of ICP, Please see Policies 12A2, “Care Management Requirements – Health Risk Assessment,” 12A3, “Care Management Requirements – Individualized Care Plan,” and 12A4, “Care Management Requirements – Interdisciplinary Care Team,” for more information on these delegated responsibilities.

#### Data Sharing

- A. IEHP transfers to another health plan all information necessary to support continuity of care when the Member disenrolls from the health plan. This information includes, but is not limited to: assessment, ICP, and other pertinent information. IEHP provides the information to the Member’s new health plan no later than thirty (30) calendar days from receipt of the notice of disenrollment to IEHP and no later than the effective date of transfer in the method and format specified by the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS).
- B. In order to provide the information within this timeframe, IPAs must provide to IEHP the Member’s ICP and ICT information within fourteen (14) business days of IEHP’s request.

#### Monitoring and Oversight

- A. IEHP performs monitoring and oversight of the IPAs’ care management activities through the review of care management report logs and files monthly, annually and as needed.
- B. On a routine basis and utilizing the IPA Care Management Review Tools, IEHP reviews the IPA’s care coordination/care management activities for elements which may include, but are not limited to, the following (See Attachment, “IPA Care Management Review Tool - Medicare” in Section 25):<sup>3</sup>
  1. A process for offering care management to all Members;
  2. A person-centered, outcome-based approach;

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<sup>2</sup> DHCS Cal AIM Dual Eligible Special Needs Plans Policy Guide August 2022, Section VI. Quality and Reporting Requirements

<sup>3</sup>DHCS Cal AIM Dual Eligible Special Needs Plans Policy Guide August 2022, Section VI. Quality and Reporting Requirements

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## 25. DELEGATION AND OVERSIGHT

### C. Care Management -

#### 1. Delegation and Monitoring

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3. Spanning medical and LTSS systems, including coordination with IHSS, with a focus on transitions;
  4. Coordination with county agencies and IEHP, if applicable, for Behavioral Health services;
  5. Development of ICPs with Members;
  6. Stratification levels for the care management program and appropriate stratification of Members;
  7. A process for ICT meetings; and
  8. Frequency of care management contact for each care management stratification level.
- C. IEHP selects and reviews, at a minimum, ten (10) targeted cases each month to ensure that care management requirements are met. Additional files may be selected depending on population size.
- D. IEHP provides education and training on care coordination annually, per IPA request and as needs are identified through oversight activities.
- E. Upon request, the IPA must submit a complete and comprehensive Corrective Action Plan (CAP) to IEHP that adequately addresses all deficiencies noted on the audit tool. See Policy 25A3, “Delegation Oversight – Corrective Action Plan Requirements” for more information.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	July 1, 2012
<b>Chief Title:</b> Chief Medical Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION AND OVERSIGHT

- C. Care Management
    - 2. Reporting Requirements
- 

### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice Members.

### **POLICY:**

- A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable state and federal laws, as well as all contractual and reporting requirements.
- B. IEHP oversees, monitors, and evaluates the performance of delegated and non-delegated care management activities.<sup>1</sup> Oversight activities include, but are not limited to, reviewing reports submitted by the IPAs, as described below.

### **PROCEDURES:**

- A. All reports must be submitted to IEHP timely and in the correct format via IEHP's Secure File Transfer Protocol (SFTP) (see Attachment, "Medicare Provider Reporting Requirements Schedule" in Section 25). Files not submitted in the correct format will be rejected, and the IPA will be required to resubmit in the appropriate format.
- B. Each IPA must submit the information noted in the monthly Medicare Care Management logs (see Attachments, "Monthly Medicare Care Management Log," "Monthly Medicare Care Plan Outreach Log," and "Monthly Medicare Interdisciplinary Team Log," in Section 25). These logs are to include all Members, including those that the IPA are unable to contact, those enrolled into care management, Interdisciplinary Care Team (ICT) enrollment, and Long-Term Services and Supports (LTSS) services, as well as those that decline to participate.
- C. IEHP will select cases from various data sources for monthly file review. IPAs will be provided with file selections by the 1<sup>st</sup> business day of the month for submission via the SFTP by the 15th day of the same month.
- D. Repeated failure to submit required reports timely and in the right format may result in the request of a Corrective Action Plan (CAP), freezing of new Member enrollment or termination or non-renewal of the IEHP Agreement. Upon request, the IPA must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies noted on the audit tool. See Policy 25A3, "Delegation Oversight – Corrective Action Plan Requirements" for more information.

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<sup>1</sup> Title 28 California Code of Regulations (CCR) § 1300.70

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## 25. DELEGATION AND OVERSIGHT

- C. Care Management
    - 2. Reporting Requirements
- 

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## 25. DELEGATION AND OVERSIGHT

### D. Quality Management

#### 1. Quality Management Reporting Requirements

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##### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice Delegates contracted to maintain and/or provide Quality Management (QM) programs, and activities.

##### **POLICY:**

- A. IEHP maintains the responsibility of ensuring that Delegates continue maintain compliance with all applicable State and federal laws, contractual and reporting requirements.<sup>1</sup>
- B. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated quality improvement (QI) activities.<sup>2</sup> Oversight activities include but are not limited to the review of semi-annual and annual reports.

##### **DEFINITION:**

- A. Delegate - A medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medicare eligible IEHP Member.

##### **PROCEDURES:**

#### A. Semi-Annual Reporting Requirements:

1. Reporting requirements include a QM semi-annual assessment, which documents the progress of the QM, QI and Utilization Management (UM) activities found in the QM Work Plan.
  - a. **Quality Management** – Reports must identify and address the following:
    - 1) Quality of Clinical Care;
    - 2) Quality of Service;
    - 3) Safety of Clinical Care;
    - 4) Members' Experience;
    - 5) Program Scope;
    - 6) Yearly Objectives;
    - 7) Yearly Planned Activities;

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<sup>1</sup> Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, "Subcontractual Relationships and Delegation"

<sup>2</sup> Title 28 California Code of Regulations (CCR) § 1300.70

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## 25. DELEGATION AND OVERSIGHT

### D. Quality Management

#### 1. Quality Management Reporting Requirements

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- 8) Timeframe within which each activity is to be achieved;
  - 9) Staff member(s) responsible for each activity;
  - 10) Monitoring of previously identified issues; and
  - 11) Evaluation of the QM/QI program.
2. QM Semi-Annual Reports must be submitted to IEHP via IEHP's Secure File Transfer Protocol (SFTP) by these due dates, regardless of whether these dates fall on a weekend or holiday:
    - a. 1<sup>st</sup> Semi-Annual report covers period from January 1<sup>st</sup> through June 30<sup>th</sup> and must be submitted by August 15<sup>th</sup>; and
    - b. 2<sup>nd</sup> Semi-Annual report covers period from July 1<sup>st</sup> through December 31<sup>st</sup> and must be submitted by February 15<sup>th</sup>.
  3. Failure to submit required reports may result in actions that include, but are not limited to, request for Corrective Action Plan (CAP), being frozen to new Member assignment, or termination or non-renewal of the IEHP Agreement. See Policy 25A3 "Delegation Oversight - Corrective Action Plan Requirements."
- B. Annual Reporting Requirements:** The following reports must be submitted annually to IEHP via IEHP's SFTP no later than the 15<sup>th</sup> of February each calendar year regardless of whether this date falls on a weekend or holiday:
1. **Quality Management<sup>3</sup>**
    - a. **Quality Management Program Description:** Reassessment of the QM Program Description must be done on an annual basis by the QM Committee and reported to IEHP. The following must be included with the submission to IEHP:
      - 1) Any changes made to the QM Program Description during the past year or intended changes identified during the annual evaluation; and
      - 2) Signature page noting date of committee approval.
    - b. **Quality Management Work Plan:** Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include planned audits, follow-up activities and interventions related to identified problem areas.
    - c. **Quality Management Program Annual Evaluation:** The evaluation should include a description, trending, barrier analysis and evaluation of the overall effectiveness of the QM Program. Please see Policy 25D2, "Quality Management - Quality Management Program Structure Requirements," for more information.
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## 25. DELEGATION AND OVERSIGHT

### D. Quality Management

#### 1. Quality Management Reporting Requirements

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C. IEHP's Quality Management Department monitoring, and oversight duties include:

1. Review of all monthly, semi-annual, and annual Delegate reports for tracking and trending levels of activity; comparison to other Delegates, variances compared to other Delegates and other significant data issues. Reports include but are not limited to those listed above.
2. Review and approval of the semi-annual and annual reports submitted by the Delegates (e.g., QM Program Description and Work Plan).

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## 25. DELEGATION AND OVERSIGHT

### D. Quality Management

#### 2. Quality Management Program Structure Requirements

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##### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice Delegates contracted to maintain and/or provide Quality Management (QM) programs, and activities.

##### **POLICY:**

- A. IEHP is accountable for all quality improvement functions and responsibilities that are delegated, and maintains the responsibility of ensuring that Delegates maintain compliance with all applicable State and Federal laws, contractual and reporting requirements.<sup>1</sup>
- B. Delegates are required to have a Quality Management (QM) Program per their Delegation Agreement with IEHP and as outlined in the IEHP Provider Manual (See Attachment, “IPA Delegation Agreement – IEHP DualChoice” in Section 25). IEHP monitors Delegates’ QM Program Structure and implementation of quality management activities to ensure the delegate is continuously monitoring and improving the quality of care, access to care, service and patient safety delivered to IEHP Members.
- C. Delegates must maintain a written QM Program Description, QM Work Plan, Annual QM Evaluation, and related QM Policies and Procedures that meet Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA) and IEHP standards for Quality Management.

##### **DEFINITION:**

- A. Delegate- A medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medicare eligible IEHP Member.

##### **PROCEDURES:**

- A. **QM Program Requirements** – Delegates’ QM Program must consist of the following:

1. **Quality Management**

- a. **Quality Structure** – Delegates are required to have a structure in place that monitors quality activities, including a formal Committee structure and sufficient personnel in place to perform quality management activities.
- b. **Quality Studies** – Delegates are required to perform a minimum of two (2) quality studies for their Membership per calendar year. One (1) study must be in the area of access; the other study should be an area pertinent to the Delegate, IEHP Membership served by the Delegate, and quality issues identified by the Delegate. Study results

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<sup>1</sup> Medicare Managed Care Manual, “Chapter 11 – Medicare Advantage Application Procedures and Contract Requirements” Section 110.2



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## 25. DELEGATION AND OVERSIGHT

### D. Quality Management

#### 2. Quality Management Program Structure Requirements

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must be made available to Primary Care Providers (PCPs) and IEHP Members upon request. IEHP has the right to mandate the type of access study required if IEHP has identified quality or access issues.

- c. **Peer Review** – Delegates must perform peer review. All Delegates are required to have a Peer Review Committee made up of Physicians and representatives of the network that provides peer review of any Practitioner noted to have potential quality issues. The Delegates' Peer Review Committees are responsible for reviewing Provider, Member, or Practitioner grievances and/or appeals, Practitioner-related quality issues and other peer review matters. Should a significant practitioner problem or quality issue arise that cannot be resolved at this level, the Delegate's QM Committee may refer the issue to the IEHP Peer Review Subcommittee for resolution. In addition, the Delegate's Peer Review Committee performs oversight of the Credentialing Program and activities, grievance and appeals processes with recommendations for modification as necessary. Data utilized to identify candidates for peer review include quality studies by IEHP or the Delegate, grievances received by the Delegate or IEHP, utilization and/or encounter data, and other data sources.
  - d. **Clinical Data** – IEHP provides Member experience and clinical performance data to all Delegates in order for them to conduct quality studies and perform all delegated functions. This data will be provided upon request from the Delegate or as both parties agree to specific quality studies where IEHP has the necessary data. In addition, all Delegates are free to collect their own clinical and Member experience data to support Quality Improvement (QI) initiatives.
2. **Utilization Management (UM)** – IEHP delegates the utilization management process to those Delegates that have sufficient administrative capacity, with accompanying policies and procedures, to meet all IEHP, DHCS, CMS, and NCQA standards for utilization management activities. Refer to Section 14, "Utilization Management" and see Policy 25E1, "Utilization Management - Delegation and Monitoring," for more information.
  3. **Credentialing/Recredentialing** – IEHP may delegate the responsibility for credentialing and recredentialing of participating Practitioners, as identified in Section 25, "Delegation and Oversight." This includes a signed attestation by the Delegate's Medical Director that states all Practitioner-required reviews were conducted. IEHP's Chief Medical Officer, Chief Quality Officer and/or Medical Director designee review all Providers (PCPs and Specialists) individually for quality-related issues prior to assignment of Members. The IEHP Peer Review Subcommittee performs peer review on Practitioners and Providers identified through the Ongoing Monitoring of Sanctions process conducted by Credentialing and those Practitioners referred by the Chief Medical Officer, Chief Quality Officer, or Medical Director for potential quality of care concerns. IEHP also performs Credentialing/Recredentialing functions for those Practitioners that are directly contracted with IEHP.

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4. **Care Management (CM)** – IEHP delegates care management for Members including case finding, assessment of needs and care coordination, referral to outside agencies, and all other necessary care management activities. Refer to Section 12, “Coordination of Care” and see Policy 25C1, “Care Management – Delegation and Monitoring,” for more information.
5. **Practitioner Education<sup>2</sup>** – Delegates and IEHP share Provider education and training responsibilities including orientation to IEHP DualChoice line of business, delineation of IEHP policies and procedures pertinent to the Practitioner, site and medical record audit preparation, specialized support, and training such as pediatric or adult preventive services and health education.
  - a. Delegates are also required to be aware and require their Practitioners’ use of certain forms, supplied by IEHP on the Provider website, including the Perinatal Risk Assessment Forms, Individual Health Education Behavioral Assessment (IHEBA) forms, etc. IEHP forms are available online at [www.iehp.org](http://www.iehp.org).
6. **Health Education** – IEHP notifies the Delegate’s CM department for the purpose of individualized care management and referral to appropriate health education programs. IEHP works collaboratively with Providers and Practitioners to identify and educate these Members. IEHP provides certain network-wide health education programs to all Members. IEHP supplies Delegates and PCPs with health education brochures, materials, forms and a Provider Resource Directory. Refer to Section 15, “Health Education” for more information.
7. **Medical Records Maintenance** – IEHP and Delegates are required to monitor Physician offices for compliance with medical record requirements. Practitioners are required to maintain policies and procedures consistent with IEHP requirements, see policy 7A, “Provider and Delegated IPA Medical Records Requirements.”
8. **Preventive Care and Non-Preventive Care Guidelines** – Practice guidelines are developed by IEHP using current published literature, current practice standards, and expert opinions. They are based upon specific medical issues commonly found within IEHP’s Membership. Delegates are expected to monitor Practitioner’s care related to clinical practice guidelines as applicable.
9. **Access Standards<sup>3</sup>** – Delegates are required to adhere to IEHP standards for availability and accessibility of services, see policy 9A, “Access Standards.” IEHP ensures network compliance with the standards for appointment availability, after-hours access, Practitioner office wait time, Physician site hours, emergency service availability, medical triage both during and after hours, proximity of Specialists and Hospitals, and

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### D. Quality Management

#### 2. Quality Management Program Structure Requirements

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follow-up care through studies and audits. The Delegate is required to perform access studies on their Practitioners to ensure they meet IEHP requirements.

- B. **Pre-Delegation Audit** - To ensure that newly contracted Delegates have the capacity and capability to perform required functions and meet regulatory requirements, IEHP performs pre-delegation audit within twelve (12) months prior to implementing delegation activities using an audit tool that reflects current NCQA, DHCS, and IEHP standards.<sup>4</sup>

### C. Annual Quality Management Program Description

1. Contracted Delegates must have a written QM Program Description that is reviewed at least annually and describes the structure of the Delegate's QM Program. This program must include the following:
  - a. QM Program goals, objectives, and structure;
  - b. Accountability to the Delegate's Governing Body;
  - c. Designated Physician involvement in the QM Program;
  - d. Patient Safety;
  - e. Member Experience;
  - f. Description of behavioral health care aspects of the program, as applicable;
  - g. Description of behavioral health care Practitioner involvement in behavioral health care aspects of the program; as applicable;
  - h. Description of QM Committee oversight of quality management functions;
  - i. Role, structure and function of the QM Committee and related Subcommittees including meeting frequency;
  - j. An annual work plan;
  - k. Description of the resources that devote time and staff dedicated to meeting the objectives of the QM Program (i.e., employees, consultants, data sources, and analytic resources such as statistical persons and/or programs);
  - l. Objectives for serving a culturally and linguistically diverse membership; and
  - m. Objectives for serving Members with complex health needs and Seniors and Persons with Disabilities (SPD).
2. The Delegate must document all resources devoted to the QM Program, not merely the QM Program staff. Documentation must indicate the planned number and type of quality management activities to ensure activities are completed in a competent and timely manner.

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### **D. Quality Management**

#### **2. Quality Management Program Structure Requirements**

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3. The Delegate must have access to, and the ability to manage, the data supporting measurement of quality management activities documented in the QM Work Plan.
4. There must be evidence of the Board of Directors' review and approval of the QM Program Description on an annual basis.
5. The Delegate's QM Program Description must outline their approach to address Members with complex needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions, and severe mental illness.

### **D. Quality Management Work Plan**

1. The QM Work Plan must be a separate document included in the QM Program Description. The Work Plan must document the QM activities scheduled for the calendar year with a brief explanation of timing and party responsible for the activity. The Work Plan must include the following:
  - a. Yearly planned QI activities and objectives for improving;
    - 1) Quality of clinical care;
    - 2) Quality of service;
    - 3) Safety of clinical care; and
    - 4) Members' experience.
  - b. Program scope;
  - c. Timeframe for each activity's completion;
  - d. Staff members responsible for each activity;
  - e. Monitoring of previously identified issues; and
  - f. Evaluation of the QM Program.
2. The Work Plan must be submitted to IEHP. Please see policy 25D1, "Quality Management - Quality Management Reporting Requirements" for information on schedule and method of submission.

### **E. Quality Management Semi-Annual Reports**

1. The Delegate's QM Semi-Annual Reports document the progress of the QM activities found in the QM Work Plan and assist the Delegate in its development of the QM annual evaluation.
2. The QM Semi-Annual Report must include:
  - a. Component/Activity;
    - 1) Clinical Improvement;
    - 2) Continuity and Coordination of Care;

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#### 2. Quality Management Program Structure Requirements

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- General Medical Care
  - General Medical and Behavioral Health
- 3) Access;
  - 4) Experience Improvement;
  - 5) Patient Safety; and
  - 6) Other QI Activities.
- b. Each Component must include:
    - 1) Objectives;
    - 2) Activities planned;
    - 3) Responsible person for each activity; and
    - 4) Timeframe within which each activity is to be completed.
  - c. Semi-annually, the Delegate must include a description of the following areas for each separate component:
    - 1) Reporting Period;
    - 2) Key findings;
    - 3) Interventions taken;
    - 4) Analysis of findings along with progress; and
    - 5) Any follow-up actions.
3. QM Semi-Annual Reports must be submitted to IEHP. Please see policy 25D1, “Quality Management - Quality Management Reporting Requirements” for information on schedule and method of submission.

### F. QM Program Annual Evaluation

1. The QM Annual Evaluation may be included in the QM Work Plan or be a separate document. The Annual Evaluation must evaluate the Delegate’s performance on planned QM Activities described in its QM Program Description and Work Plan, including all delegated activities. The Annual Evaluation must include the following:
  - a. A description of completed and ongoing QM and QI activities that address quality and safety of clinical care and quality of service;
  - b. Trending of measures to assess performance in the quality and safety of clinical care and quality of service;
  - c. Analysis of the results of QM and QI initiatives, including barrier analysis; and

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### D. Quality Management

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- d. Analysis and evaluation of the overall effectiveness of the QM program and of its progress toward influencing network-wide safe clinical practices.
  2. The QM Annual Evaluation must be submitted to IEHP. See policy 25D1, “Quality Management - Quality Management Reporting Requirements” for more information on schedule and method of submission.
- G. **QM Reporting Requirements** - Delegates are required to report the following information on a periodic basis. See Policy 25D1, “Quality Management - Quality Management Reporting Requirements,” for more information on these reporting requirements:
1. QM Program Description;
  2. QM Work Plan;
  3. QM Semi-Annual Reports of quality improvement activities; and
  4. QM Program Annual Evaluation; and
  5. Quality Studies performed by the Delegate when appropriate or as requested by IEHP.
- H. **Quality Management Committee**<sup>5</sup>
1. The QM Committee is an interdisciplinary committee with participation from the Delegate’s appointed Practitioners who represent network Physicians. The Delegate’s QM Committee is responsible for monitoring, measuring, and evaluating the quality, effectiveness, safety, coordination and appropriateness of the care provided by Practitioners to Members for the purpose of continued quality improvement.
  2. The Delegate’s description of the QM Committee must include the following:
    - a. Role;
    - b. Function;
    - c. Structure that includes organizational structure and reporting responsibility;
    - d. Membership;
    - e. Terms of service;
    - f. Voting rights;
    - g. Quorum definition;
    - h. Meeting frequency;
    - i. Minute format and storage; and
    - j. Committees associated with oversight of delegated activities.
  3. The Delegate’s description of the QM Committee must its involvement and oversight of
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the following activities:

- a. Recommending policy decisions;
  - b. Analyzing and evaluating QM Activity findings;
  - c. Ensuring Practitioners' participation in the QM Program through planning, design and implementation or review;
  - d. Implementing needed actions;
  - e. Ensuring needed follow-up; and
  - f. Maintain signed and dated meeting minutes.
4. The Delegate's QM Committee must meet at least quarterly and follow a prescribed agenda.
  5. The Delegate's QM Committee discussions, conclusions, recommendations, and actions must be documented in the signed Committee minutes.
- I. **Confidentiality** - Providers must fully comply with all State, Federal and IEHP regulatory requirements pertaining to confidentiality, privacy and information disclosure of medical records. See Policy 7B "Information Disclosure and Confidentiality of Medical Records."
1. **Medical Records Release** – Medical records contain confidential information that must not be released to any party other than the Member's Primary Care Provider (PCP) without the expressed written consent of the Member or legal representative. The PCP must maintain procedures for obtaining such written consent prior to release of records. See Policy 7B, "Information Disclosure and Confidentiality of Medical Records," for more information.
  2. **Members' Right to Confidentiality** – Members have the right to confidentiality of medical information.<sup>6</sup> All Provider contracts and subcontracts include the provision to safeguard the confidentiality of Member health records and treatment in accordance with applicable state and federal laws. Release of Member medical information may be necessary to protect the health of the Member and/or for coordination of services between Practitioners, Specialists, or other health care Providers of service. See Policy 7B, "Information Disclosure and Confidentiality of Medical Records" for more information.
  3. **Education of PCP Staff Regarding Confidentiality Issues** – Delegates must educate Providers and associated staff regarding confidentiality issues. Signed confidentiality statements are required for participation in the IEHP Practitioner network and monitored as part of the facility site review process. Referral or access to sensitive services requires the maintenance of high standards of confidentiality. Members requiring family planning services, treatment for sexually transmitted diseases, abortion information and/or treatment, and Human Immunodeficiency Virus (HIV) testing or are requesting assistance

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with highly sensitive issues, must be treated with respect and consideration for confidentiality. See Policy 9D, “Access to Services with Special Arrangements.”

4. **Conflict of Interest**<sup>7</sup> – Should an issue arise involving care provided by a Physician member of the QM Committee or any Subcommittee, that Physician is replaced by a substitute until the issue is resolved. The Member involved in the issue has all rights normally given to anyone with a case presented to the Committee or Subcommittee. Committee members are required to sign a confidentiality and conflict of interest statement.
5. **Informed Consent for Treatment** – Practitioners must obtain appropriate written consent for treatment prior to actual procedure performance. See Policy 7C, “Informed Consent,” for more information.

### J. Provider Participation

1. **Provider Information** – Delegates are required to inform network Practitioners of guidelines, policy and procedure changes, and other important information. Delegates’ methods of Practitioner education or notification are evaluated annually during Delegation Oversight Audits. Providers are informed of policy and procedure changes and other important information through the IEHP Provider Newsletter, letters, memorandums, distribution of updates to the Provider Manual, and training sessions. Delegates are notified through letters, memorandums, Provider Manual updates, training sessions for specific issues, Joint Operations Meetings, and by attending IEHP University, when available.
2. **Provider Cooperation:** IEHP requires that Delegates and Hospitals cooperate with IEHP QM Program studies, audits, monitoring, and quality related activities. Requirements for cooperation are included in Hospital and Delegate Provider contract language that describes contractual agreements for access to information.

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

1. Delegate and Provider Agreements include the following provisions:
  - a. Delegate is subject to, and agrees to participate in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievance and/or appeal resolution.
  - b. Delegate shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records, financial records pertaining to the cost of operations and income received by Delegate for



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medical services rendered to Members. Delegate shall ensure that Providers allow IEHP to access and use Provider performance data.

- c. Delegate shall cooperate with IEHP's QM Program and, upon reasonable request, shall provide IEHP with summaries of or access to records maintained by Delegate and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.
- d. Delegate shall not impede open Practitioner-patient communication. Members are allowed to participate with doctors in decision-making about their own health care including the ability to talk with their doctor about their medical condition regardless of cost or benefit.

#### 2. Hospital contracts include provisions for the following:

- a. Hospital agrees to participate with IEHP in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievances and resolution. Hospital shall also provide access to IEHP utilization review and case management personnel for the purpose of conducting concurrent review and case management on Members who are receiving Hospital services.
- b. Hospital shall implement an ongoing QM Program and shall develop procedures for ensuring that the quality of care provided by Hospital conforms with generally accepted Hospital practices prevailing in the managed care industry. Hospital shall develop written procedures for remedial action whenever, as determined by the QM Program, inappropriate or substandard services have been furnished, or services that should have been furnished have not been furnished.
- c. Hospital shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records and financial records pertaining to the cost of operations and income received by Hospital with a five (5) working day prior written notice of any such inspection. Hospital shall ensure that Providers allow IEHP to access and use Provider performance data.
- d. Hospital shall cooperate with IEHP's QM Program and, upon reasonable request, provide IEHP with summaries of or access to records maintained by Hospital and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.

#### L. **Auditing and Monitoring Activities**<sup>8</sup> - IEHP performs a series of activities to monitor Delegate functions including the following:

- 1. **Delegation Oversight Audit** – IEHP performs an annual Delegation Oversight Audit of all contracted Delegates using an audit tool that is based upon current CMS, DHCS,

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## 25. DELEGATION AND OVERSIGHT

### D. Quality Management

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NCQA and IEHP standards. This audit assesses Delegate’s operational capabilities in the areas of QM, QI, Credentialing, UM, CM, and Compliance. See Policy 25A2, “Delegation Oversight – Audit,” for more information.

2. **Joint Operations Meetings (JOMs)** - JOMs with Delegates are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities that the Delegates are required to perform. JOMs may address specific UM, QM, QI, CM, grievance, study results, or any other pertinent quality issues.
3. **Member or Practitioner Grievance Review** - IEHP reviews individual grievances and their resolutions for Delegate policies or procedures, actions, or behaviors that could potentially negatively impact health care delivery or Member health status.
4. **Specified Audits** - IEHP performs specific audits of Delegates and PCPs to assess compliance with IEHP standards. These audits include facility reviews, claims audits, CM audits, and health education audits.
5. **Focused Audits** - IEHP performs focused audits of Delegates or Practitioners as indicated whenever a quality or clinical issue is identified.
6. **Review of Referral Universes** - All Delegates are required to submit monthly referral universes to IEHP as well as denial letters sent to Members. All denials are reviewed for appropriateness and trends or patterns of concern. See Policy 25E2, “Utilization Management Reporting Requirements” for complete information on UM reporting requirements.
7. **Review of CM Logs and Case Files** - All Delegates are required to submit monthly CM Logs to IEHP listing all CM cases from the previous month. In addition, Delegates are required to submit copies of CM files. All files are reviewed for appropriateness and trends or patterns of concern. See Policy 25C2, “Care Management - Reporting Requirements” for complete information on CM reporting requirements.
8. **Delegated Reporting Requirements Review** - IEHP performs review of scheduled submitted reports as defined in the IPA Reporting Requirements Schedule (See Attachment, “IPA Reporting Requirements Schedule – Medicare” in Section 25), and delegated activities as defined in the Delegation Agreement (See Attachment, “IPA Delegation Agreement – IEHP DualChoice” in Section 25).
9. **Focused Referral and Denial Audits** - IEHP performs focused audits of the referral and denial process for Delegates when quality of care issues are identified. Audits examine source data at the Delegate to review referral process timelines, appropriateness of denials and the denial process, including denial letters. See Policy 25E3, “Utilization Management – Referral and Denial Audits,” for more information.

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10. **Member and Physician Experience Surveys** - IEHP performs Member and Physician experience surveys to assess their experience with IEHP, their Delegate and managed care.
- M. Delegates that are out of compliance with QM requirements will be issued a Corrective Action Plan (CAP). See Policy 25A3, “Delegation Oversight – Corrective Action Plan Requirements.”

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<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	July 1, 2012
<b>Chief Title:</b> Chief Quality Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

#### 1. Delegation and Monitoring

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##### **APPLIES TO:**

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Members.

##### **POLICY:**

- A. IEHP delegates utilization management activities related to medical services for assigned Members to its Delegates.<sup>1</sup>
- B. IEHP and its Delegates shall develop, implement, and continuously update and improve a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services.
- C. IEHP maintains responsibility of ensuring that its Delegates comply with all applicable State and federal laws and other requirements set forth by the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and IEHP.<sup>2</sup>
- D. Authorization and financial responsibilities are delineated in the Division of Financial Responsibilities (DOFR).

##### **PURPOSE:**

A. To ensure a well-structured UM program and make utilization decisions affecting the health care of Members in a fair, impartial and consistent manner.

##### **DEFINITION:**

A. Delegate – A medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medicare eligible IEHP Member.

##### **PROCEDURES:**

##### **UM Program Requirements**

- A. Delegates must have a UM Program Description that includes, at minimum, the following information:
  - 1. Mission statement, goals, and objectives;
  - 2. Program structure, which includes at minimum:

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<sup>1</sup> Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.4.3

<sup>2</sup> Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.4.3

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- a. UM staff's assigned activities;
  - b. UM staff who have the authority to deny coverage;
  - c. Involvement of a designated physician;
  - d. The process for evaluating, approving and revising the UM Program, and the staff responsible for each step;
  - e. The UM Program's role in the Quality Improvement (QI) program, including how the organization collects UM information and uses it for QI activities; and
  - f. The organization's process for handling appeals and making appeal determinations.
3. Senior-level physician involvement, including their responsibilities in setting UM policies, supervising program operations, reviewing UM cases, participating on the UM committee, and evaluating the overall effectiveness of the UM program;<sup>3</sup>
  4. Processes and information sources used to make determinations, which includes but is not limited to:
    - a. UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity;
    - b. How medical necessity and benefits coverage for inpatient and outpatient services are determined and guide the UM decision-making process; and
    - c. The description of the data and information the Delegate uses to make determinations; and
  5. Other UM program requirements.
- B. Delegates must, on at least an annual basis, evaluate their UM program to ensure that this remains current and appropriate. Delegates must update their UM program based on this program evaluation, which must include but not be limited to the review of the following:
1. UM program structure;
  2. Program scope, processes, information sources used to determine benefit coverage and medical necessity;
  3. The level of involvement of the senior-level physician in the UM program; and
  4. Member and Provider experience data.
- C. Delegates must have the following UM structure in place:
1. Delegates must have a designated senior-level physician who holds an unrestricted license in the state of California, responsible for the following. Please see Policy 18N, "IPA Medical Director Standards" for more information:

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<sup>3</sup> Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.2

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- a. Ensuring the process by which the Delegate reviews and approves, partially approves (modifies) or denies, based in whole or in part on medical necessity, requests by Providers prior to, retrospectively, or concurrent with the provision of health care services to Members comply with State, federal and contractual requirements;<sup>4,5</sup>
- b. Ensuring that medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations;<sup>6</sup>
- c. Participation in staff training;
- d. Monitoring documentation for adequacy;
- e. Be available to UM staff on site or by telephone;
- f. Signing off on all internal policies and procedures related to UM; and
- g. Chairing the UM Committee or designating a Chair.

Delegates shall communicate to the IEHP Senior Medical Director any changes in the status of their UM Medical Director.

2. **UM Committee** –Delegates must establish a UM Committee that directs the continuous monitoring of all aspects of UM, including the development of appropriate standards administered to Members, with oversight by the Medical Director. For more information on a UM Committee’s functions, structure, membership, and other requirements, please see Policy 2G, “Utilization Management Subcommittee.”
3. **Use of Appropriate Professionals for UM Decisions:** To ensure that first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, IEHP requires its Delegates to adopt the following standards for personnel making review decisions and reviewing denials. The following types of personnel can perform the functions listed:
  - a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with Provider offices to obtain any needed non-medical information,<sup>7</sup> and approval of authorizations as determined appropriate (auto authorizations). Delegates should be able to provide a list of all services approvable by UM Technicians/Coordinators.
  - b. Licensed Vocational Nurses (LVN) – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information,<sup>8</sup> as needed, from the Provider’s offices, approval of referrals based on IEHP-approved

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<sup>4</sup> California Health and Safety Code (Health & Saf. Code) §1367.01

<sup>5</sup> Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.4.2

<sup>6</sup> Title 22, California Code of Regulations (CCR) § 53857

<sup>7</sup> Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.6

<sup>8</sup> Ibid.

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authorization criteria, concurrent inpatient, and initiate denials for non-covered benefits and carve outs.

- c. Registered Nurses (RN) – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information as needed, from the Provider’s office,<sup>9</sup> approval of referrals based on medical necessity or IEHP-approved authorization criteria, and providing medical necessity recommendation to the physician reviewer.
  - d. Physician-Reviewer - A designated physician with unrestricted license in the state of California must review all denials and partial approvals (modifications) based in whole or in part on medical necessity and obtain additional medical information from the treating physician as needed.<sup>10</sup>
4. **Use of Board-Certified Physicians for UM Decisions:** Delegates must have a written policy and procedure demonstrating their use of designated physicians with current unrestricted license for UM decisions.
- a. When a case review falls outside the clinical scope of the reviewer, or when medical decision criteria do not sufficiently address the case under review, a Board-certified physician in the appropriate specialty must be consulted prior to rendering a decision.
  - b. Delegates must either maintain a list of Specialists to be utilized for UM decisions or consult with an organization contracted to perform such review. The interaction may be completed by a telephone call to a network specialist, a written request for review, or use of a contracted vendor that provides Board Specialist review.
  - c. The physician reviewer determines the type of specialty required for consultation.

#### Clinical Criteria for UM Decisions

- A. Delegates must use nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when making decisions related to medical care. Criteria sets approved by IEHP include CMS Local Coverage Determination, Local Coverage Articles and National Coverage Determination, DHCS Duals Plan Letter (DPLs), Milliman Care Guidelines, InterQual, Apollo Managed Care Guidelines/Medical Review Criteria, World Professional Association for Transgender Health standards of care, and IEHP UM Subcommittee-Approved Authorization Guidelines.<sup>11</sup> IEHP may distribute additional criteria following approval by the IEHP UM Subcommittee.
- 1. **Development:** Criteria or guidelines that are developed by IEHP and used to determine whether to authorize, partially approve (modify), or deny health care services are developed with involvement from actively practicing health care Practitioners. IEHP

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<sup>9</sup> Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.6

<sup>10</sup> Ibid.

<sup>11</sup> CA Health & Saf. Code § 1363.5(b)

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ensures these criteria are consistent with sound clinical principles and processes and are evaluated at least annually and updated if necessary.<sup>12</sup>

2. **Application:** Delegates must apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual Members. The application of criteria takes into consideration individual factors such as, age, co-morbidities, complications, progress of treatment, psychosocial situation, previous claims history, home environment, and all submitted clinical information. Decisions to deny services cannot be solely based on codes being listed as non-covered, i.e. Medi-Cal Treatment Authorization Request (TAR) and Non-Benefit list of codes. Additionally, criteria applied takes into consideration whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual Member's treatment plan. The organization also considers characteristics of the local delivery system available for specific Members, such as:
  - a. Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the Member after hospital discharge;
  - b. Coverage of benefits for skilled nursing facilities, subacute care facilities or home care, Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Managed Long-Term Services and Support (MLTSS), Multipurpose Senior Services Program (MSSP), or Behavioral Health; and
  - c. Local in-network hospitals' ability to provide all recommended services within the estimated length of stay.

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

- a. IEHP Member Handbook (Evidence of Coverage); **then**
- b. Local Coverage Determination (LCD); **then**
- c. Local Coverage Article (LCA); **then**
- d. National Coverage Determination (NCD); **then**
- e. Medicare Benefit Policy Manual; **then**
- f. World Professional Association for Transgender Health standards of care; **then**
- g. National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium **or** IBM Watson Health Products: Micromedex; **then**
- h. MCG Health Informed Care Strategies Care Guidelines; **then**
- i. InterQual Criteria; **then**

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<sup>12</sup> CA Health & Saf. Code §1363.5



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- j. Apollo Medical Review Criteria Guidelines for Managing Care; **then**
  - k. IEHP Utilization Management (UM) Subcommittee Approved Authorization Guidelines **or** Pharmacy and Therapeutics (P&T) Subcommittee Approved Prior Authorization Criteria.
3. **Annual Review and Adoption of Criteria:** IEHP develops and/or presents criteria to the IEHP UM Subcommittee for adoption and implementation. Delegates may develop and recommend criteria for review and approval by the IEHP UM Subcommittee. After approval by UM Subcommittee, the criteria are sent to the IEHP Quality Management (QM) Committee for reference and disseminated to Delegates and Providers via letter, website or email. Members of the IEHP UM Subcommittee and Practitioners in the appropriate specialty, review clinical criteria annually and update, as necessary.
4. **Process for Obtaining Criteria:** Delegates must disclose to Providers, Members, Members' representative or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested.<sup>13</sup>

Delegates may distribute the guidelines and any revision through the following methods:

- a. In writing by mail, fax, or e-mail; or
- b. On its website, if it notifies Providers that information is available online.

Coverage decision letters must state the address and phone number to call for obtaining the utilization criteria or benefits provision used in the decision. Every disclosure must be accompanied by the following statement: "The materials provided to you are guidelines used by the plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your health plan" (See Attachment, "Response to Request for UM Criteria" in Section 25).<sup>14</sup> Delegates must maintain a log of all requests for criteria (See Attachment, "Request for UM Criteria Log" in Section 25).

5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** Delegates are responsible for evaluating, at least annually, the consistency with which healthcare professionals involved in utilization review apply appropriate criteria for decision-making. Delegates must act on identified opportunities to improve consistency. The sample assessed must be statistically valid, or Delegates may use one (1) of the following three (3) auditing methods:
- a. Five percent (5%) or fifty (50) of its UM determination files, whichever is less;
  - b. NCQA 8/30 methodology; or
  - c. Ten (10) hypothetical cases.

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<sup>13</sup> CA Health & Saf. Code §1363.5

<sup>14</sup> Ibid.

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##### Review of UM Data

- A. Delegates must collect, report, and analyze UM data related to Members for potential over or under utilization.
1. UM data includes, at a minimum, the following:
    - a. Enrollment;
    - b. Re-admits within thirty (30) days of discharge;
    - c. Total number of prior authorization requests;
    - d. Total number of denials;
    - e. Denial percentage;
    - f. Emergency encounters; and
    - g. Disease-specific over and under utilization metrics.
  2. Delegate must present the above data in summary form to its UM Committee for review and analysis at least quarterly.
  3. Delegates must present selected data from above to its PCPs, Specialists, and/or Hospitals as a group, e.g., Joint Operations Meetings (JOMs), or individually, as appropriate; and
  4. Delegates must be able to provide evidence of review of data above by its UM Committee for trends by physicians for both over-utilization and under-utilization.

##### UM Authorization Process Requirements

- A. Delegates must have written policies and procedures regarding the process to review, approve, partially approve (modify) or deny prospective, concurrent, or retrospective requests by Providers concerning the provision of health care services for Members. These policies and procedures must be available to the public upon request.<sup>15</sup>
1. **Specialty Referral Systems:** Delegates must maintain a specialty referral system to track and monitor referrals requiring prior authorization. The system shall include approved, partially approved (modified), and denied referrals received from both contracted and non-contracted providers, as well as the timeliness of these referrals.
  2. **System Controls:** Delegates must have and be able to demonstrate system controls to protect data specific to denial and appeal notifications and receipt dates from being altered outside of prescribed protocols.
  3. **Out-of-Network Services:** Authorization and notification of decision for proposed services, referrals, or hospitalizations involves utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting Provider. Part of this review process is to determine if the service requested is available

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<sup>15</sup> CA Health & Saf. Code § 1367.01(b)

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in network, and to ensure coordination of medically necessary care from the non-network specialist. If the service is not available in network, arrangements are made for the Member to obtain the service from an out-of-network provider for this episode of care.

When an outpatient or inpatient service requested appears to be unavailable within the IEHP network and IEHP is responsible for paying for the facility charges, the Delegate must review the request to determine if the request meets criteria. Once the Delegate determines that criteria is met, the clinical information must be sent to IEHP to make the final decision. If IEHP determines the requested service cannot be provided within its network, IEHP will initiate the Letter of Agreement (LOA) process. It is therefore critical that the Delegate submit the referral with all supporting documentation as soon as possible to the Plan via the secure IEHP Provider Portal to prevent delay in care. If the request can be handled within the network or does not meet the criteria, the Delegate can modify or deny as appropriate.

4. **Prior Authorization Requirements:** Delegates must maintain a list of services that require prior authorization or have a list of services that do not require prior authorization like below, at minimum:
  - a. The prior authorization described in this policy do not apply to these services, which do not require prior authorization:
    - 1) Emergency services and services necessary to treat and stabilize an emergency medical condition (See Policy 14C, “Emergency Services”);<sup>16</sup>
    - 2) Family planning (See Policy 10K, “Family Planning Services”);
    - 3) Abortion Services (See Policy 9D, “Access to Services with Special Arrangements”);
    - 4) Sexually Transmitted Infection (STI) services (See Policy 10G, “Sexually Transmitted Infection (STI) Services”);
    - 5) Sensitive and confidential services (See Policy 9D, “Access to Services with Special Arrangements”);
    - 6) HIV testing and counseling (See Policy 10H, HIV Testing and Counseling”);
    - 7) Routine OB/GYN services, including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IPA’s network;
    - 8) Out of area renal dialysis;<sup>17</sup>
    - 9) Biomarker testing for advanced or metastatic stage 3 or 4 cancers;<sup>18</sup>

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<sup>16</sup> Medicare Managed Care Manual, “Chapter 4 - Benefits and Beneficiary Protections,” §20.3

<sup>17</sup> Medicare Managed Care Manual “Chapter 4 - Benefits and Beneficiary Protections” §110.1.3

<sup>18</sup> California Health and Safety Code (CA HSC) §1367.665

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- Please visit the United States Food and Drug Administration (FDA) website for a continually updated list of FDA-approved cancer therapies for which associated biomarker tests may be ordered.<sup>19</sup>

10) Urgent Care

11) Preventive services; and

12) Other services as specified by CMS.

- a. Delegates must allow Members direct access to Specialists, appropriate for their condition and identified need for special healthcare needs.
  - b. Delegates shall ensure Members have access to American Indian Health Services Programs (AIHSP). AIHSP, whether contracted or not, can provide referrals directly to network Providers without first requesting a referral from a PCP.
5. **Medical Necessity Determination:** Delegates must determine medical necessity for a specific requested service as follows:
- a. Employ IEHP-approved UM authorization guidelines, as outlined in this policy and utilize the following definition for determining medical necessity of a health care service:
    - 1) The health care service is reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member,<sup>20</sup> or otherwise medically necessary under CMS; and
  - b. If information reasonably necessary to make a determination is not available with the referral, the requesting Provider should be contacted for the additional clinical information by telephone at least two (2) times and with a third attempt being made by a Medical Director. The request for additional information must be annotated and include the date of request.<sup>21</sup>
  - c. Consider all factors related to the Member including barriers to care related to access or compliance, impact of a denial on short- and long-term medical status of the Member and alternatives available to the Member if denied; and
  - d. Obtain input from Specialists in the area of the health care services requested either through an UM Committee member, telephonically, or use of an outside service.
6. **Review Process and Timeframes:** Mandated timeframes for decisions including approval, denial or partial approval (modification) of a request and subsequent notification to the Member and Provider are outlined in this Provider Manual. For Members with Dual coverage, the primary insurance will determine the decision

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<sup>19</sup> <https://www.accessdata.fda.gov/scripts/cder/daf/>

<sup>20</sup> Social Security Act § 1862 (a)(1)

<sup>21</sup> Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.6

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timeframe (see Attachment, “UM Timeliness Standards – IEHP DualChoice” in Section 14).

- a. The prior authorization process is initiated when the Member, Member’s representative, or the Member’s Physician requests a referral or authorization for a procedure or service. The timeframe begins upon receipt of the request.
  - 1) For non-urgent preservice or concurrent referrals, Providers have two (2) working days from the determination that a referral is necessary to submit the referral and all supporting documentation.
  - 2) Providers must sign and date the referral and provide a direct phone number and fax number to the referring Physician for any questions or communication regarding the referral.
  - 3) Delegate will identify upon intake any prior authorization request in which IEHP is responsible for making a determination (including requests for behavioral health, optometry and general anesthesia for routine dental requests) and will ensure these requests are forwarded to IEHP within one (1) business day of receipt by forwarding the request to the Plan through the secure IEHP Provider Portal.
  - 4) For concurrent decisions, care shall not be discontinued until the Member’s treating Provider has been notified of the plan’s decision and a care plan has been agreed upon by the treating Provider that is appropriate for the medical needs of the Member.<sup>22</sup>
- b. *Prior Authorization for Expedited Initial Organization Determinations (EIOD) and Urgent Concurrent:*<sup>23</sup> Delegates are required to perform Expedited Initial Organization Determinations (EIOD) for service authorization requests where the Provider indicates or the Delegate determines that following the standard timeframe could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function.<sup>24</sup> The following requests should be classified as concurrent: Continued Home Health, Physical Therapy (PT), Speech Therapy (ST), Occupational Therapy (OT) and Durable Medical Equipment (DME) when the original preservice authorization has not expired. Please see Policy 14I, “Expedited Initial Organization Determination” for more information.
- c. *Post-Service Organization Determinations (Retrospective Review):* Services that require prior authorization but are rendered without such authorization must be reviewed retrospectively to determine medical necessity and/or benefit coverage. This can include out-of-area admissions, continuity of care and/or services

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<sup>22</sup> CA Health & Saf. Code § 1367.01

<sup>23</sup> Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 40.8

<sup>24</sup> Ibid.

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or treatments rendered by a contracted or non-contracted Provider without prior authorization.

- 1) If a request for retrospective review is received more than one hundred twenty (120) calendar days after the date that the service was rendered, the Delegate must direct the Provider to instead submit a request for claims payment.
  - 2) Relevant clinical information must be obtained and reviewed for medical necessity based on IEHP-approved authorization criteria. If medical necessity is not met, denial determinations must be made by the Delegate Medical Director. Both the Member and Provider must be notified of post-service (retrospective review) determinations.
- d. The timeframes for rendering decisions and sending notifications to the Member and Provider are outlined in this Provider Manual (See Attachment, “UM Timeliness Standards – IEHP DualChoice” in Section 14).
7. **Experimental and Investigational Determinations:** The determination for all experimental and investigational services is the responsibility of IEHP.
- a. The Delegate must send to IEHP all authorization requests for experimental/investigational services as soon as possible after receipt. This must be sent via the secure IEHP Provider Portal. The request must include all supporting clinical information including diagnosis (ICD) and procedure (CPT) codes.
  - b. The Milliman Care Guidelines (MCG) term “role remains uncertain” does not indicate that a request is considered experimental/investigational. The Delegate must review these requests utilizing the next criteria set in the hierarchy. If there are no other criteria to review, the Delegate must forward the request to IEHP as outlined above.
  - c. IEHP is responsible for decision-making and notifying the Provider, Member and Delegate of the determination, per standard timeframes for level of urgency.
8. **Out-of-Network/Capitated Providers:** Prior to redirecting a referral from an out-of-network provider to a contracted or capitated Provider, the Delegate must first verify and document the following:
- a. That the redirected Provider is of the same discipline and able to provide equivalent service dependent on the Member’s medical condition; and
  - b. That the Member can receive services within IEHP’s access standards. Please see Policy 9A, “Access Standards” for more information.

Documentation of the above must include:

- a. Name and title of contact at Provider’s office;
- b. Date of outreach;
- c. Expected date of Member’s appointment; and

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- d. Confirmation that the Provider is of the same discipline and able to provide equivalent service dependent on the Member's medical condition.
9. **Denial Notices:** Any decision to deny a service authorization based on medical necessity or to authorize a service that is less than requested in an amount, duration, or scope must be reviewed and approved by the Delegate Medical Director or physician designee.<sup>25</sup> Members and Providers must receive denial letters for any requested referral that is denied or modified.<sup>26</sup>
- a. IEHP-approved notification templates are available online at [www.iehp.org](http://www.iehp.org). The Delegate is responsible for ensuring they are utilizing the most recent version of the template. Denial notices must adhere to the following:
- 1) Include required CMS language;
  - 2) Be typed in 12-point font and written in a manner, format, and language that can be easily understood;<sup>27</sup>
  - 3) Be made available in IEHP Threshold Languages;
  - 4) Include information about how to request translation services and alternative formats, which shall include materials that can be understood by persons with limited English proficiency;<sup>28</sup>
  - 5) Sixth (6th) grade level language appropriate for the Member population describing the reason for the denial;
    - Medical necessity denials must cite the criteria used and the reason why the clinical information did not meet criteria;<sup>29,30</sup>
    - Non-covered benefit denials must cite the specific provision in the Evidence of Coverage (EOC) (i.e., the IEHP Member Handbook), CMS guideline (LCD, LCA, NCD, or Medicare Benefit Policy Manual) or State/Federal regulations that excludes that coverage.
  - 6) Information for the Member regarding alternative treatment and direction for follow-up care; and

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<sup>25</sup> CA Health & Saf. Code § 1367.01

<sup>26</sup> Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 40.12.1

<sup>27</sup> Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 10.4.4

<sup>28</sup> Ibid.

<sup>29</sup> CA Health & Saf. Code § 1367.01

<sup>30</sup> Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance," Section 40.12.1

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- 7) Information on how to file an oral or written expedited grievance, file a standard or fast appeal, or file an immediate review or appeal as applicable.<sup>31</sup>

The Delegate must have in place Quality Assurance (QA) procedures to monitor the items listed above and check for deficiencies in the medical rationale for the denial, the clarity of the language and the inclusion of correct information in the letter.

- b. The written communication to a Provider of a denial based on medical necessity must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial.<sup>32</sup> This communication must offer the requesting Provider the opportunity to discuss any issues or concerns regarding the decision. This written notification of denial or partial approvals (modifications) must include language informing the Provider of the appeal process. See Section 16, “Grievance and Appeals Resolution System” for more information.
- c. On a monthly basis, for monitoring purposes, the Delegate must send to IEHP all documentation for each denial including the following. Please see Policy 25E2, “Utilization Management – Reporting Requirements” for more information:
- 1) Referral Universes (See Attachments, “IEHP Universe Standard Auth MSSAR Template” and “IEHP Universe Expedited Auth MESAR Template” in Section 25);
  - 2) Letters and attachments;
  - 3) Clinical documentation;
  - 4) Referral;
  - 5) Outreach/call logs, if any
  - 6) Supporting evidence of the following:
    - Received Date;
    - Decision Date and Time;
    - RN/LVN or physician reviewer note from medical management system; and
    - Proof of date and time letter was mailed to the Member.
  - 7) Criteria used for the determination;
  - 8) Initial notification including opportunity to discuss; and
  - 9) Audit trail to include all changes and dates made to the case.
- c. For Delegates responsible for Medicare benefit only:

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<sup>31</sup> Ibid.

<sup>32</sup> CA Health & Saf. Code § 1367.01



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- 1) If a service request is covered by both Medicare and Medi-Cal, and does not meet Medicare criteria but does meet Medi-Cal criteria, no Medicare denial letter is issued prior to forwarding to IEHP.
- 2) If a service request is not a covered benefit under Medicare, but is a covered benefit under Medi-Cal, no Medicare denial letter is needed prior to forwarding to Health Plan (see Attachment 14, “Medicare Non-Covered Services”).

For both instances, IEHP is responsible for making the determination. As such, the Delegate shall forward these requests to the Plan through the secure IEHP Provider Portal.

#### Other UM Program Requirements

- A. **Referral Requests:** PCPs are responsible for supervising, coordinating, and providing initial primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. PCP and Specialist requests for referral to specialty care should be initiated through the Member’s IPA. Please see Policies 14A1, “Review Procedures – Primary Care Provider (PCP) Referrals” and 14D, “Pre-Service Referral Authorization Process.”
- B. **Continuity of Care:** Delegates must maintain policies and procedures that ensure Members are given the option to continue treatment for up to twelve (12) months with an out-of-network provider per DHCS requirements. Please see Policy 12A5, “Coordination of Care – Continuity of Care.”
- C. **Standing Referrals:** Delegates must have policies and procedures by which a PCP may request a standing referral to a Specialist for a Member who requires continuing specialty care over a prolonged period of time or an extended referral to a Specialist or a specialty care center for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist. IEHP and its Delegates must have a system in place to track open, unused; and standing referrals.<sup>33</sup> For more information, please see Policy 14A2, "Standing Referral/Extended Access to Specialty Care " for more information.
- D. **Second Opinions:** IEHP provides for its Members second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network, if services are not available within the network. Refer to Policy 14B, “Second Opinions” for more information.
- E. **Behavioral Health:** Behavioral Health benefits for IEHP DualChoice Members are obtained through the IEHP Behavioral Health Program.
- F. **Vision Services:** Vision is not a Medicare benefit unless specifically for covered lenses post cataract surgery. IEHP DualChoice Members may have additional limited benefits through Medi-Cal.

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<sup>33</sup> CA Health & Saf. Code § 1374.16

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

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- G. **Pharmacy Services:** Please refer to the Division of Financial Responsibility (DOFR) in your contract regarding pharmacy services.
- H. **Supplemental Benefits:** Supplemental benefits may vary and are the responsibility of the Health Plan. Please refer to IEHP's website for a list of current benefits.
- I. **Communication Services:** Delegates must provide access to staff for Members and Providers seeking information about the UM Process and the authorization of care by providing these communication services:
1. Delegate shall maintain telephone access for Providers to request authorization for healthcare services.<sup>34</sup>
  2. Delegate UM staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. Communications received after normal business hours will be returned on the next business day.
  3. Outbound communication from staff regarding inquiries about UM are made during normal business hours.
  4. Staff identify themselves by name, title, and organization when initiating or returning calls regarding UM issues.
  5. Staff can receive inbound communication regarding UM issues after normal business hours.
  6. There is a toll-free TDD/TTY services for Members who are deaf, hard-of-hearing, or speech impaired.
  7. Language assistance is available for IEHP Members to discuss UM issues.
- J. **Rescinding or Modifying Authorization** - Any authorization provided by IEHP or its Delegate must not be rescinded or modified after the Provider has already rendered the health care service in good faith pursuant to the authorization.<sup>35</sup>
- K. **Record Retention:** Delegates shall retain information on decisions, i.e., authorizations, denials or partial approvals (modifications) for a minimum period of ten (10) years.<sup>36</sup>
- L. **Documentation of Medical Information and Review Decisions:** IEHP and its Delegates must base review decisions on documented evidence of medical necessity provided by the attending physician. Regardless of criteria, the Member's condition must always be considered in the review decision.
1. **Physician Documentation:** Attending Physicians must maintain adequate medical record information to assist the decision-making process. The requesting Provider must

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<sup>34</sup> CA Health & Saf. Code § 1367.01

<sup>35</sup> CA Health & Saf. Code § 1371.8

<sup>36</sup> Title 42 Code of Federal Regulations (CFR) §422.504(b)

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

#### 1. Delegation and Monitoring

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document the medical necessity for requested services, procedures, or referrals and submit all supporting documentation with the request.

2. **Reviewer Documentation:** Delegate reviewers must abstract and maintain review process information in written format for monitoring purposes. Decisions must be based on clinical information and sound medical judgment with consideration of local standards of care. Documentation must be legible, logical, and follow a case from beginning to end. Rationale for approval, modification or denial must be a documented part of the review process. Documentation must also include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based.
3. **Documentation:** Delegates must have procedures in place to log requests by date and receipt of information so that timeframes and compliance with those timeframes can be tracked. Delegate documentation of authorizations or referrals must include, at a minimum: Member name and identifiers, description of service or referral required, medical necessity to justify service or referral, place for service to be performed or name of referred physician, and proposed date of service. Delegate documentation must also include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based. Any denial of a proposed service or referral must be signed by the Medical Director, or physician designee.

M. **Inpatient Stay:** The utilization management process must include:

1. Determining medical necessity.
2. Determining appropriate level of care.
3. Coordinating with hospital Case Manager's discharge plan.

Please see Policy 14G, "Acute Admission and Concurrent Review" for more information.

N. **Discharge Planning:** The UM process must include the following activities related to discharge planning:<sup>37</sup>

1. Determining level of care (SNF, office visit, home health, home without services);
2. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc); and
3. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office.

Please see Policy 14G, "Acute Admission and Concurrent Review" for more information.

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<sup>37</sup> Medicare Managed Care Manual, "Chapter 17 – Subchapter F: Benefits and Beneficiary Protections." §120.6 – Continuity of Care

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## 25. DELEGATION AND OVERSIGHT

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#### 1. Delegation and Monitoring

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- O. **Repatriation:** IEHP and its Delegates must assist with the transfer of Members, as medically appropriate, back into the IEHP network.
- P. **Non-Discrimination:** All Members must receive access to all covered services without restriction based on race, color, ethnicity, ethnic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claim experience, medical history, claims history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment. Please see Policy 9H3, “Cultural and Linguistic Services – Non-Discrimination” for more information.
- Q. **Confidentiality:** IEHP recognizes that Members’ confidentiality and privacy are protected. It is the policy of IEHP and Delegates to protect the privacy of individual Member health information by permitting UM staff to obtain only the minimum amount of Protected Health Information (PHI) necessary to complete the healthcare function of activity for Member treatment, payment or UM operations.
- R. **Affirmative Statement Regarding Incentives:** UM decisions for Members must be based only on appropriateness of care and service. Delegates do not provide compensation for Practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Delegates ensure that contracts with physicians do not encourage or contain financial incentives for denial of coverage or service. The Affirmative Statement about incentives is distributed annually to all Practitioners, Providers, and employees involved in authorization review, as well as Members.
- S. **Economic Profiling:** Economic profiling is defined as any evaluation performed by the physician reviewer based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician reviewer. Delegates that engage in economic profiling must document the activities and information sources used in this evaluation and ensure that decisions are rendered, unhindered by fiscal and administrative management.<sup>38</sup>
- T. **Prohibition of Penalties for Requesting or Authorizing Appropriate Medical Care:** Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care.

#### Grievance and Appeals Process

- A. IEHP maintains a formal Appeals and Grievance Resolution System to ensure a timely and responsive process for addressing and resolving all Member grievances and appeals. The Member may file an appeal or grievance by phone, by mail, fax, website, or in person. Please refer to Section 16, “Grievance Resolution System”.

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<sup>38</sup> CA Health & Saf. Code § 1367.02

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

#### 1. Delegation and Monitoring

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- B. A Member or Provider who is not able to obtain a timely referral to an appropriate Provider can file a complaint with the DMHC:<sup>39</sup>
1. Member complaint line: By phone toll-free at (888)466-2219  
By email at [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov)
  2. Provider complaint line: By phone toll-free at (877)525-1295  
By email at [plans-providers@dmhc.ca.gov](mailto:plans-providers@dmhc.ca.gov)

#### Monitoring Activities and Oversight of Delegate

- A. IEHP monitors and oversees delegated UM activities performed by the Delegates.<sup>40</sup> The following oversight activities are performed to ensure compliance with IEHP UM and regulatory standards:
1. **Delegation Oversight Audits (DOA)** – IEHP performs a Delegation Oversight Audit of its Delegates’ UM program and objectives, policies and procedures, activities and their progress. This audit re-assesses the Delegates’ operational capabilities in the areas of UM and other delegated activities. Please refer to Policy 25A1, “Delegation Oversight Audit,” for further details.
  2. **Analysis of Provider Data Reports** – Through its delegation oversight process, IEHP reviews health plan and delegate reports and utilization data including denial and approval universes and letters, Readmissions, quarterly and annual work plan. Provider reports and utilization data is subsequently reviewed by the Delegation Oversight Committee (DOC).
  3. **Review of SARAG Approval and Denial Universe Pre-Service Reports and Letters** – IEHP and its Delegates are required to submit a monthly Referral Universe from which authorizations are selected for review. Please refer to Policy 25E2, “Utilization Management – Reporting Requirements” for more information.
  4. **Focused Referral and Denial Audits** – IEHP performs focused audits of the referral and denial process for Delegates. Please refer to Policy 25E3, “Referral and Denial Audits.” Audits examine source data at the Delegate to determine referral process timelines and appropriateness of denials and the denial process, including denial letters.
  5. **Member or Practitioner Grievance Review** – IEHP performs review, tracking, and trending of Member or Practitioner grievances and appeals related to UM. IEHP reviews Delegate grievances and recommended resolutions for policies, procedures, actions, or behaviors that could potentially negatively impact Member health care.
  6. **Joint Operations Meetings (JOMs)** – JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. JOMs are held with Hospitals and Delegates to address specific Provider Services, UM, QM, CM, grievance, study results,

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<sup>39</sup> CA Health & Saf. Code § 1367.01(e)

<sup>40</sup> Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance,” Section 10.4.3

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

#### 1. Delegation and Monitoring

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or any other pertinent quality issues. These meetings are designed to address issues from an operational level.

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

- B. **Enforcement/Compliance:** IEHP monitors and oversees delegated UM activities performed by Delegates. Enforcing compliance with IEHP standards is a critical component of monitoring and oversight of IEHP Providers, particularly related to delegated activities. Delegates that demonstrate a consistent inability to meet standards can be subject to contract termination.

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

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

#### 2. Reporting Requirements

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#### **APPLIES TO:**

A. This policy applies to all IEHP DualChoice Members.

#### **POLICY:**

- A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.
- B. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated utilization management activities.<sup>1,2</sup> Oversight activities include but are not limited to the review of these monthly, quarterly, and annual reports.

#### **DEFINITION:**

A. Delegate – A medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medicare eligible IEHP Member..

#### **PROCEDURES:**

##### **A. Monthly Reporting Requirements:**

1. Monthly reports are due to IEHP by the 15<sup>th</sup> of the month following the month in which services were approved, denied, partially approved (modified), or dismissed and include the following:
  - a. **Referral Universe** – Using the universe templates in Excel file format, the Delegate must report all approved, denied, partially approved (modified), and dismissed referrals during the report period (See Attachments, “IEHP Universe Standard Auth MSSAR Template,” “IEHP Universe Standard Auth MSSAR Data Dictionary,” “IEHP Universe Expedited Auth MESAR Template,” and “IEHP Universe Expedited Auth MESAR Data Dictionary” in Section 25).
  - b. **Denials and Partial Approvals (Modifications)** – The Delegate must submit all referral and clinical information, as well as copies of all denial letters from the reporting period. Partial approvals (modifications) occur when a decision is made, and proposed care is denied or altered.

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<sup>1</sup> Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance”, Section 10.4.3

<sup>2</sup> Title 28 California Code of Regulations (CCR) § 1300.70

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

#### 2. Reporting Requirements

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##### 1) **Reasons for Denials and Partial Approvals:**

- **Not Medically Necessary** – Does not meet approved nationally recognized criteria or IEHP UM Subcommittee Approved Authorization Guidelines. Please see Policy 25E1, “Utilization Management Delegation and Monitoring” for a list of these criteria.
  - **Out-of-Network** – Requested provider is a non-contracted Provider. Out-of-Network requests must be reviewed by a physician and must be considered as a medical necessity decision.
  - **Experimental** – Requested service has not been approved by the Food and Drug Administration (FDA) and/or is not an accepted practice in the medical community and/or has not been proven to have a therapeutic benefit.
  - **Non-Benefit** – Not a covered benefit.
- c. **Approval File Review** – Using the universe reports submitted by the Delegate, IEHP will select ten (10) Approval Files to audit. Delegate submissions of Approval Letters need to include the supporting documentation used to make the decisions. Delegates must submit all required documentation related to the file selections by the 15<sup>th</sup> day of the following month.
- d. **Second Opinion Tracking Log** – Using the Second Opinion Tracking Log, the Delegate must report all authorizations, partial approvals (modifications), and denial information for second opinion requests. The Log must include the reason the second opinion was requested (See Attachment, “Second Opinion Tracking Log” in Section 25).

##### B. **Quarterly Reporting Requirements:**

1. Quarterly report deadlines are outlined in Policy Attachment 25, “Medicare Provider Reporting Requirements Schedule.” Delegates should refer to this document for specific report due dates. The reports should include, at a minimum, the Delegate’s IEHP Member-specific UM goals and activities, trending of utilization activities for under and over utilization, Member and Practitioner satisfaction activities, interrater reliability activities, and a narrative of barriers and improvement activities. The quarterly reports must also include:
  - a. **UM Program Annual Evaluation/HICE Report** - The Delegate’s evaluation of the overall effectiveness of the UM Program, including whether goals were met, data, performance rates, barrier analysis, and improvement activities; and
  - b. **UM Workplan Update** - Submit an update of the Annual Workplan which includes planned activities for the year, timelines, responsible person(s) and committee(s). The Work Plan should include measurable goals, planned audits, follow-up activities



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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management 2. Reporting Requirements

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and interventions related to identified problem areas.

- C. **Annual Reporting Requirements:** The following reports must be submitted annually to IEHP by February 15<sup>th</sup> of each calendar year:
1. **UM Program Description:** Reassessment of the UM Program Description must be completed annually by the UM Committee and/or Quality Management (QM) Committee and reported to IEHP including the following:
    - a. Any changes made to the UM Program Description during the past year or intended changes identified during the annual evaluation; and
    - b. UM Program Description Signature Page.
  2. **UM Work Plan/Initial HICE Report:** Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include measurable goals, planned audits, follow-up activities and interventions related to identified problem areas.
- D. Delegate reports must be received by IEHP electronically using a Secure File Transfer Protocol (SFTP) server.
- E. Reports are due on or before the due dates regardless of whether the due date lands on a weekend or a holiday.
- F. Repeated failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), and may lead to freezing of new Member enrollment, termination, or non-renewal of the IEHP Agreement.

INLAND EMPIRE HEALTH PLAN		
<b>Chief Approval:</b> <i>Signature on file</i>	<b>Original Effective Date:</b>	July 1, 2012
<b>Chief Title:</b> Chief Medical Officer	<b>Revision Date:</b>	January 1, 2023

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management 3. Referral and Denial Audits

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#### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice Members

#### **POLICY:**

- A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.
- B. IEHP oversees, monitors and evaluates performance of delegated and non-delegated utilization management activities.<sup>1,2</sup> Oversight activities include but are not limited to monthly, annual and focused audits.

#### **DEFINITION:**

- A. Delegate – A medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medicare eligible IEHP Member. .

#### **PROCEDURES:**

##### **Monthly Retrospective Audit of Denials and Partial Approvals (Modifications)**

- A. IEHP performs a monthly retrospective audit of up to thirty (30) denied and partially approved (modified) referrals submitted by the Delegate (See Attachment, “Denial Log Review Tool – IEHP DualChoice” in Section 25).
- B. IEHP may request for more denied and partially approved referral files in addition to those submitted monthly by the Delegate.
- C. IEHP uses the standard and expedited authorization universes for the monthly retrospective denial audits to evaluate referral timeliness and document the examined referral results.
- D. In order to pass the Monthly Retrospective Audit for Denials and Partial Approvals (Modifications) audit, the Delegate must achieve an overall score of 90%:
  - 1. See the Denial Log Review Tool for a list of Audit Elements (see Attachment, “Denial Log Review Tool – IEHP DualChoice” in Section 25).
  - 2. The overall denial rate must not exceed 5%, which may include non-benefit, out-of-network, medical necessity denials, etc.

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<sup>1</sup> Medicare Managed Care Manual, “Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance”, Section 10.4.3

<sup>2</sup> Title 28 California Code of Regulations (CCR) § 1300.70

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

#### 3. Referral and Denial Audits

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3. IEHP may require the Delegate to overturn denial and/or partial approval decision that was not medically appropriate and issue new Member and Provider notification of the overturned decision.
- E. If the Delegate fails to achieve a Compliance score of 90% for two (2) consecutive months on any of the audit areas above, a Corrective Action Plan (CAP) will be required. IEHP may issue a CAP in any given month for significant declines in performance. At its discretion, IEHP may also enforce one (1) or more of the following:
1. Concurrent denial/partial approval review for a percentage of total denials/partial approvals (modifications) may be initiated at which time the Delegate may receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
  2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
  3. A focused meeting with the Delegate's administration and IEHP's leadership;
  4. Sanctions may be enforced as outlined in the Delegate's contract with IEHP under Retrospective Denial Audits; and/or
- F. Other actions as recommended by IEHP's Delegation Oversight Committee.
- G. Repeated non-compliance may result in the termination of the Delegate's contract.
- H. Delegates who disagree with the audit score can appeal in writing to the IEHP Senior Medical Director within thirty (30) calendar days after the release of the final audit results.

#### **Denial Letter Sanction Program**

- A. IEHP applies the Denial Letter Sanction to ensure that denial letters meet CMS standards (See Attachment, "Program Description - Denial Letter Sanction – IEHP DualChoice" in Section 25).
- B. The Denial Letter Sanction Program includes the following components:
1. Denial Letters must meet, with 100% accuracy, the below components (See Attachment, "Denial Log Review Tool – IEHP DualChoice" in Section 25);
  2. Use of correct letter template including attachments; Member denial language that is understandable (sixth (6<sup>th</sup>) grade reading level);
  3. Denial letter is processed timely, with the inclusion of accurate dates of receipt; and
  4. Denial reason is in accordance with appropriate criteria cited and coincides with denial type.

#### **Monthly Retrospective Audit of Approvals**

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

#### 3. Referral and Denial Audits

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- A. IEHP performs a monthly retrospective audit of ten (10) approved referral files selected by IEHP from the SARAG SOD and SARAG EOD universes submitted by the Delegate for the reporting month.
- B. IEHP may request for more approved referral files in addition to the ten (10) referral files submitted monthly by the Delegate.
- C. IEHP uses standard and expedited authorization universes for the monthly retrospective approval audits to evaluate referral timeliness and document the examined referral results.
- D. In order to pass the Monthly Retrospective Audit of Approvals, the Delegates must achieve a score of 90% or greater on the Overall Approval File Review (See Attachment, “Approved Referral Audit Tool” in Section 25).
- E. If the Delegate fails to achieve a Compliance score of 90% for two (2) consecutive months, a Corrective Action Plan (CAP) will be issued. IEHP may issue a CAP in any given month for significant declines in performance. At its discretion, IEHP may also enforce one (1) or more of the following:
  - 1. Concurrent approval review for a percentage of total approvals may be initiated at which time the Delegate may receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
  - 2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
  - 3. A focused meeting with the Delegate’s administration and IEHP’s leadership; and/or
  - 4. Other action as recommended by the Delegation Oversight Committee.
- F. Repeated non-compliance may result in the termination of the Delegate’s contract.
- G. Delegates who disagree with the audit score can appeal in writing to the IEHP Senior Medical Director within thirty (30) calendar days after the release of the final audit results.

#### **Delegation Oversight Audit (DOA)**

- A. IEHP performs an annual Delegation Oversight Audit (DOA) of all Delegates to review their UM process. Please see Policy 25A2, “Delegation Oversight – Audit” and the Delegation Oversight Audit Preparation Instructions (See Attachment, “Delegation Oversight Audit Preparation Instructions – IEHP DualChoice” in Section 25) for more information.
- B. UM Process Review Components:
  - 1. IEHP selects, at minimum, fifteen (15) approved/denied/partially approved/dismissed referrals to review. File review will be performed via webinar. The Delegate is responsible for walking IEHP through each referral via the Delegate’s medical management system.

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management 3. Referral and Denial Audits

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2. IEHP ensures that mechanisms are in place to ensure data integrity.
  3. One (1) hour before the audit, the Delegate will be provided with the list of referrals to be reviewed with the exception of the dismissed referrals.
  4. IEHP will request details of the process used by the Delegate to ensure ongoing compliance with CMS regulations and Plan policies.
- C. In order to pass the UM Referral and Denial audit sections of the DOA, the Delegate must achieve a score of at least 90% on the file review.
- D. Delegates that score below 90% on the approved referral and/or denial and partial approval (modification) sections above are required to submit a CAP addressing all deficiencies noted at the audit within a specified timeframe. Delegates who disagree with the audit results can appeal through the IEHP Provider appeals process by submitting an appeal in writing to the IEHP Senior Medical Director within thirty (30) calendar days after the release of the final audit results.
- E. Delegates that score 90% may still be required to submit a CAP to address any deficiencies.
- F. Audit results are included in the overall annual assessment of Delegates.

#### **Focused Audits**

- A. Focused audits are conducted under the following circumstances:
1. Follow-up audit for deficiencies identified from prior audits including but not limited to the DOA and monthly retrospective audit;
  2. Review of approvals, denials, partial approvals (modifications), and/or dismissals demonstrate that decisions are being made inconsistently, do not appear to be medically appropriate, or are not based on nationally recognized clinical criteria.
  3. Number of Corrective Action Responses (CARs) issued to Delegate as a result of IEHP routine monitoring;
  4. Compliance issues self-reported by the Delegate;
  5. Potential risk areas identified by IEHP (i.e., Member and Provider grievances, appeals);
  6. Number of months IEHP has placed Delegate on concurrent review for specific delegated UM functions;
  7. Significant increase in volume of IEHP assigned Members in the applicable LOB;
  8. A specific inquiry initiated by the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), or Centers of Medicare and Medicaid Services (CMS); and

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management

#### 3. Referral and Denial Audits

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9. Any other circumstance that in the judgment of the IEHP Chief Medical Officer or designee requires a focused audit.
- B. Prior to the Focused Audit case file review the Delegate must submit the requested universe within the specified timeframe and successfully complete the Universe Integrity Audit:
  1. Five (5) samples are randomly selected by the auditor and provided to the Delegate one (1) hour before the start of the audit webinar.
  2. Each data element or column of the universe must be validated against the Delegate's medical management system or documentation to ensure the information is consistent and accurate. Inconsistent or inaccurate data must be substantiated; otherwise, the case is considered a fail.
  3. The Delegate must successfully pass three (3) of the five (5) cases selected. A failed Universe Integrity Audit will result in the auditor requesting the Delegate's resubmission of a corrected universe. Three (3) failed universe resubmissions will result in an audit finding.
- C. IEHP is responsible for conducting timeliness tests on identified measures via submitted universes, to ensure the Delegate's compliance. Timeliness results falling below thresholds will be considered non-complaint and will be noted as a finding in the audit report.
- D. IEHP selects thirty (30) cases which consist of approvals, denials and partial approvals (modifications) for the case file review. The cases are provided to the Delegate one (1) hour before the start of the audit webinar. Sample cases are reviewed against defined compliance standards to determine any areas of non-compliance and/or systemic problems within the Delegate's utilization management process.
- E. IEHP will also select five (5) dismissed referrals from the submitted universe to review for appropriateness. The dismissed referrals will not be provided to the Delegate prior to the audit webinar.
- F. If IEHP identifies a potential issue during the case file review, additional detail will be required to determine:
  1. If the issue is systemic;
  2. The root cause of the issue; and
  3. How many Members were impacted.

If the issue negatively impacted (the) Member(s), an Impact Analysis is requested immediately following the case file review to provide the Delegate adequate time to research and respond while still providing the auditors time to evaluate and influence the findings report.
- G. IEHP determines the significance of audit findings based on results of the case review and impact analysis, if applicable. Audit findings can result in an Immediate Corrective Action

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management 3. Referral and Denial Audits

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Required, Corrective Action Required, an Invalid Data Submission, or Observation as described below:

1. **Immediate Corrective Action Required (ICAR)** – An ICAR is the result of a systemic deficiency identified during an audit that is so severe that it requires immediate correction. These types of issues are limited to situations where the identified deficiency resulted in a lack of access to medications and/or services or posed an immediate threat to the Member’s health and safety. ICARs must be immediately addressed or remediated within three (3) business days from receipt of ICAR notification.
  2. **Corrective Action Required (CAR)** – A CAR is the result of a systemic deficiency identified during an audit that must be corrected but does not rise to the level of significance of an ICAR. These issues may affect Members but are not of a nature that immediately affects their health and safety. Generally, they involve deficiencies with respect to non-existent or inadequate policies and procedures, systems, internal controls, training, operations or staffing. CARs must be addressed within thirty (30) calendar days from receipt of CAR notification.
  3. **Invalid Data Submission (IDS)** – An IDS condition is cited when the Delegate fails to produce an accurate universe within three (3) attempts.
  4. **Observations (OBS)** – Observations are identified conditions of non-compliance that are not systemic or represent a “one-off issue”.
- H. IEHP will issue the audit findings report which will include the following and any corrective action requests:
1. Executive summary of the audit detailing the audit elements, the audit period, the number of cases reviewed, and the number of cases failed during the Universe Integrity audit (by category);
  2. Universe integrity findings by listing noncompliance with instructions for populating each column in the Referral Universe;
  3. The results of timeliness testing for each authorization priority level (urgent, routine and retrospective), including the percent of compliance for decision-making, Member notification and Provider notification; and
  4. All identified findings (conditions) for each authorization priority level (urgent, routine and retrospective) referencing the specific regulation, accreditation standard or Plan policy found deficient, including specific examples from the case review audit, and the action steps required.
- I. IEHP will review and approve ICARs and CARs after IEHP determines that CAPs adequately address all the identified deficiencies.

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## 25. DELEGATION AND OVERSIGHT

### E. Utilization Management 3. Referral and Denial Audits

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- J. IEHP will perform a CAP validation webinar audit to ensure that all CAPs have been implemented per Delegate's CAP.
- K. Once validation is complete, and all findings have been resolved, then IEHP will close out the focused audit CAP and notify the Delegate accordingly. Any unresolved findings will require for the CAP to remain open. At its discretion, IEHP may also enforce one (1) or more of the following:
1. Concurrent denial review for a percentage of total denials may be initiated at which time the Delegate will receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
  2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly Focused audit for two (2) consecutive months;
  3. A focused meeting with the Delegate's Administration and IEHP's leadership; and/or
  4. Sanctions may be enforced as outlined in the Delegate's contract with IEHP under Retrospective Approval and Denial Audits.

<b>INLAND EMPIRE HEALTH PLAN</b>		
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## 25. DELEGATION AND OVERSIGHT

### F. Encounter Data Reporting

#### 1. Medicare MMP Reporting Requirements – IEHP DualChoice Plan

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##### **APPLIES TO:**

- A. This policy applies to IPAs contracting with IEHP DualChoice Plan.

##### **POLICY:**

- A. IEHP requires IPAs to submit all Medicare – Medicaid Plan (MMP) Core and California-Specific reports according to the IEHP DualChoice MMP Core and California-Specific Measures Reporting Schedule. All IPAs must meet timeliness and accuracy for all the most current MMP Core and California-Specific reporting requirements.

##### **PURPOSE:**

- A. IPAs are required to submit this data to enable IEHP to comply with regulatory reporting requirements.

##### **PROCEDURES:**

- A. IPAs are required to provide the MMP Core and California-Specific data elements that are reported to the Centers for Medicare and Medicaid Services (CMS) on a pre-determined schedule. IPAs must submit IEHP DualChoice data for all MMP Core measures and California-Specific measures as follows:
1. MMP Core Reporting Requirements (See Attachment, “2021 MM Capitated Financial Alignment Model Reporting,” in Section 25).  
California-Specific Reporting Requirements (See Attachment, “California Specific Reporting Requirements,” in Section 25).
- B. IPAs must submit their required report(s) using the appropriate naming convention on a monthly, quarterly, semi-annual and/or annual basis via IEHP’s Secure File Transfer Protocol (SFTP) (See Attachment, “Medicare Provider Reporting Requirements Schedule” in Section 25).
- C. IPAs must provide complete and accurate data submissions for each element requested for each reportable measure. Details for the Universe template layouts are available as follows:
1. Attachment, “IEHP Universe M\_Claims Data Dictionary” in Section 25;
  2. Attachment, “IEHP Universe Standard Auth MSSAR Data Dictionary” in Section 25; and
  3. Attachment, “IEHP Universe Expedited Auth MESAR Data Dictionary” in Section 25.
- D. For each reportable measure, IPAs must use the provided reporting template that supports the required reporting elements:

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## 25. DELEGATION AND OVERSIGHT

### F. Encounter Data Reporting

#### 1. Medicare MMP Reporting Requirements – IEHP DualChoice Plan

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1. Reporting Template - The report includes aggregate metrics supporting each element specified for each measure (See Attachments, “Care Transition Cases Log,” “IEHP Universe M\_Claims Template”, “IEHP Universe Standard Auth MSSAR Template,” “IEHP Universe Expedited Auth MESAR Template,” –“Monthly Medicare Care Management Log,” “Monthly Medicare Care Plan Outreach Log” and “Enrollee Protections Report Template” in Section 25).
- E. If CMS releases revised MMP Core and/or California-Specific Reporting specifications for the measures requested during the reportable calendar year, IPAs must re-submit reports using reporting templates with the most current reporting specifications. IEHP may re-issue a revised template if necessary. Resubmissions must be complete within IEHP-defined timelines.
- F. Any questions IPAs have regarding CMS MMP Core or California-Specific reporting requirements should be communicated through IEHP’s Delegation Oversight Department.
- G. IEHP works with each Delegate to ensure that any identified problem areas are corrected in a timely manner. Additionally, when a report and/or data file is not submitted to IEHP by the due date, IEHP requests a Corrective Action Plan (CAP) from the Delegate to remedy the problem, see Policy 25A4, "Delegation Oversight - Corrective Action Plan Requirements." Failure to submit MMP Core and/or California-Specific Reports that meet IEHP’s submission requirements for Timeliness and Accuracy may result in IEHP deducting one percent, unless successfully appealed, of the Delegate’s monthly capitation for reports that fails to meet Timeliness and Accuracy reporting requirement. Appeals must be submitted following the appeal process as defined in Policy MA\_25A1, “Delegation Oversight - Delegated Activities.”

#### **ATTACHMENTS (SEE IN SECTION 25):**

- A. Care Transition Cases Log (TOC Log)
- B. Care Coordinator to Member Ratio Template (5.1)
- C. IEHP Universe Expedited Auth MESAR Template
- D. IEHP Universe Standard Auth MSSAR Template
- E. IEHP Universe M\_Claims Template
- F. Monthly Medicare Care Management Log
- G. Enrollee Protections Report Template, CA2.1
- H. Care Coordinator Training for Supporting Self-Direction
- I. Medicare Provider Reporting Requirements Schedule
- J. California Specific Reporting Requirements

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## 25. DELEGATION AND OVERSIGHT

- F. Encounter Data Reporting
    - 1. Medicare MMP Reporting Requirements – IEHP DualChoice Plan
- 

- K. MM Capitated Financial Alignment Model Reporting
- L. Monthly Medicare Care Plan Outreach Log

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## 25. DELEGATION AND OVERSIGHT

- F. Encounter Data Reporting
    - 2. IEHP DualChoice Data Sharing Program
- 

### **APPLIES TO:**

- A. This policy applies to all IEHP DualChoice Delegates and Providers.

### **POLICY:**

- A. Delegates are required to have a process to receive and act on all information sent to them from IEHP for purposes of supporting Member care coordination activities.
- B. Each IPA and subcontractor agree to share with IEHP available supplemental data related to Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>), Star Ratings Program, Risk Adjustment and other Quality Management (QM) and Quality Improvement (QI) Activities.

### **DEFINITION:**

- A. Delegate – For the purpose of this policy, a delegate is defined as a medical group, Health Plan, IPA, or any contracted organization delegated to maintain and/or provide QM programs and activities.

### **PROCEDURES:**

- A. IEHP provides IPAs and Provider Subcontractors, Member information that supports Care Coordination activities for its Members, specifically;
  - 1. Completed Health Risk Assessment (HRA) data;
  - 2. Care Management Care Plans (if applicable);
  - 3. Care Management Program Details;
  - 4. Open Authorizations;
  - 5. Medicare Hierarchical Condition Categories (HCC) information;
  - 6. Monthly Membership Report (MMR) and MOR (Model Output Report) data files;
  - 7. Annual Model Output Report Final (MORF);
  - 8. Supplemental Data (e.g. Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>), Encounter Data System (EDS), lab results, pharmacy claims data);
  - 9. Eligibility;
  - 10. Encounters;
  - 11. Capitation; and

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## 25. DELEGATION AND OVERSIGHT

### F. Encounter Data Reporting

#### 2. IEHP DualChoice Data Sharing Program

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12. Historical Utilization (e.g., Historical claims for assigned IEHP DualChoice Members, Medi-Cal Fee-For-Service Claims, Medicare Part A, Part B and Part D data and In-Home Supportive Services (IHSS) Payment Data).

- B. On a daily basis, IEHP will provide a file of all newly completed initial HRAs to the IPAs for their assigned IEHP DualChoice Members via the secure IEHP Provider web portal.
- C. On a weekly basis, IEHP will provide a file of all newly completed annual reassessment HRAs to the IPAs for their assigned IEHP DualChoice Members via the secure IEHP Provider web Portal.
- D. On a daily basis, IEHP will provide the IPA the following Care Management information on all newly transitioned Members from IEHP-Direct:
  - 1. Most current HRA completed survey (if applicable); and
  - 2. Most current and up-to-date Care Plan (if applicable).

The IPA is required to review this information and assess the Member's needs for continued support from the IPA's Care Management program/s.

- E. On a monthly basis, IEHP will provide a listing of all open authorizations for Members newly transitioned from IEHP Direct into an IPA. This information is transmitted via IEHP's Secure File Transfer Protocol (SFTP).
- F. On a monthly basis, IEHP provides a roster of all Members due for preventive care services or who have gaps in care based on the IEHP Quality Improvement program via the secure IEHP Provider web portal. This information should be reviewed and incorporated into the IPAs Quality Improvement program activities/work plan.
- G. During the first week of each month, IEHP will provide a listing of all CMS-stored HCC Member Information Profile report information related to Members who newly transitioned from IEHP Direct to an IPA (including the MMR, MOR, Annual MORF and EDS Return Files) via SFTP. This information should be reviewed and incorporated into the IPA's HCC program activities/annual work plan.
- H. During the first week of each month, IEHP will provide HCC Member Information Profile reports for all Members assigned to the IPA via SFTP. This information should be reviewed and incorporated into the IPAs HCC program activities/work plan.
- I. On a monthly/weekly basis, IEHP will provide a listing of assigned membership. This information will be transmitted via SFTP.
- J. On a monthly/weekly/daily basis, IEHP will provide a summary of encounters submitted to the health plan via SFTP.
- K. On a monthly basis, IEHP will provide capitation information for the prior month. This information will be transmitted via SFTP.

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## 25. DELEGATION AND OVERSIGHT

### F. Encounter Data Reporting

#### 2. IEHP DualChoice Data Sharing Program

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- L. On a monthly basis, IEHP will provide historical claims for assigned IEHP DualChoice Members, Medi-Cal FFS claims, Medicare Part A, Part B and Part D data and IHSS payment data. This information will be transmitted via SFTP.
- M. On a semi-annual basis (or more frequently), the IPA will share with IEHP any supplemental data to support HEDIS<sup>®</sup>, Quality Withhold, Risk Adjustment or any other Quality Improvement Activities.
1. The type, format, mode of transmission and frequency of this supplemental data sharing will be mutually agreed-upon by both the IPA and IEHP. IEHP will accept the IEHP Alternative Submission Method (ASM) file template in lieu of a EDS submission. Additionally, the IPA will also be required to submit an encounter for each DOS submitted on the ASM file.
  2. For HCC supplemental data sharing, the format of HCC supplemental data files must be approved by IEHP prior to submission for EDS processing. The IPA must submit any additional validated HCC data following CMS Risk Adjustment data submission timelines (e.g., CMS Sweeps). To process data files prior to the CMS Sweeps deadline, all data files should be submitted to IEHP according to the following Sweeps timeline:

Risk Score Run	Dates of Service	Deadline for Submission of EDS Data to IEHP for Sweeps
2022 Interim Final Run	01/01/2021 – 12/31/2021	Tuesday, 01/17/2023
2023 Mid-Year	01/01/2022 – 12/31/2022	Friday, 02/17/2023
2022 Final Run	01/01/2021 – 12/31/2021	Monday, 07/17/2023

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## 25. DELEGATION AND OVERSIGHT

### Attachments

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<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
Practitioner Profile Template	5A8
MM Capitated Financial Alignment Model Reporting	25F1
Approved Referral Audit Tool	25E3
California Specific Reporting Requirements	25F1
Care Coordinator to Member Ratio Template 5.1	25F1
Care Coordinator Training for Supporting Self-Direction Under the Demo	25F1
Care Transition Cases Log (TOC Log)	25F1
Credentialing DOA Audit Tool	25B8, 5A8
Credentialing and Recredentialing Report	25B10
Enrollee Protections Reporting Template	25F1
IEHP ASM File Template	25E1, 25E3, 25F1
IEHP Universe Expedited Auth MESAR Data Dictionary	
IEHP Universe Expedited Auth MESAR Template	25E1, 25E2, 25E3, 25F1
IEHP Universe M_Claims Data Dictionary	25F1
IEHP Universe M_Claims Template	25F1
IEHP Universe Standard Auth MSSAR Data Dictionary	25E1, 25E3, 25F1
IEHP Universe Standard Auth MSSAR Template	25E1, 25E2, 25E3, 25F1
IPA Biographical Information Sheet	25A1
Delegated IPA Delegation Agreement – IEHP DualChoice	25A1
Delegated IPA Denial Log Review Tool – IEHP Dual Choice	25E3
Delegation Oversight Audit Preparation Instructions – IEHP DualChoice	25A1, 25E3, 5A8
Medicare Provider Reporting Requirements Schedule	25A1, 25C2; 25D2, 25F1
IPA Care Management Review Tool	25C1
Monthly Medicare Care Management Log	25C2, 25F1, 10L, 10M, 10N
Monthly Medicare Care Plan Outreach Log	25F1
Monthly Medicare Interdisciplinary Team Log	25C2
Precontractual Audit Preparation Instructions – IEHP DualChoice	
Program Description – Denial Letter Sanction – IEHP DualChoice	25E3

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## 25. DELEGATION AND OVERSIGHT

### Attachments

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<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
Second Opinion Tracking Log	25E2
QI UM CM DOA Audit Tool	25E1
Response to Request for UM Criteria	25E1
Request for UM Criteria Log	25A2
Subcontracted Facility/Agency Services and Delegated Functions Attachment I – Statement of Agreement by Supervising Provider	25B10





DualChoice

IEHP Utilization Management Delegation Oversight  
 LOB: Medicare  
 Approval Review Tool

Delegate/IPA:	
Service Month:	
Review Date:	
Reviewer:	

Overall Score	N/A
Overall Points Possible	
Overall Points Received	

Timeliness*	
Total Auths Approved	###
Notification Timely	%
Decisioned Timely	%

\*Details Provided by IEHP HCI Dept

	File #1	File #2	File #3	File #4	File #5	File #6	File #7	File #8	File #9	File #10	Elemental Score
(a) Approval Tracking #											
(b) File Type Requested											
(c) Authorization Received Date / Time											
(d) Authorization Decision Date / Time											
(e) Date Referral Deemed Necessary											
(f) Date receipt of information reasonably necessary to make the determination											
(g) Member/Provider Language											
(h) Notification of Letter Sent											
(i) Clinical Documentation											
(j) Provider Outreach											
(k) Correct Template											
(l) Points Received											
(m) Points Possible											
(n) Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Comments											

**File Review Instructions:**

IEHP selects 10 approved Authorizations for review from the IPA Delegated *Monthly Referral Tracking Log*. Each file will be reviewed against the elements listed below and noted as follows: "1" yes the file review element meets, "0" when the file review element does not meet. Each file reviewed has a maximum score of 5 possible points. Findings related to each file review will be listed within the comments for IPA review.

<b>Data Dictionary</b>			
<i>Element Letter</i>	<i>Element Description</i>	<i>Methodology</i>	<i>Regulatory Criteria/ Citation/ Policy</i>
(a)	Approval Tracking #	<b>Element Not Scored:</b> The authorization reference number located on the referral form for tracking purposes.	IEHP Provider Policy and Procedure - Dual Choice MA_25E1: <i>Utilization Management - Delegation Oversight &amp; Monitoring</i>
(b)	File Type requested	<b>Element Not Scored:</b> The authorization type: Pre-Service Routine , Pre-Service Expedited, Post Service Retrospective Review, Concurrent Standard, Concurrent Expedited.  Review of documentation for a proper downgrade from an expedited determination request to a standard determination and for proper notification to the enrollee that explains that the organization will process the request using the 14-day timeframe for standard determinations, informs the enrollee of the right to file an expedited grievance, informs the enrollee of the right to resubmit a request for an expedited determination with any physician's support, and provides instructions about the grievance process and timeframes.	
(c)	Authorization Received Date / Time	<b>Element Not Scored:</b> The date the authorization request was received.	
(d)	Authorization Decision Date / Time	<b>Element Not Scored:</b> The date the authorization request was approved.	
(e)	Date Referral Deemed Necessary	<b>Element Not Scored:</b> The date/time the Provider deemed the referral necessary.	
(f)	Date receipt of information reasonably necessary to make the determination	<b>Element Not Scored:</b> The date the Plan or Delegate received information reasonably necessary to make the determination.	
(g)	Member Language	<b>Scored Element:</b> Review of the authorization approval letter sent to the Member/Provider or enrollee's authorized representative when an AOR is in place, must be written in a manner, format, and language that can be easily understood.	IEHP Provider Policy and Procedure - Dual Choice MA_25E1: <i>Utilization Management - Delegation Oversight &amp; Monitoring</i>
(h)	Notification of Letter Sent	<b>Scored Element:</b> Review of documentation must demonstrate evidence that a approved authorization letter was sent to the Member/Provider.	
(i)	Clinical Documentation	<b>Scored Element:</b> Review of supportive clinical information must demonstrate the application of the criteria utilized to determine decision. Documentation must include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based. Element excludes automated authorization approvals.	
(j)	Provider Outreach	<b>Scored Element:</b> In the event initial request submitted by Provider does not include information reasonably necessary to make a determination of the authorization, evidence must demonstrate IPA outreach to the requesting Provider for additional clinical information.	



**IEHP Utilization Management Delegation Oversight**  
**LOB: Medicare**  
**Approval Review Tool - Instructions and Data Dictionary**

(k)	<b>Correct Template</b>	<p><b>Scored Element:</b>  Review of the authorization letter demonstrates the use of IEHP approved CMS template and attachments- Correct template with attachments can be found on the IEHP website at: <a href="http://iehp.org">iehp.org</a>. Member authorization letter must be mailed in the Member's appropriate threshold language.</p>	
(l)	<b>Points Received</b>	Each file reviewed has a maximum score of 5 possible points. Total points earned from letters (e)-(i) above.	N/A
(m)	<b>Points Possible</b>	Each file reviewed has a maximum score of 5 possible points. Total points possible from letters (e)-(i) above, excluding non applicable elements.	
(n)	<b>Individual File Score</b>	Total points earned from letters (e)-(i) above divided by total points possible from letters (e)-(i) above, excluding non applicable elements for each file reviewed.	

**MEDICARE-MEDICAID  
CAPITATED FINANCIAL ALIGNMENT MODEL  
REPORTING REQUIREMENTS:  
CALIFORNIA-SPECIFIC REPORTING  
REQUIREMENTS**

Issued February 28, 2020

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## CALIFORNIA-SPECIFIC REPORTING REQUIREMENTS APPENDIX

### Introduction

The measures in this appendix are required reporting for all MMPs in the Cal MediConnect Demonstration. CMS reserves the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements, which can be found at the following web address:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

MMPs should refer to the core document for additional details regarding Demonstration-wide definitions, reporting phases and timelines, and sampling methodology.

The core and state-specific measures supplement existing Part C and Part D Reporting Requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS<sup>®1</sup> and HOS. CMS and the State will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

For the measures contained within the California state-specific appendix, MMPs will be required to submit data at the contract level. Additional information regarding the Data Submission process is provided on page CA-11.

MMPs should contact the CA HelpDesk at [CAHelpDesk@norc.org](mailto:CAHelpDesk@norc.org) with any questions about the California state-specific appendix or the data submission process.

### Definitions

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: January 1 to March 31, April 1 to June 30, July 1 to September 30, and October 1 to December 31.

Calendar Year: All annual measures are reported on a calendar year basis. For example, Calendar Year (CY) 2020 represents January 1, 2020 through December 31, 2020.

Case Management, Information and Payrolling System II (CMIPS II): A system that tracks case information and processes payments for the California Department of Social Services In-Home Supportive Services Program, enabling nearly 400,000 qualified aged, blind, and disabled individuals in California to remain in their own homes and avoid institutionalization.

In-Home Supportive Services (IHSS): Pursuant to Article 7 of the California Welfare and Institutions Code (WIC) (commencing with Section 12300) of Chapter 3, and WIC

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<sup>1</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

Sections 14132.95, 14132.952, and 14132.956, IHSS is a California program that provides in-home care for people who cannot safely remain in their own homes without assistance. To qualify for IHSS, an Enrollee must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program. IHSS includes the Community First Choice Option (CFCO), Personal Care Services Program (PCSP), and IHSS-Plus Option (IPO).

Implementation Period: The initial months of the demonstration during which MMPs reported to CMS and the state on a more intensive reporting schedule. The Implementation Period started with the first effective enrollment date until the end of the first full quarter following the third wave of passive enrollment (therefore, all MMPs had an Implementation Period of at least six months). For MMPs that added a county in 2015, the Implementation Period continued for a full quarter following the first effective date of enrollment. For MMPs with less than three waves of passive enrollment, the Implementation Period ended September 30, 2014.

Individualized Care Plan (ICP or Care Plan): The plan of care developed by an Enrollee and/or an Enrollee's Interdisciplinary Care Team or health plan.

Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following:

1. IHSS provided pursuant to Article 7 of California WIC (commencing with Section 12300) of Chapter 3, and WIC Sections 14132.95, 14132.952, and 14132.956;
2. Community-Based Adult Services (CBAS);
3. Multipurpose Senior Services Program (MSSP) services; and
4. Skilled nursing facility (SNF) services and subacute care services.

Primary Care Provider (PCP): A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

## **Variation from the Core Reporting Requirements Document**

### Core Measure 9.2

The following section provides additional guidance about identifying individuals enrolled in the MMP as "nursing home certifiable," or meeting the nursing facility level of care (NF LOC), for the purposes of reporting Core 9.2.

Within Core 9.2, "nursing home certifiable" members are defined as "members living in the community but requiring an institutional level of care" (see the Core Reporting Requirements for more information). Please reference Title 22, CCR Division 3,

sections 51173.1, 51120, 51124, 51124.5, 51125.6, 51334, and 51335 of the CA Code of Regulations for additional information and definitions as it relates to this measure.

The Medicaid 834 eligibility file provided to MMPs by the state on a daily and monthly basis contains variables indicating an individual's status with regard to meeting the NF LOC. The relevant variables are as follows:

- Variable 3.8. Institutional Indicator (Y): Identifies actual institutional placement (i.e., anyone residing in a SNF for 90 or more consecutive days).
- Variable 3.7. CCI Exclusion Indicator (M, N): Indicates that a member lives in the community and meets the NF LOC for CBAS and MSSP only.
- Eligibility status code 2K, Loop 2300 REF 01 under 'CE' (Note: Status code 2K could be found in any of the following fields - SPEC1-AID, SPEC2-AID, SPEC3-AID): Indicates that a member lives in the community and meets the NF LOC for IHSS only.

In addition to these variables in the 834 file, MMPs should use claims data to ensure the member qualifies as nursing home certifiable, (i.e., is living in the community or has resided in a NF for fewer than 100 days). This may include individuals who have resided in a NF for 90 – 99 days and have thus triggered the long-term care (LTC) indicator, but still fall below the 100-day threshold for the purposes of Core 9.2.

It is possible that some individuals who have never been assessed for LTSS (e.g., community well or individuals stratified as HCBS low) will indeed be nursing home certifiable and this status will be unknown to the MMP. This is a limitation of this measure. Provided that MMPs comply with the requirements for assessment and care planning under the Demonstration, no further action by the MMP to identify these individuals is necessary.

### **Quality Withhold Measures**

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, state-specific quality withhold measures are marked with the following symbol for Demonstration Year 1: (i) and the following symbol for Demonstration Years 2 through 8: (ii). Note that an additional DY 2 through 8 state-specific quality withhold measure is reported separately through the Core Reporting Requirements. For more information about the state-specific quality withhold measures, refer to the Quality Withhold Technical Notes (DY 1): California-Specific Measures and the Quality Withhold Technical Notes (DY 2-8): California-Specific Measures at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html>.

### **Reporting on HRAs and ICPs Completed Prior To First Effective Enrollment Date**

MMPs may complete Health Risk Assessments (HRAs) prior to individuals' effective date of enrollment, provided that the MMP meets the requirements as articulated in the National MMP Enrollment and Disenrollment Guidance. Note that for individuals who



are passively enrolled, the MMP may reach out to complete an HRA no sooner than 20 days before the individual's effective date of the passive enrollment.

For purposes of reporting data on HRAs (Core 2.1 and Core 2.2), MMPs should report any HRAs completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the HRA for that member was completed on May 25, the MMP should report the HRA as if it was completed on June 1.

MMPs should refer to the Core Reporting Requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period. Members enrolled into the MMP on June 1 would reach their 90th day (three full months) on August 31. Therefore, these members would be reported in the data submission for the Quarter 3 reporting period, even if their HRA was marked as complete on the first effective enrollment date (i.e., June 1).

MMPs must comply with contractually specified timelines regarding completion of ICPs following the HRA. In the event that an ICP is also finalized prior to the first effective enrollment date, MMPs should report completion of the ICP (for measures Core 3.2, CA1.5, and CA1.6) as if it was completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the ICP for that member was completed on May 27, the MMP should report the ICP as if it were completed on June 1.

## **Guidance on HRAs and ICPs for Members with a Break in Coverage**

### Health Risk Assessments

To determine if an HRA should be conducted for a member who re-enrolled in the same or a different MMP, the MMP should determine if the member previously received an HRA from any MMP in the Cal MediConnect Demonstration. If the member received an HRA from the same MMP within one year of his/her most recent enrollment date, or from a different MMP within six months of changing MMPs, then the MMP is not necessarily required to conduct a new HRA, until there is a change in the enrollee's condition. Instead, the MMP can:

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member's condition since the HRA was conducted; and
2. Ask the member (or his/her authorized representative) if there has been a change in the member's health status or needs since the HRA was conducted.

The MMP must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member's condition. The MMP must also document its outreach attempts and the discussion(s) with the member (or his/her authorized representative) to determine if there was a change in the member's health status or needs.

If a change is identified, the MMP must conduct a new HRA within the timeframe prescribed by the three-way contract. If there are no changes, the MMP is not required

to conduct a new HRA unless requested by the member (or his/her authorized representative). Please note, if the MMP prefers to conduct HRAs on all re-enrollees regardless of status, it may continue to do so.

Once the MMP has conducted a new HRA as needed or confirmed that the prior HRA is still accurate, the MMP can mark the HRA as complete for the member's current enrollment. The MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these measures, the MMP should count the number of enrollment days from the member's most recent enrollment effective date and should report the HRA based on the date the prior HRA was either confirmed to be accurate or a new HRA was completed. Additionally, in certain circumstances a new assessment that has been completed for a member upon reenrollment may also be reported in Core 2.3.

If the MMP is unable to reach a re-enrolled member to determine if there was a change in health status, then the MMP may report that member as unable to be reached so long as the MMP made the requisite number of outreach attempts. If a re-enrolled member refuses to discuss his/her health status with the MMP, then the MMP may report that member as unwilling to participate in the HRA.

If the MMP did not complete an HRA for the re-enrolled member within one year of his/her most recent date of enrollment into the same MMP or an HRA was not completed for the member within the previous six months by a different MMP for those members who changed MMPs, the MMP is required to conduct an HRA for the member within the timeframe prescribed by the three-way contract and relevant Duals Plan Letter (DPL). The MMP must make the requisite number of attempts to reach the member (at minimum) after his/her most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during his/her prior enrollment. Similarly, members who refused the HRA during his/her prior enrollment must be asked again to participate (i.e., the MMP may not carry over a refusal from one enrollment period to the next).

#### Individualized Care Plans

If the MMP conducts a new HRA for the re-enrolled member, the MMP must revise the ICP accordingly within the timeframe prescribed by the three-way contract. Once the ICP is revised, the MMP may mark the ICP as complete for the member's current enrollment. If the MMP determines that the prior HRA is still accurate and, therefore, no updates are required to the previously completed ICP, the MMP may mark the ICP as complete for the current enrollment at the same time that the HRA is marked complete. The MMP would then follow the Core 3.2, CA1.5, and CA1.6 measure specifications for reporting the completion. Please note, for purposes of reporting, the ICP for the re-enrolled member should be classified as an *initial* ICP.

If the MMP did not complete an ICP for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's ICP was completed, the MMP is required to complete an ICP for the member within the timeframe prescribed by the three-way contract. The MMP must also follow the above guidance regarding reaching out to members who previously refused to participate or were not reached.

### Annual Reassessments and ICP Updates

The MMP must follow the three-way contract requirements regarding the completion of annual reassessments and updates to ICPs. If the MMP determined that an HRA/ICP from a member's prior enrollment was accurate and marked that HRA/ICP as complete for the member's current enrollment, the MMP should count continuously from the date that the HRA/ICP was completed in the prior enrollment period to determine the due date for the annual reassessment and ICP update. For example, when reporting Core 2.3, the MMP should count 365 days from the date when the HRA was actually completed, even if that date was during the member's prior enrollment period.

### **Reporting on Passively Enrolled and Opt-In Enrolled Members**

When reporting all California state-specific measures, MMPs should include all members who meet criteria for inclusion in the measure regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

### **Reporting on Disenrolled and Retro-disenrolled Members**

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMP. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each state-specific measure.

Due to retro-disenrollment of members, there may be instances where there is a lag between a member's effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and, therefore, was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are *not* required to re-submit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member's enrollment status.

### **Hybrid Sampling**

Some demonstration-specific measures may allow medical record/supplemental documentation review to identify the numerator. In these instances, the sample size should be 411, plus additional records to allow for substitution. Sampling should be systematic to ensure that all individuals eligible for a measure have an equal chance of inclusion.

MMPs should complete the following steps for each measure that requires medical record review:

- Step 1:** Determine the eligible population. Create a list of eligible members, including full name, date of birth, and event (if applicable).
- Step 2:** Determine the final sample size. The final sample size will be 411 plus an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20 percent. If oversampling, round up to the next whole number when determining the final sample size.
- Step 3:** If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 5. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 4.
- Step 4:** If the eligible population is less than or equal to the final sample size as determined in Step 2, the sample size can be reduced from 411 cases to a reduced final sample size by using the following formula:

$$\text{Reduced Final Sample Size} = \frac{\text{Original Final Sample Size}}{1 + \left( \frac{\text{Original Final Sample Size}}{\text{Eligible Population}} \right)}$$

Where the *Original Final Sample Size* is the number derived from Step 2, and the *Eligible Population* is the number derived from Step 1.

- Step 5:** Sort the list of eligible members in alphabetical order by last name, first name, date of birth, and event (if applicable). Sort this list by last name from A to Z during even reporting periods and from Z to A in odd reporting periods (i.e., name will be sorted from A to Z in 2014, 2016, and 2018 and from Z to A in 2015, 2017, and 2019).

**Note:** Sort order applies to all components. For example, for reporting period 2014, the last name, first name, date of birth, and events will be ascending.

- Step 6:** Calculate  $N$ , which will determine which member will start your sample. Round down to the nearest whole number.

$$N = \frac{\text{Eligible Population}}{\text{Final Sample Size}}$$

Where the *Eligible Population* is the number derived from Step 1. The *Final Sample Size* is either:

- The number derived from Step 2, for instances in which the eligible population exceeds the final sample size as determined in Step 2.
- OR
- The number derived in Step 4, for instances in which the eligible population was less than or equal to the number derived from Step 2.

- Step 7:** Randomly select starting point,  $K$ , by choosing a number between one and  $N$  using a table of random numbers or a computer-generated random number.

**Step 8:** Select every *Kth* record thereafter until the selection of the sample size is completed.

### Value Sets

The measure specifications in this document refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The California-Specific Value Sets Workbook includes all value sets and codes needed to report certain measures included in the California-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The California-Specific Value Sets Workbook can be found on the CMS website at the following address: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.

### California's Implementation, Ongoing, and Continuous Reporting Periods

Phase	Dates	Explanation	
<b>Demonstration Year 1</b>			
Continuous Reporting	Implementation Period	Varies	The period of time starting with the first effective enrollment date until the end of the first full quarter following the third wave of passive enrollment. For MMPs adding a county in 2015, the implementation period continues for a full quarter following the first effective enrollment date.
	Ongoing Period	Varies	From the first effective enrollment date through the end of the first full calendar year of the demonstration.
<b>Demonstration Year 2</b>			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1, 2016 through the end of the second full calendar year of the demonstration.

Phase		Dates	Explanation
<b>Demonstration Year 3</b>			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1, 2017 through the end of the third full calendar year of the demonstration.
<b>Demonstration Year 4</b>			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1, 2018 through the end of the fourth full calendar year of the demonstration.
<b>Demonstration Year 5</b>			
Continuous Reporting	Ongoing Period	1-1-19 through 12-31-19	From January 1, 2019 through the end of the fifth full calendar year of the demonstration.
<b>Demonstration Year 6</b>			
Continuous Reporting	Ongoing Period	1-1-20 through 12-31-20	From January 1, 2020 through the end of the sixth full calendar year of the demonstration.
<b>Demonstration Year 7</b>			
Continuous Reporting	Ongoing Period	1-1-21 through 12-31-21	From January 1, 2021 through the end of the seventh full calendar year of the demonstration.
<b>Demonstration Year 8</b>			
Continuous Reporting	Ongoing Period	1-1-22 through 12-31-22	From January 1, 2022 through the end of the eighth full calendar year of the demonstration.

### Data Submission

All MMPs will submit state-specific measure data through the web-based Financial Alignment Initiative Data Collection System (FAI DCS) (unless otherwise specified in the measure description). All data submissions must be submitted to this site by 5:00 p.m. ET on the applicable due date. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

(Note: Prior to the first use of the system, all MMPs will receive an email notification with the username and password that has been assigned to their MMP. This information will be used to log in to the FAI DCS and complete the data submission.)

All MMPs will submit core measure data in accordance with the Core Reporting Requirements. Submission requirements vary by measure, but most core measures are reported through the Health Plan Management System (HPMS).

Please note, late submissions may result in compliance action from CMS.

### **Resubmission of Data**

MMPs must comply with the following steps to resubmit data after an established due date:

1. Email the CA HelpDesk ([CAHelpDesk@norc.org](mailto:CAHelpDesk@norc.org)) to request resubmission.
  - a. Specify in the email which measure(s) need resubmission;
  - b. Specify for which reporting period(s) the resubmission is needed; and
  - c. Provide a brief explanation for why the data need to be resubmitted.
2. After review of the request, the CA HelpDesk will notify the MMP once the FAI DCS and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the CA HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.

**Section CAI. Care Coordination**

- CA1.1 High-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the timely initial Health Risk Assessment (HRA). – **Retired**
- CA1.2 High-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA). – **Retired**
- CA1.3 Low-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the timely initial Health Risk Assessment (HRA). – **Retired**
- CA1.4 Low-risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the initial Health Risk Assessment (HRA). – **Retired**
- CA1.5 Members with an Individualized Care Plan (ICP) completed.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
CA1. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the first month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
CA1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period



A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of high-risk members enrolled for 90 days or longer as of the end of the reporting period.	Total number of high-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.	Field Type: Numeric
B.	Total number of high-risk members who had an initial ICP completed.	Of the total reported in A, the number of high-risk members who had an initial ICP completed as of the end of the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of low-risk members enrolled for 90 days or longer as of the end of the reporting period.	Total number of low-risk members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.	Field Type: Numeric
D.	Total number of low-risk members who had an initial ICP completed.	Of the total reported in C, the number of low-risk members who had an initial ICP completed as of the end of the reporting period.	Field Type: Numeric Note: Is a subset of C.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.
  - MMPs should validate that data element D is less than or equal to data element C.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:
- High-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period.
    - Percentage =  $(B / A) * 100$
  - Low-risk members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period.
    - Percentage =  $(D / C) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- High-risk members are members who are at increased risk for having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact within 45 calendar days after their effective enrollment date.
- Low-risk members are members who do not meet the minimum requirements of a high-risk member.

#### Data Elements A and C

- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment (or longer) with no gaps in enrollment.
- For the purposes of reporting data elements A and C, 90 days of enrollment will be equivalent to three full calendar months.

#### Data Elements B and D

- The completed initial ICPs reported in data elements B and D could have been completed at any point from the member's first day of enrollment through the end of the reporting period.
- MMPs should only report completed ICPs in data elements B and D when the member or the member's authorized representative was involved in the development of the ICP.

#### General Guidance

- MMPs should refer to the California three-way contract for specific requirements pertaining to ICPs.
- Risk level should be determined using an approved health risk stratification mechanism or algorithm. The health risk stratification shall be conducted in accordance with the most recent DHCS DPL. MMPs should use the

member’s initial risk level categorization for purposes of reporting this measure.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

CA1.6 Members with documented discussions of care goals.<sup>i, ii</sup>

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
CA1. Care Coordination	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an initial Individualized Care Plan (ICP) completed.	Total number of members with an initial ICP completed during the reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members with at least one documented discussion of care goals in the initial ICP.	Of the total reported in B, the number of members with at least one documented discussion of care goals in the initial ICP.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of existing ICPs revised.	Total number of existing ICPs revised during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of revised ICPs sampled that met inclusion criteria.	Of the total reported in D, the number of revised ICPs sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of revised ICPs with at least one documented discussion of new or existing care goals.	Of the total reported in E, the number of revised ICPs with at least one documented discussion of new or existing care goals.	Field Type: Numeric Note: Is a subset of E.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- The quality withhold benchmark is 55% for DY 2 and 3, 60% for DY 4, and 65% for DY 5. For more information, including benchmarks for DY 6 – 8, refer to the Quality Withhold Technical Notes (DY 2-8): California-Specific Measures.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data element B is less than or equal to data element A.
  - MMPs should validate that data element C is less than or equal to data element B.
  - MMPs should validate that data element E is less than or equal to data element D.
  - MMPs should validate that data element F is less than or equal to data element E.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:
- Members with an initial ICP completed during the reporting period who had evidence of creation of at least one care goal documented in the initial ICP.
    - Percentage =  $(C / B) * 100$
  - Existing ICPs revised during the reporting period that had at least one documented discussion of new or existing care goals.
    - Percentage =  $(F / E) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the

reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

- Data element A should include all members with ICPs that were completed for the first time during the reporting period (i.e., the member did not previously have an ICP completed prior to the start of the reporting period). There can be no more than one initial ICP completed per member.
- Only ICPs that included participation from the member (or his/her authorized representative) in the completion of the ICP should be reported.

#### Data Elements B and E

- For reporting, the MMPs may elect to sample since this measure may require documentation review to identify data elements C and F. For further instructions on selecting the sample size, please see pages CA-9 to CA-10 of this document.
- If an MMP does not elect to sample, data element B should be equal to data element A and data element E should be equal to data element D.

#### Data Element C

- The MMP should only count members in data element C when the discussion of care goals with the member (or his/her authorized representative) is clearly documented in the member's initial ICP.

#### Data Element D

- MMPs should include all ICPs for members who meet the criteria outlined in data element D, regardless of whether the members are disenrolled as of the end of the reporting period (i.e., include all ICPs regardless of whether the members are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element D should include all existing ICPs that were revised during the reporting period. MMPs should refer to the California three-way contract for specific requirements pertaining to updating the ICP.
- Only ICPs that included participation from the member (or his/her authorized representative) in the revision to the ICP should be reported.
- If a member's ICP is revised multiple times during the same reporting period, each revision should be reported in data element D.
  - For example, if a member's ICP is revised twice during the same reporting period, two ICPs should be counted in data element D.

#### Data Element F

- MMPs should only include ICPs in data element F when a new or previously documented care goal is discussed with the member (or his/her authorized representative) and is clearly documented in the member's revised ICP.
- If the initial ICP clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the ICP, then that ICP should not be reported in data element F.

General Guidance

- If a member has an initial ICP completed during the reporting period, and has their ICP revised during the same reporting period, then the member’s initial ICP should be reported in data element A and the member’s revised ICP should be reported in data element D.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

CA1.7 Members receiving Medi-Cal specialty mental health services that received care coordination with the primary mental health provider.<sup>ii</sup>

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
CA1. Care Coordination	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving Medi-Cal specialty mental health services.	Total number of members who have been continuously enrolled in the same MMP for at least five months during the reporting period and who have received Medi-Cal specialty mental health services for three or more consecutive months during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members for whom the MMP was unable to reach the member's county mental health provider/county clinic, following at least three documented outreach attempts, for the purpose of care coordination of the member's mental health needs.	Of the total reported in A, the number of members for whom the MMP was unable to reach the member's county mental health provider/county clinic, following at least three documented outreach attempts, for the purpose of care coordination of the member's mental health needs during the reporting period.	Field Type: Numeric  Note: Is a subset of A.
C.	Total number of members for whom the MMP successfully contacted the member's county mental health provider/county clinic for the purpose of care coordination of the member's mental health needs.	Of the total reported in A, the number of members for whom the MMP successfully contacted the member's county mental health provider/county clinic for the purpose of care coordination of the member's mental health needs during the reporting period.	Field Type: Numeric  Note: Is a subset of A.
D.	Total number of members the MMP was unable to reach, following at least three documented outreach attempts, for the purpose of care coordination of the member's mental health needs.	Of the total reported in A, the number of members the MMP was unable to reach, following at least three documented outreach attempts, for the purpose of care coordination of the member's mental health needs during the reporting period.	Field Type: Numeric  Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of members the MMP successfully contacted for the purpose of care coordination of the member's mental health needs.	Of the total reported in A, the number of members the MMP successfully contacted for the purpose of care coordination of the member's mental health needs during the reporting period.	Field Type: Numeric  Note: Is a subset of A.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data elements B, C, D, and E are less than or equal to data element A.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who have been continuously enrolled in the same MMP for at least five months during the reporting period and who have received Medi-Cal specialty mental health services for three or more consecutive months during the reporting period:
- For whom the MMP successfully contacted the member's county mental health provider/county clinic for the purpose of care coordination of the member's mental health needs during the reporting period.
    - Percentage =  $(C / A) * 100$
  - For whom the member's county mental health provider/county clinic could be reached and who the MMP was able to successfully contact for the purpose of care coordination of the member's mental health needs during the reporting period.
    - Percentage =  $(C / (A - B)) * 100$
  - Who the MMP successfully contacted for the purpose of care coordination of the member's mental health needs during the reporting period.
    - Percentage =  $(E / A) * 100$
  - Who could be reached and who the MMP was able to successfully contact for the purpose of care coordination of the member's mental health needs during the reporting period.
    - Percentage =  $(E / (A - D)) * 100$



- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definition

- Medi-Cal specialty mental health services are financed and administered by county agencies under the provisions of the 1915(b) SMHS waiver. For more information, including a list of specialty mental health services, refer to the Coordinated Care Initiative and Behavioral Health Services Fact Sheet available at: <http://www.calduals.org/wp-content/uploads/2013/03/FAQ-BH.pdf>.

Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- To identify members who have received Medi-Cal specialty mental health services for three or more consecutive months during the reporting period, MMPs should refer to information provided by the county agencies and/or claims data provided by the state.

Data Element B

- For data element B, the MMP should only report those members for whom the MMP was unable to reach the member's county mental health provider/county clinic following at least three documented outreach attempts for the purpose of care coordination of the member's mental health needs during the reporting period. Documentation of outreach attempts must include:
  - The name of the member's county mental health provider/county clinic;
  - The name of the person the MMP attempted to contact at the member's county mental health provider/county clinic;
  - The time and date of the outreach attempt;
  - The method of the outreach attempt (e.g., phone, email, fax, in-person, etc.);
  - The outcome of the outreach attempt.

Data Element C

- For data element C, successful contact occurs when the MMP and county provider discuss diagnoses (including medical, behavioral, and social needs), review treatment plans, and/or coordinate mental health services provided by the county provider with any of the services (e.g., medical, LTSS, etc.) provided by the MMP. This exchange of information may be conducted via phone, secure email, fax, or in person.
- If the county provider is reached but is not able to discuss the member's case at that time (e.g., due to lack of signed release), then the contact is not considered successful, but may be counted as an outreach attempt.

- If the member's county mental health provider/county clinic was not reached after three outreach attempts, but then subsequently is successfully contacted during the reporting period for the purpose of care coordination of the member's mental health needs, then the member should be counted in data element C.

#### Data Element D

- For data element D, the MMP should only report those members the MMP was unable to reach following at least three outreach attempts to contact the member for the purpose of care coordination of the member's mental health needs during the reporting period. Documentation of outreach attempts must include:
  - The time and date of the outreach attempt;
  - The method of the outreach attempt (e.g., phone, email, fax, in-person, etc.);
  - The outcome of the outreach attempt.

#### Data Element E

- For data element E, successful contact occurs when the MMP and member discuss the member's mental health needs and services, and how those services may be coordinated with other services (e.g., medical, LTSS, etc.) provided by the MMP. This discussion may be conducted via phone, secure email, fax, or in person.
- If the member was not reached after three outreach attempts, but then subsequently is successfully contacted during the reporting period for the purpose of care coordination of the member's mental health needs, then the member should be counted in data element E.

#### General Guidance

- Data elements B and C are mutually exclusive (i.e., the same member should not be counted in both data elements B and C).
- Data elements D and E are mutually exclusive (i.e., the same member should not be counted in both data elements D and E).
- Data elements B and C are not mutually exclusive with data elements D and E.
  - For example, if a member's county mental health provider/county clinic was not reached after three outreach attempts, but the member was successfully contacted during the reporting period for the purpose of care coordination of his/her mental health needs, then the member would be reported in both data elements B and E.
- The MMP does not have to conduct separate outreach to the member for the specific purpose of care coordination of the member's mental health needs (i.e., the MMP may discuss the member's mental health needs as part of its broader care coordination efforts, such as when conducting the HRA or developing the ICP). If the MMP discusses the member's mental health needs when conducting the HRA or developing the ICP (or as part of other care

coordination efforts), the MMP must clearly document the outcome of the interaction with the member, following the instructions for documenting outreach attempts as noted above.

- The outreach attempts are meant to coordinate the mental health services being provided at the county with any of the services (e.g., medical, LTSS, etc.) that the MMP is providing.
- For information about care coordination expectations, MMPs should refer to the California three-way contract, which delineates care coordination requirements in several sections. The three-way contract also highlights the California Welfare and Institutions (WIC) Code for the definition and administration of care coordination (see WIC Sections 14182.17(d)(4) and 14186(b)). MMPs are encouraged to reference the three-way contract and the WIC code for guidance on care coordination for all members, including members receiving Medi-Cal specialty mental health services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

CA1.8 Unmet Need in IHSS. – **Retired**

CA1.9 IHSS social worker contact with member. – **Retired**

CA1.10 Satisfaction with IHSS social worker, home workers, personal care. – **Retired**

CA1.11 Members with first follow-up visit within 30 days of hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
CA1. Care Coordination	Annually	Contract	Calendar Quarters Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth month following the last day of the final quarterly reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of acute inpatient hospital discharges.	Total number of acute inpatient hospital discharges that occurred during the reporting period for members who were continuously enrolled from the date of the inpatient hospital discharge through 30 days after the inpatient hospital discharge, with no gaps in enrollment.	Field Type: Numeric
B.	Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	Of the total reported in A, the number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will:

- Evaluate the percentage of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the inpatient hospital stay.
  - Percentage = (B / A) \* 100

- Use enrollment data to evaluate the total number of acute inpatient hospital discharges per 10,000 member months during the reporting period.
  - $\text{Rate} = (\text{A} / \text{Total Member Months}) * 10,000$

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should include all acute inpatient hospital discharges for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period.
- The denominator for this measure is based on acute inpatient hospital discharges, not members.
- To identify all acute inpatient hospital discharges during the reporting period:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
  - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
  - Identify the discharge date for the stay. The date of discharge must be within the reporting period.
  - Report on all inpatient stays identified with discharges within the reporting period, including denied and pended claims.

Additionally, MMPs should use UB Type of Bill codes 11x, 12x, 41x, and 84x or any acute inpatient facility code to identify discharges from an inpatient hospital stay.

- If the discharge is followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period, count only the last discharge for reporting in data element A. To identify readmissions and direct transfers to an acute inpatient care setting:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
  - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
  - Identify the admission date for the stay.

#### Data Element A Exclusions

- Exclude discharges for members who use hospice services or elect to use a hospice benefit at any time between the hospital discharge date and 30 days following the hospital discharge. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data (Hospice Encounter value set; Hospice Intervention value set) or supplemental data.
- Exclude discharges due to death, using the Discharges due to Death value set.
- Exclude from data element A any discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period. To identify readmissions and direct transfers to a nonacute inpatient care setting:

- Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
- Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay value set) on the claim.
- Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

- For example, the following direct transfers/readmissions should be excluded from this measure:
  - An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1 (a direct transfer).
  - An inpatient discharge on June 1, followed by a readmission to a hospital on June 15 (readmission within 30 days).

#### Data Element B

- The date of discharge must occur within the reporting period, but the follow-up visit may or may not occur in the same reporting period.
  - For example, if a discharge occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the follow-up visit.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in the Ambulatory Visits value set and Other Ambulatory Visits value set.
- MMPs should report ambulatory care follow-up visits based on all visits identified, including denied and pended claims, and including encounter data as necessary in cases where follow-up care is included as part of a bundled payment covering the services delivered during the inpatient stay. MMPs should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.

#### F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

CA1.12 Members who have a care coordinator and have at least one care team contact during the reporting period.<sup>i, ii</sup>

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
CA1. Care Coordination	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members who have/had a care coordinator.	Total number of members continuously enrolled for six months during the reporting period with no gaps in enrollment who have/had a care coordinator during the reporting period.	Field Type: Numeric
B.	Total number of members who had at least one care coordinator or other care team contact.	Of the total reported in A, the number of members who had at least one care coordinator or other care team contact.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The quality withhold benchmark is 78% for DY 2 and 3, 83% for DY 4, and 88% for DY 5. For more information, including benchmarks for DY 6 – 8, refer to the Quality Withhold Technical Notes (DY 2-8): California-Specific Measures.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members who have/had a care coordinator who had at least one care coordinator or other care team contact during the reporting period.
  - Percentage =  $(B / A) * 100$

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

#### Data Element B

- The contact can be from the care coordinator or another member of the care team, depending on the member's needs.
- MMPs should include only successful care coordinator or other care team contacts in data element B.
- MMPs should refer to the California three-way contract for specific requirements pertaining to the care team.
- For the purposes of reporting this measure, care coordinator or care team contact includes a discussion by phone or in person between the member or the member's authorized representative and the care coordinator or care team.
- Communication via secure emails or mailing/receiving completed HRAs via mail are not acceptable forms of contact for the purposes of reporting this measure.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.



**Section CAII. Enrollee Protections**

CA2.1 The number of critical incident and abuse reports for members receiving LTSS.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
CA2. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
CA2. Enrollee Protections	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members receiving IHSS.	Total number of members receiving IHSS during the reporting period.	Field Type: Numeric
B.	Total number of members receiving CBAS.	Total number of members receiving CBAS during the reporting period.	Field Type: Numeric
C.	Total number of members receiving MSSP services.	Total number of members receiving MSSP services during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members receiving nursing facility (NF) services.	Total number of members receiving NF services during the reporting period.	Field Type: Numeric
E.	Total number of critical incident and abuse reports among members receiving IHSS.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric
F.	Total number of critical incident and abuse reports among members receiving CBAS.	Of the total reported in B, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric
G.	Total number of critical incident and abuse reports among members receiving MSSP services.	Of the total reported in C, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric
H.	Total number of critical incident and abuse reports among members receiving NF services.	Of the total reported in D, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- N/A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

CMS and the state will evaluate the number of critical incident and abuse reports per 1,000 members receiving the following during the current reporting period:

- IHSS.
  - Rate =  $(E / A) * 1,000$
- CBAS.
  - Rate =  $(F / B) * 1,000$

- MSSP services.
  - Rate =  $(G / C) * 1,000$
- NF services.
  - Rate =  $(H / D) * 1,000$

CMS and the state will evaluate the average number of critical incident and abuse reports for members receiving the following during the prior four reporting periods (i.e., rolling year):

- IHSS.
  - Average number = Sum of E for prior four reporting periods / 4
- CBAS.
  - Average number = Sum of F for prior four reporting periods / 4
- MSSP services.
  - Average number = Sum of G for prior four reporting periods / 4
- NF services.
  - Average number = Sum of H for prior four reporting periods / 4

CMS and the state will evaluate the weighted average number of critical incident and abuse reports per 1,000 members receiving the following during the prior four reporting periods:

- IHSS.
  - Rate =  $(\text{Sum of E for prior four reporting periods} / \text{Sum of A for prior four reporting periods}) * 1,000$
- CBAS.
  - Rate =  $(\text{Sum of F for prior four reporting periods} / \text{Sum of B for prior four reporting periods}) * 1,000$
- MSSP services.
  - Rate =  $(\text{Sum of G for prior four reporting periods} / \text{Sum of C for prior four reporting periods}) * 1,000$
- NF services.
  - Rate =  $(\text{Sum of H for prior four reporting periods} / \text{Sum of D for prior four reporting periods}) * 1,000$

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member.
- Abuse refers to:
  - Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
  - Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which place that individual at risk of injury or death;
  - Rape or sexual assault;

- Corporal punishment or striking of an individual;
- Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
- Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.
- Community-Based Adult Services (CBAS) is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal beneficiaries, aged 18 years and older, blind, or disabled.
- Multipurpose Senior Services Program (MSSP) is a California-specific program, the 1915(c) Home and Community-Based services waiver that provides HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.
- Nursing facility (NF) services include any type of nursing facility care, including skilled and custodial services.

#### Data Elements A, B, C, and D

- MMPs should include all members who meet the criteria outlined in data elements A, B, C, and D regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- For quarterly reporting, if a member is enrolled at any point in time during the reporting period and received one of the specified categories of services, he/she should be included in this measure.
- It may be possible for a member to receive services from IHSS, CBAS, MSSP, and/or NF during the same quarterly reporting period. Certain services, such as NF services, cannot be received during the same month as IHSS, CBAS, and MSSP services, but they can be received during sequential months during the same quarterly reporting period.
- If a member receives services from more than one type of LTSS, they should be reported in all applicable data elements.
  - For example, if a member received both IHSS and MSSP services during the same reporting period, he/she would be reported in data elements A and C.

#### Data Elements E, F, G, and H

- For data elements E through H, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless of whether the case status is open or closed as of the last day of the reporting period.
- Critical incident and abuse reports could be reported by the MMP or any provider and are not limited to only those providers defined as LTSS providers.

- It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All new critical incident and abuse reports during the reporting period should be counted.
- MMPs should report the critical incident/abuse report for the service during which the incident or abuse occurred.
  - For example, if the member had a reported critical incident while receiving MSSP services, the critical incident would be reported in data element G only.
- If the member received multiple services during the reporting period, the critical incident/abuse should only be reported once and MMPs should use their best judgment on which data element to report the critical incident/abuse.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

CA2.2 Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing.<sup>i</sup>

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
CA2. Enrollee Protections	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing.	Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing.	Field Type: N/A  Note: File will be emailed to the state.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm that the appropriate policies and procedures submitted align with the MOU(s) with county behavioral health agency(ies).
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will verify that the policies and procedures contain, at a minimum, the roles and responsibilities of the MMP and the county behavioral health agency(ies) regarding assessments, referrals, coordinated care planning, and information sharing.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- These policies and procedures should be specific to each MMP/county behavioral health agency(ies) and reflect the appropriate roles and responsibilities of each organization.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- File will be submitted directly to the state via email to: [pmmp.monitoring@dhcs.ca.gov](mailto:pmmp.monitoring@dhcs.ca.gov).

**Section CAIII. Organizational Structure and Staffing**

CA3.1 MMPs with an established physical access compliance policy and identification of an individual who is responsible for physical access compliance.<sup>i</sup> – **Retired**

CA3.2 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
CA3. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of care coordinators who have been employed by the MMP for at least 30 days.	Total number of full-time and part-time care coordinators who have been employed by the MMP for at least 30 days at any point during the reporting period.	Field Type: Numeric
B.	Total number of care coordinators who have undergone training for supporting self-direction under the demonstration within the reporting period.	Of the total reported in A, the number of care coordinators who have undergone training for supporting self-direction under the demonstration within the reporting period.	Field Type: Numeric  Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.

- As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data element B is less than or equal to data element A.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of full-time and part-time care coordinators who have undergone training for supporting self-direction within the reporting period.
    - Percentage =  $(B / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- If a care coordinator was not currently with the MMP at the end of the reporting period but was with the MMP for at least 30 days at any point during the reporting period, they should be included in this measure.

#### General Guidance

- MMPs should refer to the California three-way contract for specific requirements pertaining to care coordinators and training for supporting self-direction.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.



**Section CAIV. Utilization**

CA4.1 Reduction in emergency department (ED) use for seriously mentally ill (SMI) and substance use disorder (SUD) members.<sup>ii</sup>

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
CA4. Utilization	Annually	Contract	Calendar Year, beginning in CY2	By the end of the fourth month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members enrolled for at least five months with an indication of either SMI or SUD.	Total number of members continuously enrolled for at least five months during the reporting period, with no gaps in enrollment, with an indication of either SMI or SUD problems during the 12 months prior to the reporting period.	Field Type: Numeric
B.	Total number of member months.	Of the total reported in A, the number of member months during the reporting period.	Field Type: Numeric
C.	Total number of ED visits.	Of the total reported in A, the number of ED visits during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The quality withhold benchmark for DY 2 through 5 is a 10% decrease in the performance rate for the measurement year compared to the performance rate for the baseline year. For more information, including benchmarks for DY

6 – 8, refer to the Quality Withhold Technical Notes (DY 2-8): California-Specific Measures.

- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- Each member should have a member month value between 5 and 12. A value greater than 12 is not acceptable.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the number of ED visits for members with an indication of either SMI or SUD problems during the 12 months prior to the reporting period per 1,000 member months.
    - $\text{Rate} = (C / B) * 1,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- A member with SMI is defined as someone with a mental illness diagnosis in Medicare or Medicaid claims in the 12 months prior to the reporting period (Mental Health Diagnosis value set).
  - In the case where the member enrolled for the first time within the reporting period (e.g., February 1, 2019 or later in 2019), MMPs can use Medicare or Medicaid claims in the 12 months prior to the member's effective enrollment date to identify a SMI diagnosis.
- A member with SUD is defined as someone with a SUD diagnosis in Medicare or Medicaid claims in the 12 months prior to the reporting period (AOD Abuse and Dependence value set).
  - In the case where the member enrolled for the first time within the reporting period (e.g., February 1, 2019 or later in 2019), MMPs can use Medicare or Medicaid claims in the 12 months prior to the member's effective enrollment date to identify a SUD diagnosis.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year.

#### Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Members diagnosed with SMI and/or SUD should be included in this measure (i.e., members with both SMI and SUD diagnoses should also be included).
- MMPs should include all members with any diagnosis of SMI and/or SUD, regardless of whether the diagnosis of SMI and/or SUD is the primary diagnosis on the claim.

Data Element B

- Each member should have a member month value between 5 and 12. A value greater than 12 is not acceptable.
- Determine member months using the 15th of the month. This date must be used consistently from member to member, from month to month, and from year to year.
  - For example, if Ms. X is enrolled in the MMP as of January 15, Ms. X contributes one member month in January.

Data Element C Exclusion

- MMPs should exclude ED visits (ED value set) or observation stays (Observation value set) that resulted in an inpatient stay (Inpatient Stay value set). An ED visit or observation stay results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

CA4.2 In-Home Supportive Services (IHSS) utilization. – **Retired**

CA4.3 Readmissions of short- and long-stay nursing facility (NF) residents after hospitalization for diabetes, chronic obstructive pulmonary disease (COPD), or any medical diagnosis.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
CA4. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of short-term stay NF residents.	Total number of short-term stay NF residents who were continuously enrolled in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of short-term stay NF residents with diabetes.	Of the total reported in A, the number of short-term stay NF residents with diabetes.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of short-term stay NF residents with COPD.	Of the total reported in A, the number of short-term stay NF residents with COPD.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of transfers for short-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF.	For the members reported in A, the number of transfers for short-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric
E.	Total number of transfers for short-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF.	For the members reported in B, the number of transfers for short-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of transfers for short-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF.	For the members reported in C, the number of transfers for short-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric
G.	Total number of long-term stay NF residents.	Total number of long-term stay NF residents who were continuously enrolled in the MMP during the reporting period.	Field Type: Numeric
H.	Total number of long-term stay NF residents with diabetes.	Of the total reported in G, the number of long-term stay NF residents with diabetes.	Field Type: Numeric Note: Is a subset of G.
I.	Total number of long-term stay NF residents with COPD.	Of the total reported in G, the number of long-term stay NF residents with COPD.	Field Type: Numeric Note: Is a subset of G.
J.	Total number of transfers for long-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF.	For the members reported in G, the number of transfers for long-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
K.	Total number of transfers for long-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF.	For the members reported in H, the number of transfers for long-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric
L.	Total number of transfers for long-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF.	For the members reported in I, the number of transfers for long-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data elements B and C are less than or equal to data element A.
  - MMPs should validate that data elements H and I are less than or equal to data element G.

- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

### **Short-Term Stay Analysis**

CMS and the state will evaluate the number of transfers among short-term stay NF residents:

- Who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period per 100 short-term stay NF residents.
  - Rate =  $(D / A) * 100$
- With diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period per 100 short-term stay NF residents with diabetes.
  - Rate =  $(E / B) * 100$
- With COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period per 100 short-term stay NF residents with COPD.
  - Rate =  $(F / C) * 100$

### **Long-Term Stay Analysis**

CMS and the state will evaluate the number of transfers among long-term stay NF residents:

- Who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period per 100 long-term stay NF residents.
  - Rate =  $(J / G) * 100$
- With diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period per 100 long-term stay NF residents with diabetes.
  - Rate =  $(K / H) * 100$
- With COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period per 100 long-term stay NF residents with COPD.
  - Rate =  $(L / I) * 100$

- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

### Definitions

- A short-term stay resident is defined as having resided in the nursing facility for less than or equal to 100 cumulative days.
- A long-term stay resident is defined as having resided in the nursing facility for greater than 100 cumulative days.

### Data Elements A and G

- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

### Data Elements B and H

- There are two ways for MMPs to identify members with diabetes: claim/encounter data and pharmacy data. The MMP must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the current reporting period or the year prior to the current report period.
  - *Claim/encounter data.* Members who met any of the following criteria during the current reporting period or the year prior to the current reporting period (count services that occur over both years):
    - At least two visits of any combination of outpatient visits (Outpatient value set), observation visits (Observation value set), ED visits (ED value set), or nonacute inpatient encounters (Nonacute Inpatient value set) on different dates of service, with a diagnosis of diabetes (Diabetes value set). Visit type need not be the same for the two visits (e.g., one outpatient visit and one ED visit).
    - At least one acute inpatient encounter (Acute Inpatient value set) with a diagnosis of diabetes (Diabetes value set).
  - *Pharmacy data.* Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the current reporting period or the year prior to the current reporting period (Diabetes Medications List).

### Data Elements C and I

- MMPs should identify members with a diagnosis of COPD using claims/encounter data. The member must have a least one diagnosis of COPD (COPD Diagnosis value set) during the reporting period to be captured in data elements C and I.

### Data Elements D and J

- When determining members with a transfer from the NF and admission to an acute care hospital for **any** medical diagnosis (i.e., data elements D and J), include members with diabetes and COPD. In other words, members included in data elements D and J can have diabetes, COPD, and other medical diagnoses such as hypertension, asthma, heart failure, etc.



#### Data Elements E and K

- To identify a diabetes-related hospital admission, the member must have a primary diagnosis code listed in the Diabetes value set.

#### Data Elements F and L

- To identify a COPD-related hospital admission, the member must have a primary diagnosis code listed in the COPD Diagnosis value set.

#### Data Elements D, E, F, J, K, and L

- The date of transfer and the discharge back to any NF must occur within the same reporting period.
- It is possible for a member to have more than one transfer during the reporting period. MMPs should count all transfers that occur for each member during the reporting period.

#### Data Elements D, E, F, J, K, and L Exclusion

- If a member was transferred to a hospital but only had an ED visit or observation stay and then returned to the nursing facility, then the transfer is not counted as an admission to the acute care hospital. A member must be admitted to the hospital to be considered a numerator positive event.

#### General Guidance

- It is possible for a member to have multiple conditions (i.e., both diabetes and COPD). If a member has both a diabetes and a COPD diagnosis, then these members should be reported in all applicable data elements (i.e., data elements B, C, H, and I).
- MMPs should include sub-acute care facilities and intermediate care facilities as part of NFs, as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5.
- MMPs should determine short-term and long-term stay NF residents using the best information available. MMPs should use their plan experience and, whenever possible, integrate analysis of historical claims data to determine if the member's NF stay qualifies as short-term or long-term.
  - For example, a member may reside in a NF at the time of enrollment (or the first day of the reporting period) and the MMP may use historical data to determine the number of days the member has resided in the NF at the time of enrollment (or on the first day of the reporting period).
- When determining a short-term or long-term stay, if a member is transferred from the NF and then is readmitted to any NF within 30 days (including day 30), the transfer and subsequent readmission does not disrupt the count of cumulative days.
  - For example, if a member is transferred from the NF to the acute care hospital on day 193 and is subsequently readmitted to any NF 24 days later, this will be counted as the same long-term stay episode. The member's first day back in the NF (i.e., the day the member is

readmitted to the NF) will count as day 194 for that episode, not as day 1.

- When determining a short-term or long-term stay, if a member is transferred from the NF and then is readmitted to any NF after 30 days, the date of readmission is the start of a new episode in the NF and will count as day 1 toward the member's cumulative days in the facility.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

IPA Name:  
 Reporting Period:  
 Date of Submission:  
 IPA Contact:

### 5.1 - Care Coordinator to Member Ratio

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of full time equivalent (FTE) care coordinators working on the Demonstration as of the last day of the reporting period.	Total number of full time equivalent (FTE) care coordinators working on the Demonstration as of the last day of the reporting period.	Field Type: Numeric
B.	Total FTE care coordinators assigned to care management and conducting assessments.	Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period.	Field Type: Numeric  Note: Is a subset of A.
C.	Total number of FTE care coordinators that left the MMP during the reporting period.	TOTAL number of FTE care coordinators that left the MMP during the reporting period.	Field Type: Numeric
D.	Number of Members per FTE care coordinator.	Total Members Enrolled / A	Field Type: Numeric
E.	Percentage of FTE care coordinators who were assigned to care management and conducting assessments	Percentage = (B / A) * 100	Field Type: Percentage
F.	Percentage of FTE care coordinators that left the MMP during the reporting period	Percentage = (C / (C + A)) * 100	Field Type: Percentage

Source: DSNP Policy Guide, 08/19/2022

**Care Coordinator:** A clinician or other trained individual employed or contracted by the PCP or the Contractor who is accountable for providing Care Coordination services, which include assuring appropriate referrals and timely two-way transmission of useful Enrollee information; obtaining reliable and timely information about services other than those provided by the Primary Care Provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one (1) or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves.

To provide further guidance, IEHP considers the following internal positions as Care Coordinators:

- All clinical and non-clinical staff reporting up to our Care Management Manager for Medicare; and
- All clinical and non-clinical staff reporting up to our Care Management Manager for Long-Term Services and Supports.
- Given that leaders (supervisors, managers, and directors) and support staff (administrative assistants, analysts, etc) do not consistently and directly provide the services noted above, they are therefore, excluded from this definition.

**IPA Name:**  
**Reporting Period:**  
**Date of Submission:**  
**IPA Contact:**

### CA3.2 - Care Coordinator Training for Supporting Self-Direction Under the Demonstration

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of full-time and part-time care coordinators who have been employed by the MMP for at least 30 days at any point during the reporting period.	Total number of full-time and part-time care coordinators who have been employed by the MMP for at least 30 days at any point during the reporting period.	Field Type: Numeric
B.	Total number of care coordinators that have undergone training for supporting self-direction under the demonstration within the reporting period.	Of the total reported in A, the number of care coordinators that have undergone training for supporting self-direction under the demonstration within the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Percentage of full-time and part-time care coordinators who have undergone training for supporting self-direction within the reporting period.	Percentage = (B / A) * 100	Field Type: Percentage

*DSNP Policy Guide, 08/19/22*

#### Definitions

**Care Coordinator:** A clinician or other trained individual employed or contracted by the PCP or the Contractor who is accountable for providing Care Coordination services, which include assuring appropriate referrals and timely two-way transmission of useful Enrollee information; obtaining reliable and timely information about services other than those provided by the Primary Care Provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one (1) or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves.

To provide further guidance, IEHP considers the following internal positions as Care Coordinators:

- All clinical and non-clinical staff reporting up to our Care Management Manager for Medicare; and
- All clinical and non-clinical staff reporting up to our Care Management Manager for Long-Term Services and Supports.
- Given that leaders (supervisors, managers, and directors) and support staff (administrative assistants, analysts, etc) do not consistently and directly provide the services noted above, they are therefore, excluded from this definition.



INLAND EMPIRE HEALTH PLAN  
Care Transition Cases Log

Date Submitted: \_\_\_\_\_

Submitted By: \_\_\_\_\_ Phone # \_\_\_\_\_

Member First Name	Member Last Name	IEHP Member ID #	DOB	Date Identified	Discharge Date	Date Discharge Summary Received	Type of Transition (Planned or Unplanned)	Sending Setting (Home/Hospital/Facility)	Receiving Setting (Home/Hospital/Facility)	Date Sending setting's care plan was sent to the receiving setting	Date the PCP was notified of the transition

**Identify the number of :**  
Total Cases reported for this month:



Date Member or responsible party was notified of the care transition process	Name of IPA Consistent Contact for Transition	Date Member or responsible party was notified of changes to health status and plan of care.	Date follow-up appointments made for Member within 7 days of discharge	Date contact made with Member or Caregiver for TOC assistance within 30 days of discharge	Date Medication Reconciliation completed by RN, Pharmacist, or Provider within 30 days of discharge	Date Reassessment completed by Care Manager after discharge	Date Red Flag Warnings discussed with Member or Caregiver.



## DualChoice

### Monthly Medicare Transition of Care Log v2

#### Instructions & Data Dictionary

Instructions: Submit a monthly report of all transition of care activity for members discharged from an inpatient setting. If a member had multiple discharges in one month, then there should be multiple rows for that member in one reporting month. Refer to the data dictionary for specifics on what each field should contain. Do not alter the templates in any way (e.g. adding or deleting columns or header rows). Always submit the most current template in Excel (.xlsx) format.

Column	Field type	Description
Member First Name	Free Text	
Member Last Name	Free Text	
IEHP Member ID #	Numeric	14-digit numerical IEHP ID#
DOB	00/00/0000	
Date Identified	00/00/0000	
Discharge Date	00/00/0000	Date the member was discharged from the inpatient setting
Date Discharge Summary Received	00/00/0000	if blank then not received
Type of Transition (Planned or Unplanned)	Text	Identify if the admission was planned or unplanned
Sending Setting (Home/Hospital/Facility)	Text	Options for this field include Home, Hospital, Facility
Receiving Setting (Home/ Hospital/Facility)	Text	Options for this field include Home, Hospital, Facility
Date Sending setting's care plan was sent to the receiving setting	00/00/0000	If blank then incomplete
Date the PCP was notified of the transition	00/00/0000	If blank then incomplete
Date Member or responsible party was notified of the care transition process	00/00/0000	If blank then incomplete
Name of IPA Consistent Contact for Transition	Free Text	



## DualChoice

Date Member or responsible party was notified of changes to health status and plan of care.	00/00/0000	If blank then incomplete
Date follow-up appointments made for Member within 7 days of discharge	00/00/0000	If blank then incomplete
Date contact made with Member or Caregiver for TOC assistance within 30 days of discharge	00/00/0000	If blank then incomplete
Date Medication Reconciliation completed by RN, Pharmacist, or Provider within 30 days of discharge	00/00/0000	If blank then incomplete
Date Reassessment completed by Care Manager after discharge	00/00/0000	If blank then incomplete
Date Red Flag Warnings discussed with Member or Caregiver.	00/00/0000	If blank then incomplete. All Members/Caregivers should be educated on the signs and symptoms of their health condition worsening (Red Flags) during the care transition process. If Members/Caregivers are properly prepared with this information, they are more likely to notify their Provider early and hopefully prevent readmission. Examples include but are not limited to: Fever, shortness of breath, dizziness, altered mental status, redness/pain/heat/oozing of wound site, prolonged vomiting, or prolonged diarrhea.



## 2022 Credentialing Activities Report Instructions for Credentialing Delegates

**Delegates are strongly encouraged to print and thoroughly review these instructions before preparing the lists according to the instructions below.**

To ensure that IEHP can accurately review the credentialing activities reported by the Delegate, Delegates are required to submit the lists of practitioners exactly as indicated below.

**Credentialing lists submitted in a format inconsistent with the specifications below will be returned to the organization for correction and resubmission, which may result in a delay in timeliness reporting by the Delegate to IEHP.**

- Please compile three (3) lists
  - **Credentialing Activities:** All practitioners initially credentialed within the one (1) month look back period
  - **Rec credentialing Activities:** All practitioners rec credentialled within the one (1) month look back period
  - **Terminations:** All practitioners terminated within the one (1) month look back period

If the MSO has multiple IPAs, the Delegate may submit one (1) report, however, the report must list the practitioner by IPA affiliation, by having each IPA affiliation listed on a separate row.

<b>CREDENTIALING ACTIVITIES DATA DICTIONARY</b>	
IPA NAME	Name of Delegate
INITIAL DATE	Initial Credentialing Decision Date
CRED EXPIRES	Credentialing Expiration Date
LICENSE#	License# as listed on License
TYPE	Provider Type: Primary Care Provider (PCP), Specialist Care Provider (SCP), Mid Level (ML) i.e. Physician Assistants (PAs);
LAST NAME	Last Name as listed on License
FIRST NAME	First Name as listed on License
M.I.	M.I. as listed on License
SUFFIX	Suffix as listed on License
DEGREE	Degree e.g., MD, DO, PA, NP etc.,)
SPECIALTY(1)	Primary Specialty as Credentialed
SPECIALTY(2)	Secondary Specialty as Credentialed

**If there are no activities report, please state "None to Report" on the CREDENTIALING ACTIVITIES tab**

**2022 Credentialing Activities Report Instructions for Credentialing Delegates****RECREDEATIONAL ACTIVITIES DATA DICTIONARY**

IPA NAME	Name of Delegate
PREVIOUS CRED DATE	Previous Credentialing decision date to calculate the 36 month look back period
RECREDE DATE	Recredentialing Decision Date
LICENSE#	License# as listed on License
TYPE	Provider Type: Primary Care Provider (PCP), Specialist Care Provider (SCP), Mid Level (ML) i.e. Physician Assistants (PAs);
LAST NAME	Last Name as listed on License
FIRST NAME	First Name as listed on License
M.I.	M.I. as listed on License
SUFFIX	Suffix as listed on License
DEGREE	Degree e.g., MD, DO, PA, NP etc.,)
SPECIALTY(1)	Primary Specialty as Credentialed
SPECIALTY(2)	Secondary Specialty as Credentialed

**If there are no activities report, please state "None to Report" on the RECREDEATIONAL ACTIVITIES tab**

**TERMINATIONS DATA DICTIONARY**

IPA NAME	Name of Delegate
INITIAL DATE	Initial Credentialing Decision Date
RECREDE DATE	Recredentialing Decision Date
CRED EXPIRES	Credentialing Expiration Date
LICENSE#	License# as listed on License
TYPE	Provider Type: Primary Care Provider (PCP), Specialist Care Provider (SCP), Mid Level (ML) i.e. Physician Assistants (PAs);
LAST NAME	Last Name as listed on License
FIRST NAME	First Name as listed on License
M.I.	M.I. as listed on License
SUFFIX	Suffix as listed on License
DEGREE	Degree e.g., MD, DO, PA, NP etc.,)
SPECIALTY(1)	Primary Specialty as Credentialed
SPECIALTY(2)	Secondary Specialty as Credentialed
TERMED DATE	Effective date of the Termination
REASON FOR TERMINATION	Reason for Termination
DUE TO QUALITY OF CARE (YES OR NO)	Yes or No (if the Practitioner was terminated due to Quality of Care)

**If there are no activities report, please state "None to Report" on the TERMINATIONS tab**

# CREDENTIALING ACTIVITIES 2021

IPA NAME	INITIAL DATE	CRED EXPIRES	LICENSE#	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	SPECIALTY(1)	SPECIALTY(2)

**RECREDECIATING ACTIVITIES**  
**2021**

IPA NAME	PREVIOUS CRED DATE	RECREDECIATING DATE	LICENSE#	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	SPECIALTY(1)	SPECIALTY(2)

**TERMINATIONS  
2021**

IPA NAME	INITIAL DATE	RECREATED DATE	CRED EXPIRES	LICENSE#	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	SPECIALTY(1)	SPECIALTY(2)	TERMED DATE	REASON FOR TERMINATION	DUE TO QUALITY OF CARE (YES OR NO)

## 2023 Credentialing Activities Report Instructions for Credentialing Delegates

Delegates are required to roadmap all elements identified on the Credentialing Audit Tool. Delegates are strongly encouraged to print and thoroughly review these instructions before completing the Credentialing Audit Tool.

### AUDIT INSTRUCTIONS: POLICIES AND PROCEDURES

- Prior to the scheduled audit dates, Delegates are required to submit the completed road map along with the policies referenced
- The areas in the Credentialing Audit Tool highlighted in **BLUE**, Delegates are required to populate with Name, Page, and Section of the policy or policies that meet that requirement.
- For elements not applicable to the delegate, indicate "N/A" in the section in **BLUE**, followed by the reason in the Comment column
- To receive auto-credit for NCQA elements, Delegate must provide a copy of their NCQA Certification/Accreditation respective to the look-back period.

### CREDENTIALING SYSTEM CONTROLS OVERSIGHT

- This element applies to both paper and electronic credentialing processes
- IEHP will review Delegates Credentialing System Control Report, which may be scanned and provided as an attachment.
- Delegate may also provide their audit findings on the CR 1D SYSTEMS CONTROLS OVERSIGHT tab.

### CREDENTIALING & RECREDENTIALING FILE REVIEWS

- IEHP will audit the files in the order they are listed on the Credentialing File Pull Lists.
- It is **preferred** for Delegates to review their files prior to the audit and bookmark their files to ensure compliance.
- IEHP reviews the verification of credentials within a random sample of up to forty (40) initial credentialing files and up to forty (40) recredentialing files for practitioners that were due for recredentialing during the look-back period.
- IEHP conducts onsite, virtual, and desktop file review in the presence and/or coordination with the organization's staff, if available, and works with the organization to resolve any disputes during the onsite survey.
- File review results may not be disputed or appealed once the survey is complete.
- All file review elements are "MUST-PASS ELEMENTS".

### ONGOING MONITORING AND INTERVENTIONS

- IEHP reviews the organization's policies and procedures, monitoring reports and documentation of interventions throughout the look-back period.

### ORGANIZATIONAL PROVIDER FILE REVIEWS

- IEHP reviews evidence that the organization assessed the providers by providing documentation of a tracking mechanism(s) (checklist or spreadsHeet) or file review.

### DELEGATION AGREEMENTS

- Delegates are required to submit a copy of Delegation Agreement of all sub-delegation arrangements.

- Delegates are required to provide evidence of Delegation Activities for all sub-delegation arrangements.

### **IDENTIFICATION OF HIV/AIDS SPECIALISTS**

- IEHP will review evidence that the Delegate identifies HIV/AIDS specialists on an annual basis, which includes review of the current and previous year's survey/spreadsheet/credentialing attestation/logs.
- IEHP will review the list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.
- Distribution of findings must be communicated within thirty (30) calendar days from the completion of the screening/survey assessment.

**Attachment 25 - Credentialing DOA Audit Tool**  
**2023 AUDIT RESULTS**

Review Date: \_\_\_\_\_

Delegate: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

NCQA	POINTS RECEIVED	POINTS POSSIBLE	A	B	C	D	E
CR 1: Credentialing Policies	0	4	0	0	0	0	
CR 2: Credentialing Committee	0	1	0				
CR 3: Credentialing Verification	0	0	*	*	*		
CR 4: Recredentialing Cycle Length	#DIV/0!	0	#####				
CR 5: Ongoing Monitoring and Interventions	0	1	0				
CR 6: Notification to Authorities and Practitioner Appeal Rights	0	1	0				
CR 7: Assessment of Organizational Providers	0	3	0	0	N/A	0	N/A
CR 8: Delegation of CR	1	3	0	N/A	0	1	
<b>TOTAL</b>	#DIV/0!	13	#####				

CMS/DHCS/DMHC REQUIREMENTS	MEDI-CAL POINTS RECEIVED	MEDICARE POINTS RECEIVED
<b>CR 1: Credentialing Policies</b>		
1. Recred Performance Monitoring	0	0
2. Medicare Opt Out Policy		0
3. OIG Sanction	0	0
<b>CR 3: Credentialing Verification</b>		
1. OIG Query	#DIV/0!	#DIV/0!
2. Medi-Cal Suspended & Ineligible Report	#DIV/0!	
3. Verification of Hospital Admitting Privileges	#DIV/0!	#DIV/0!
4. Opt Out Query (within 180 days)		#DIV/0!
5. Performance Monitoring at Recredentialing	#DIV/0!	#DIV/0!
<b>CR 5: Ongoing Monitoring and Interventions</b>		
1. Ongoing Monitoring for Providers who have Opted Out		*
2. Ongoing Monitoring of the Medi-Cal Suspended & Ineligible	*	*
<b>CR 6: Notification to Authorities and Practitioner Appeal Rights</b>		
1. Ensure that the majority of hearing panel members are peers of the affected physician (a hearing officer does not meet intent)		*
<b>CR 7: Assessment of Organizational Providers</b>		
B. Documented processes for additional provider types - CMS		*
D. Assessment of additional CMS provider types		*
F. Accreditation/Certification of Free Standing Surgical Centers	*	*
<b>CR 8: Delegation of CR</b>		
1. Sub-delegates must adhere to CMS regulations		1
2. Sub-delegates must submit quarterly rosters	1	
<b>CA 9: Identification of HIV/AIDS Specialists</b>		
A. Written policy	*	*
B. Evidence of Implementation	*	*
C. Distribution of Findings	*	*
<b>TOTAL</b>	#DIV/0!	#DIV/0!

**MEDI-CAL  
AUDIT SCORE  
#DIV/0!**

**MEDICARE  
AUDIT SCORE  
#DIV/0!**

<b>Credentialing</b>	10%
Actual	1
Possible	10

<b>File Review</b>	#DIV/0!
Actual	#####
Possible	0

<b>HDO Review</b>	0%
Actual	0
Possible	3

**\*MUST PASS ELEMENTS\***



## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

**CR 1: Credentialing Policies**

[CR 1 will be reviewed for all Certified or Accredited Organizations]

The organization has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to members

**Document Location:** Credentialing & Recredentialing Program, Policy and Procedure Manual and Medical Staff Bylaws, Rules and Regulation

**Source:** NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>A</b>	<b>Practitioner Credentialing Guidelines</b>	<b>0</b>		
1	The types of practitioners it credentials and recredentials (List provider types covered in scope)	*		
2	The verification sources it uses	*		
3	The criteria for credentialing and recredentialing	*		
4	The process for making credentialing and recredentialing decision	*		
5	The process for managing credentialing files that meet the organization's established criteria	*		
6	The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.	*		

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

7	The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.	*		
8	The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision.	*		
9	The medical director or other designated physician's direct responsibility and participation in the credentialing program	*		
10	The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law	*		
11	The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty	*		

<b>MET (1):</b> The organization meets 8-11 factors	<b>PARTIALLY MET (.5):</b> The organization meets 5-7 factors	<b>NOT MET (0):</b> The organization meets 0-4 factors
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### 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_

Review Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

B	Practitioner Rights	0		
	The organization notifies practitioners of their right to:			
1	Review information submitted to support their credentialing application	*		
2	Correct erroneous information	*		
3	Receive the status of their credentialing or recredentialing application, upon request	*		

<b>MET (1):</b> The organization meets 2-3 factors	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0-1 factor
---	---	--

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

C	Credentialing System Controls (NEW)	0	
	(applies to paper and electronic proceses)		
	The organization's credentialing process describes:		
1	How primary source verification information is received, dated and stored	*	.
2	How modified information is tracked and dated from its initial verification	*	.
3	Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appopriate	*	.
4	The security controls in place to protect the information from unauthorized modification	*	.
5	How the organization audits the processes and procedures in factors 1-4	*	.

**\*MUST PASS ELEMENT\***

<b>MET (1):</b> The organization meets all 5 factors	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0-4 factors
---	---	---

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS (All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract)

### 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_

Review Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

D	Credentialing System Controls Oversight (NEW)	0	
	(applies to paper and electronic proceses)		
	At least annually, the organization demonstrates that it monitors compliance with its CR controls, as described in Elemet C, Factor 5 by:		
1	Identifying all modifications that did not meet the policies and procedures	*	
2	Analyzing all modifications that did not meet the policies and procedures	*	
3	Acting on all findings	*	

**\*MUST PASS ELEMENT\***

<b>MET (1):</b> The organization meets all 3 factors	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0-2 factors
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## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>E</b>	<b>0</b>		
1	*	.	
The organization's recredentialing policies and procedures require information from quality improvement activities and member complaints in the recredentialing decision making process.			

<b>MET (1):</b> The organization meets 1 factor	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0 factors
--	---	---

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 60.2)

Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>E</b>	<b>0</b>		
1	*	.	
The Medicare Advantage organization has policies and procedures to ensure that it only contracts with physicians who have not opted out.			

<b>MET (1):</b> The organization meets 1 factor	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0 factors
--	---	---

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 60.2); DHCS All Plan Letter APL 19-004)

### 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_

Review Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>F</b>	<b>Medicare - Exclusions/Sanctions</b>	<b>0</b>		
1	The Medicare Advantage organization must have policies and procedures that prohibit employment or contracting with practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (practitioners or entities found on OIG Report)	*		

<p><b>MET (1):</b> The organization meets 1 factor</p>	<p><b>PARTIALLY MET (.5):</b> No scoring option</p>	<p><b>NOT MET (0):</b> The organization meets 0 factors</p>
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## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

### CR 2: Credentialing Committee

The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.

**Document Location:** Credentialing Committee Minutes

**Policy and Evidence Required for all Elements**

**Source:** NCQA/CMS

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>A</b>	<b>Credentialing Committee</b>	<b>0</b>		
	The organization's Credentialing Committee:			
1	Uses participating practitioners to provide advice and expertise for credentialing decisions.	*		
2	Reviews credentials for practitioners who do not meet established thresholds	*		
3	Ensures that meet files that meet established criteria are reviewed and approved by a medical director or designated physician.	*		

<b>MET (1):</b> The organization meets 2-3 factors	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0-1 factor
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## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

### CR 3: Credentialing Verification

The organization verifies credentialing information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.

**Document Location:** Practitioner Credentialing and Recredentialing files, Primary Source Verifications, Application and Attestation and Initial Sanction Information

**Scores pull from the CR 3 File Review Tool Tab**

Source: NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met N/A		Comments
<b>A</b>	<b>Verification of Credentials:</b>	*		
1	A current and valid license to practice	#DIV/0!		
2	A valid DEA (CA Address) or CDS certificate, if applicable	#DIV/0!		
3	Education and Training	#DIV/0!		
4	Board Certification Status	#DIV/0!		
5	Work History	#DIV/0!		
6	A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner	#DIV/0!		

**\*MUST PASS ELEMENT\***

<b>MET (1):</b> High (90-100%) on file review for at least 4 factors and medium (60-89%) for file review for any remaining factors	<b>PARTIALLY MET (.5):</b> High (90-100%) or medium (60-89%) on file review for all 6 factors	<b>NOT MET (0):</b> Low (0-59%) on file review for any factor
---	--	--

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

B	Sanction Information	*		
1	State sanctions, restrictions on licensure and limitations on scope of practice	#DIV/0!		
2	Medicare and Medicaid Sanctions	#DIV/0!		

**\*MUST PASS ELEMENT\***

<p><b>MET (1):</b>                  High (90-100%) on file review for at least 1 factor and medium (60-89%) for file review for any remaining factor</p>	<p><b>PARTIALLY MET (.5):</b>                  Medium (60-89%) on file review for 2 factors</p>	<p><b>NOT MET (0):</b>                  Low (0-59%) on file review for any factor</p>
--	---	---

C	Credentialing Application	*		
1	Reasons for inability to perform the essential functions of the positions	#DIV/0!		
2	Lack of present illegal drug use	#DIV/0!		
3	History of loss of license and felony convictions	#DIV/0!		
4	History of loss or limitation of privileges or disciplinary actions	#DIV/0!		
5	Current malpractice insurance coverage that verifies coverage for the locations and specialties the practitioner is credentialed for	#DIV/0!		
6	Current and signed attestation confirming the correctness and completeness of the application	#DIV/0!		

**\*MUST PASS ELEMENT\***

<p><b>MET (1):</b>                  High (90-100%) on file review for at least 4 factors and medium (60-89%) for file review for any remaining factors</p>	<p><b>PARTIALLY MET (.5):</b>                  High (90-100%) or medium (60-89%) on file review for all 6 factors</p>	<p><b>NOT MET (0):</b>                  Low (0-59%) on file review for any factor</p>
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### 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

**Scores pull from the CR C3 Credentialing Files tab**

Source: CMS; DHCS; DMHC

D	Criteria	Compliance 1/0 1=Met 0=Not Met N/A		Comments
	<b>CMS/DHCS/DMHC Requirements</b>			
1	OIG Query (CMS; DHCS)	#DIV/0!	#DIV/0!	
2	Medi-Cal Suspended & Ineligible Report (DHCS)	#DIV/0!	#DIV/0!	
3	Hospital Privileges (CMS; DMHC; DHCS)	#DIV/0!	#DIV/0!	
4	Medicare Opt-Out Query (CMS)	#DIV/0!	#DIV/0!	
5	EPLS/EEDP/SAM			
6	Performance Monitoring (CMS; DHCS)	#DIV/0!	#DIV/0!	

<b>MET (1):</b> High (90-100%) on file review	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> Medium (60-89%) or Low (0-59%) on file review
--	---	--

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

**CR 4: Recredentialing Cycle Length**

The organization formally recredentials its practitioners at least every 36 months.

**Document Location:** Practitioner Recredentialing files

**Scores pull from the CR 3 File Review Tool**

**Source:** NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met N/A		Comments
<b>A</b>	<b>Recredentialing Cycle Length</b>	<b>#DIV/0!</b>		
1	The length of the recredentialing cycle is within the required 36-month time frame	#DIV/0!		

**\*MUST PASS ELEMENT\***

<b>MET (1):</b> High (90-100%) on file review for at least 4 factors and medium (60-89%) for file review for any remaining factors	<b>PARTIALLY MET (.5):</b> High (90-100%) or medium (60-89%) on file review for all 6 factors	<b>NOT MET (0):</b> Low (0-59%) on file review for any factor
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## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

### SV: Practitioner Office Site Quality

The organization has a process to ensure that the offices of all practitioners meet its office-site standards.

#### IEHP does not delegate the responsibility of Practitioner Office Site Quality

**Document Location:** Credentialing & Recredentialing Program, Policy and Procedure Manual, Peer Review Policies, Medical Staff Bylaws, Rules and Regulation, Logs, Spreadsheets, Tracking Tools, Committee Minutes.

**Source:** CMS: (Medicare Managed Care Manual, Chapter 6 § 60.3; NCQA Medicaid MED 3: Practitioner Office Site Quality)

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>A</b>	<b>Performance standards and thresholds:</b>			
	1 Accessibility Equipment			
	2 Physician Accessibility			
	3 Physical Appearance			
	4 Adequacy of waiting and examining room space			
	5 Adequacy of medical/treatment record keeping and confidentiality			
<b>B</b>	<b>Site Visits and Ongoing Monitoring</b>			
	The organization implements appropriate interventions by:			
	1 Continually monitoring member complaints for all practitioner sites or established thresholds for targeting and monitoring practitioners			
	2 Conducting site visits of offices within 60 days of determining that the complaint thresholds was met			
	3 Instituting actions to improve offices that do not meet thresholds			
	4 Evaluating the effectiveness of the actions at least every 6 months, until deficient offices meet the thresholds			
	5 Documenting follow-up visits for offices that had subsequent deficiencies			

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

### CR 5: Ongoing Monitoring and Interventions

**Factors 1-4 requires both policy and evidence to be compliant**

The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.

**Document Location:** Credentialing & Recredentialing Program, Policy and Procedure Manual, Peer Review Policies, Medical Staff Bylaws, Rules and Regulations, Logs, Spreadsheets, Tracking Tools, Committee Minutes

**Source:** NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>A</b>	<b>Collecting and reviewing Medicare and Medicaid sanctions</b>	<b>0</b>		
	1 Collecting and reviewing Medicare and Medicaid sanctions	*		
	2 Collecting and reviewing sanctions and limitations on licensure	*		
	3 Collecting and reviewing complaints	*		
	4 Collecting and reviewing information from identified adverse events	*		
	5 Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4	*		

<b>MET (1):</b> The organization meets 4-5 factors	<b>PARTIALLY MET (.5):</b> The organization meets 3 factors	<b>NOT MET (0):</b> The organization meets 0-2 factors
---	--	---

**Policy and Evidence Required for all Elements**

**Source:** CMS (Medicare Managed Care Manual, Chapter 6 § 60.3); DHCS: (Exhibit A Attachment 4 - Plan Contract, APL 19-004, Plan Contract)

### 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>B</b>	<b>CMS Requirements</b>			
1	The delegate maintains a documented process for monitoring whether network practitioners have opted-out of accepting federal reimbursement for Medicare.	*		

<b>MET (1):</b> The organization meets 1 factor	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0 factors
--	---	---

	Monitoring Medi-Cal Suspended and Ineligible Reports			
	The delegate will verify that their contracted providers have not been terminated as Medi-Cal providers have not been placed on Suspended and Ineligible Provider List.			
1	The delegate has a policy for monitoring Medi-Cal Suspended and Ineligible Provider Reports	*		

<b>MET (1):</b> The organization meets 1 factor	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0 factors
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## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

### CR 6: Notification to Authorities and Practitioner Appeal Rights

[CR 6 will be reviewed for all Certified or Accredited Organizations]

An organization that has taken actions against a practitioner for quality reasons the action to appropriate authorities and offers the practitioner a formal appeal process.

**Document Location:** Credentialing & Recredentialing Program, Policy and Procedure Manual, Peer Review Policies, Medical Staff Bylaws, Rules and Regulation, Risk/Legal Department Policies

**Source:** NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>A</b>	<b>Actions Against Practitioners</b>	<b>0</b>		
1	The range of actions available to the organization	*	.	
2	Making the appeal process known to practitioners	*	.	

<b>MET (1):</b> The organization meets 2 factors	<b>PARTIALLY MET (.5):</b> The organization meets 1 factor	<b>NOT MET (0):</b> The organization meets 0 factors
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**Source:** CMS (Medicare Managed Care Manual, Chapter 6 § 60.4)



### 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_

Review Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>B</b>	<b>CMS Requirements</b>			
	The organization's policies and procedures regarding suspension or termination of participating physician require the organization to:			
1	Ensure that the majority of the hearing panel members are peers of the affected physician (a hearing officer does not meet intent)	*		

<p><b>MET (1):</b> The organization meets 1 factor</p>	<p><b>PARTIALLY MET (.5):</b> No scoring option</p>	<p><b>NOT MET (0):</b> The organization meets 0 factors</p>
--	---	---

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

**CR 7: Assessment of Organizational Providers**

The organization has written policies and procedures for the initial and ongoing assessment of providers with which it contracts

**Document Location:** Checklist, Spread Sheet Log, Files on Organizational Providers, Site Visit Reports and Committee Minutes.

**Source:** NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
A	<b>Policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least three years thereafter, it:</b>	<b>0</b>		
	1 Confirms that the provider is in good standing with state and federal regulatory bodies	*		
	2 Confirms that the provider has been reviewed and approved by an accrediting body	*		
	3 Conducts an onsite assessment if the provider is not accredited.	*		

<b>MET (1):</b> The organization meets 2-3 factors	<b>PARTIALLY MET (.5):</b> The organization meets 1 factor	<b>NOT MET (0):</b> The organization meets 0 factors
---	---	---

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

B	Includes at least the following providers in its assessment:	0		
1	Hospitals	*		
2	Home Health Agencies	*		
3	Skilled Nursing Facilities	*		
4	Free-Standing Surgical Centers	*		
5	Clinical Laboratories (IEHP requirement)	*		

<b>MET (1):</b> Delegate is contracted with Organizational Providers and it states so in policy	<b>NOT APPLICABLE (N/A)</b> Delegate is not contracted for Organizational Providers	<b>NOT MET (0):</b> Delegate is contracted, but Organizational Providers is not stated in the policy
--	--	---

C	Includes behavioral health facilities providing mental health or substances abuse services in the following settings:		
1	Inpatient		IEHP does not delegate this element
2	Residential		IEHP does not delegate this element
3	Ambulatory		IEHP does not delegate this element

D	Assessing Medical Providers	0	
1	Has documentation that it assessed contracted medical health care providers for at least three years thereafter. (The organization assesses contracted medical health care providers against the requirements and within the time frame in Element A.)	*	

<b>MET (1):</b> The organization meets 1 factor	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0 factors
--	---	---

### 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_

Review Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

E	Behavioral Health Facilities Assessment		
1	Has documentation that it assessed contracted behavioral healthcare providers for at least three years thereafter. (The organization assesses contracted behavioral healthcare providers against the requirements and within the time frame in Element A.)		IEHP does not delegate this element

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 70)

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>B</b>	<b>CMS Requirements</b>	*		
1	Hospices	*		
2	Clinical Laboratories	*		
3	Comprehensive Outpatient Rehabilitation Facilities (CORF)	*		
4	Outpatient Physical Therapy Providers	*		
5	Speech Pathology Providers	*		
6	End Stage renal disease service providers	*		
7	Outpatient Diabetes self-management training providers	*		
8	Portable X-Ray Suppliers	*		
9	Rural Health Clinics (RHC)	*		
10	Federally Qualified Health Centers (FQHC)	*		

<b>MET (1):</b> Delegate is contracted with Organizational Providers and it states so in policy	<b>NOT APPLICABLE (N/A)</b> Delegate is not contracted for Organizational Providers	<b>NOT MET (0):</b> Delegate is contracted, but Organizational Providers is not stated in the policy
--	--	---

### 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

C Medical Providers Assessment - CMS		0	
1	Has documentation that it assessed contracted medical health care providers for at least three years thereafter	*	.
Review spreadsheet and note compliance. If files are reviewed complete the OP Tool and note the score in Column C.			

<b>MET (1):</b> The organization meets 1 factor	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0 factors
--	---	---

D Accreditation/Certification of Free-Standing Surgical Centers in California CH&SC			
1	The organization has documentation of assessment of free-standing surgical centers to ensure that if the organizational provider is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program	*	.

<b>MET (1):</b> The organization meets 1 factor	<b>PARTIALLY MET (.5):</b> No scoring option	<b>NOT MET (0):</b> The organization meets 0 factors
--	---	---

### 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_

Review Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Organizations to which the Provider Organization delegates any credentialing functions: Always note NA in the Scoring box, when a PO does not delegate any part of the credentialing process				
	Name	Type (i.e. MSO, CVO)	NCQA Cert Expiration Date	Delegation Agreement Effective Date

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

**CR 8: Delegation of Credentialing**

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

**Document Location:** Letter of Agreement, Contract, Memorandum of Understanding, Audit Documentation, Committee Minutes

**Scores pull from the CR.8. DELEGATION tab**

**Source:** NCQA; CMS (Medicare Managed Care Chapter 11 § 110.2)

Criteria		Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>A</b>	<b>Written Delegation Agreement:</b>	<b>Example: Score each delegate for each element below</b>	1) ABC Medical Group, pg 3 2) ACME Physician Organization, pg 6. 3) Mercy Health Partners, pg. 2	
1	Is mutually agreed upon	N/A	.	
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity	N/A	.	
3	Requires at least semi-annual reporting of the delegated entity to the organization	N/A	.	
4	Describes the process by which the organization evaluates the delgated entity's performance	N/A	.	
5	Specifies the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making	N/A	.	
6	Describe the remedies available to the organization if the delegated entity does not fulfill its obligation, including revocation of the delegation agreement	N/A	.	

0

If there are no delegation arrangements, score NA

**Source:** CMS (Medicare Managed Care Chapter 11 § 110.2); DHCS (MediCal ExhibitA, Attachment 4 of Plan Contract - QI Activities)



## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

Criteria		Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
<b>CMS/DHCS Requirements</b>		<b>Example:</b>	<b>1) ABC Medical Group, pg 3</b>	
1	Documentation in the agreement showing that sub-delegates must adhere to CMS regulations	N/A	.	If there are no delegation arrangements, score NA
2	The written delegation must require at least quarterly reporting of the delegated entity to the organization	N/A	.	If there are no delegation arrangements, score NA
<b>B</b>	<b>Pre-Delegation Evaluation</b>	<b>Example: Score each delegate for each element below</b>	<b>1) ABC Medical Group, pg 3 2) ACME Physician Organization, pg 6. 3) Mercy Health Partners, pg. 2</b>	
1	For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.	N/A	.	If there are no pre-delegation arrangements, score NA

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

C	Review of Credentialing Process for Delegate	Example: Score each delegate for each element below	1) ABC Medical Group, pg 3 2) ACME Physician Organization, pg 6. 3) Mercy Health Partners, pg. 2	
1	Annually audits credentialing policies and procedures	N/A	.	
2	Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.	N/A	.	
3	Annually evaluated delegate performance against NCQA standards for delegated activities	N/A	.	
4	Semi-annually evaluates regular reports, as specified in Element A. (N/A for NCQA CVO's)	N/A	.	
5	Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually.	N/A	.	
6	Annually acts on all findings from factor 5 for each delegate and implements quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	N/A	.	
		0		If there are no pre-delegation arrangements, score NA
D	Opportunities for Improvement	Example:	1) ABC Medical Group, pg 3	
1	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization has followed up on opportunities for improvement, if applicable	N/A	.	If there are no pre-delegation arrangements, score NA

## 2023 CREDENTIALING AUDIT TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

### CA 9: Identification of HIV/AIDS Specialists

The organization documents and implements a method for identifying HIV/AIDS Specialists.

The organization is accountable for identifying practitioners who qualify as HIV/AIDS specialists to whom appropriate members may be given a standing or extended referral when the member's condition requires that specialist medical care over a prolonged period of time or its life-threatening, degenerative or disabling, to a specialist or specialty care center that has expertise in treating HIV/AIDS, in accordance with California Health and Safety Codes

Source: DMHC/DHCS

	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	
<b>A Written Policy</b>			<b>Comments</b>
1 There is a written policy and procedure describing the process that the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist according to California State regulations, on an annual basis.	*		
<b>B Evidence of Implementation</b>			
1 On an annual basis, the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist, according to California State regulations.	*		
<b>C Distribution of Findings</b>			
1 The list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.	*		







2022 CR 3-4 FILE REVIEW TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

File No.	Name	Specialty	License Type	IEHP Decision Date	Decision Date	Previous Decision Date	180 calendar days Prior (Queries must be dated after this date)	3.A1	3.A1	3.A2	3.A3	3.A4	3.A5	3.A6	3.B1	3.B2	3.D1	3.D2	3.C1	3.C2	3.C3	3.C4	3.C5	3.C6	3.D3	3.D4	3.D6	4.A	Comments	
								License to Practice (Present)	License to Practice (Current)	DEACDS Certification	Education/Training	Board Certification	Work History	Malpractice History	State Sanctions, Restrictions on Licensure/Practice	Sanction Activity by Medicare and Medicaid	Sanction Activity by Medicare and Medicaid (CMS)	Medi-Cal Suspended & Ineligible List	Reasons for Inability to perform	Lack of present illegal drug use	History of Loss of License and felony convictions	History of loss or limitations of privileges	Current Malpractice Insurance Coverage	Current and signed Attestation	Hospital Admitting Privileges	Monitoring Physicians who have Opted Out	Review of Performance Information	Recredentialing Cycle		
POINTS RECEIVED																														
POINTS POSSIBLE																														
PERCENT COMPLIANT																														
1							#####	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
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2022 CR 3-4 FILE REVIEW TOOL

Delegate: \_\_\_\_\_

Review Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

File No.	Name	Specialty	License Type	IEHP Decision Date	Decision Date	Previous Decision Date	180 calendar days Prior (Queries must be dated after this date)	3.A1	3.A1	3.A2	3.A3	3.A4	3.A5	3.A6	3.B1	3.B2	3.D1	3.D2	3.C1	3.C2	3.C3	3.C4	3.C5	3.C6	3.D3	3.D4	3.D6	4.A	Comments
								License to Practice (Present)	License to Practice (Current)	DEACDS Certification	Education/Training	Board Certification	Work History	Malpractice History	State Sanctions, Restrictions on Licensure/Practice	Sanction Activity by Medicare and Medicaid	Sanction Activity by Medicare and Medicaid (CMS)	Medi-Cal Suspended & Ineligible List	Reasons for Inability to perform	Lack of present illegal drug use	History of Loss of License and felony convictions	History of loss or limitations of privileges	Current Malpractice Insurance Coverage	Current and signed Attestation	Hospital Admitting Privileges	Monitoring Physicians who have Opted Out	Review of Performance Information	Recredentialing Cycle	
								0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
								0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
								#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
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2023 CR.7. OP TOOL

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

File #	Facility Name	Type of Organization	Cred "C"/Recred "R" [Recred files >36 months, all elements are our of compliance	Date of Completion or Cred Committee	7.A1	7.A1	7.A2-A3	CMS	Actual File Score	Possible Score	% Compliant per File	File Pass 1 =>90% 0=<89%	Comments
					License	OIG Query	Accreditation or Site Visit	CMS Certification # (Medicare only)					
1				05/01/22					0	0	N/A	N/A	
2									0	0	N/A	N/A	
3									0	0	N/A	N/A	
4									0	0	N/A	N/A	
5									0	0	N/A	N/A	
6									0	0	N/A	N/A	
7									0	0	N/A	N/A	
8									0	0	N/A	N/A	
9									0	0	N/A	N/A	
10									0	0	N/A	N/A	
11									0	0	N/A	N/A	
12									0	0	N/A	N/A	
13									0	0	N/A	N/A	
14									0	0	N/A	N/A	
15									0	0	N/A	N/A	
16									0	0	N/A	N/A	
17									0	0	N/A	N/A	
18									0	0	N/A	N/A	
19									0	0	N/A	N/A	
20									0	0	N/A	N/A	

<b>CODING</b>			<b>ACTUAL SCORE</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>PRESENT</b>		<b>1</b>	<b>POSSIBLE SCORE</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>ABSENT</b>		<b>0</b>	<b>% COMPLIANT</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>ELEMENT NOT APPLICABLE</b>		<b>N/A</b>					

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #1		
<b>Criteria</b>						
<b>A. Written delegation agreement:</b>  • Delegation agreements implemented on or after January 1, 2022, must include a description of the delegate’s system security controls. • Delegation Agreements in place prior to 1/1/2022, have until 7/1/2024 to update their agreements with the CR system control language. Prior to 7/1/2024, organizations may provide other documentation or the delegate’s system controls policies. • All delegation agreements effective July 1, 2024 must include a description of CR system security controls. (This is not applicable to entities that only store off-site files.)				Compliance	Delegation Agreement (Page / Section)	Comments
1. Is mutually agreed upon.	0	0	N/A	1/0/N/A		
2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. • Includes detailed language of specific credentialing activities	0	0	N/A			
3. Requires at least semiannual reporting of the delegated entity to the organization. • Information reported/activities delegated • How and to whom information is reported	0	0	N/A			
4. Describes the process by which the organization evaluates the delegated entity's performance. • The Agreement should, at a minimum, include the annual review of the delegate's policies and procedures and review of files, if applicable. • The delegation agreement describes: ○ The delegate's CR system, controls in place to protect data from unauthorized modification as outlined in CR 1, Element C, Factor 4. ○ How the delegate monitors its credentialing system security controls at least annually, as required in CR 8, Element C, Factor 5. ○ How the PO monitors the delegate's credentialing system controls at least annually.  <b>If not included in the Delegation Agreement, then:</b> Policies and procedures describe the process for: • Limiting physical access to the credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources. • Preventing unauthorized access, changes to and release of credentialing information. • Password-protecting electronic systems, including user requirements to: ○ Use strong passwords. ○ Discourage staff from writing down passwords. ○ User IDs and passwords unique to each other. ○ Change passwords when requested by staff or if passwords are compromised. ○ Disable or remove passwords of employees who leave the organization and alerting appropriate staff who oversee computer	0	0	N/A			
5. Specifies the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	0	0	N/A			
6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligation, including revocation of the delegation agreement.	0	0	N/A			

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #1		
<b>CR 8. CMS Requirements/MediCal (DHCS)/CMC Delegation Agreement Requirements</b>						
<b>Criteria</b>				<b>Compliance</b>	<b>Delegation Agreement (Page / Section)</b>	<b>Comments</b>
				1/0/N/A		
1. Documentation in the agreement showing that sub-delegates must adhere to CMS regulations.	0	0	N/A			
2. The written delegation agreement must require at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			
3. Review of at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			
<b>CR 8.</b>				<b>Compliance</b>	<b>Evidence of Oversight</b>	<b>Comments</b>
				1/0/N/A		
<b>B. Pre-Delegation Evaluation</b> - For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began	0	0	N/A			
<b>C. Review of Credentialing Process - for delegation arrangements in effect for 12 months or longer the organization:</b>				<b>N/A</b>		
1. Annually audits credentialing policies and procedures. (Auto-credit does not apply. There must be evidence of review.)	0	0	N/A			
2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A			
3. Annually evaluated delegate performance against NCQA standards for delegated activities. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A			
4. Semi-annually evaluates regular reports, as specified in Element A. (Mark compliant for NCQA CVO's)	0	0	N/A			
5. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually.	0	0	N/A			
6. Annually acts on all findings from factor 5 for each delegate and implements quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	0	0	N/A			
<b>D. Opportunities for Improvement</b> - For delegation arrangements that have been in effect for more that 12 months, at least once in each of the past 2 years, the organization and followed up on opportunities for improvement, if applicable.	0	0	N/A			

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #2		
<b>Criteria</b>						
<b>A. Written delegation agreement:</b>  • Delegation agreements implemented on or after January 1, 2022, must include a description of the delegate’s system security controls. • Delegation Agreements in place prior to 1/1/2022, have until 7/1/2024 to update their agreements with the CR system control language. Prior to 7/1/2024, organizations may provide other documentation or the delegate’s system controls policies. • All delegation agreements effective July 1, 2024 must include a description of CR system security controls. (This is not applicable to entities that only store off-site files.)				Compliance 1/0/N/A	Delegation Agreement (Page / Section)	Comments
1. Is mutually agreed upon.	0	0	N/A			
2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. • Includes detailed language of specific credentialing activities	0	0	N/A			
3. Requires at least semiannual reporting of the delegated entity to the organization. • Information reported/activities delegated • How and to whom information is reported	0	0	N/A			
4. Describes the process by which the organization evaluates the delegated entity's performance. • The Agreement should, at a minimum, include the annual review of the delegate's policies and procedures and review of files, if applicable. • The delegation agreement describes: ○ The delegate's CR system, controls in place to protect data from unauthorized modification as outlined in CR 1, Element C, Factor 4. ○ How the delegate monitors its credentialing system security controls at least annually, as required in CR 8, Element C, Factor 5. ○ How the PO monitors the delegate's credentialing system controls at least annually.  <b>If not included in the Delegation Agreement, then:</b> Policies and procedures describe the process for: • Limiting physical access to the credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources. • Preventing unauthorized access, changes to and release of credentialing information. • Password-protecting electronic systems, including user requirements to: ○ Use strong passwords. ○ Discourage staff from writing down passwords. ○ User IDs and passwords unique to each other. ○ Change passwords when requested by staff or if passwords are compromised. ○ Disable or remove passwords of employees who leave the organization and alerting appropriate staff who oversee computer	0	0	N/A			
5. Specifies the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	0	0	N/A			
6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligation, including revocation of the delegation agreement.	0	0	N/A			

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #2		
<b>CR 8. CMS Requirements/MediCal (DHCS)/CMC Delegation Agreement Requirements</b>						
<b>Criteria</b>				<b>Compliance</b>	<b>Delegation Agreement (Page / Section)</b>	<b>Comments</b>
				1/0/N/A		
1. Documentation in the agreement showing that sub-delegates must adhere to CMS regulations.	0	0	N/A			
2. The written delegation agreement must require at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			
3. Review of at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			
<b>CR 8.</b>						
				<b>Compliance</b>	<b>Evidence of Oversight</b>	<b>Comments</b>
				1/0/N/A		
<b>B. Pre-Delegation Evaluation</b> - For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began	0	0	N/A			
<b>C. Review of Credentialing Process - for delegation arrangements in effect for 12 months or longer the organization:</b>				<b>N/A</b>		
1. Annually audits credentialing policies and procedures. (Auto-credit does not apply. There must be evidence of review.)	0	0	N/A			
2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A			
3. Annually evaluated delegate performance against NCQA standards for delegated activities. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A			
4. Semi-annually evaluates regular reports, as specified in Element A. (Mark compliant for NCQA CVO's)	0	0	N/A			
5. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually.	0	0	N/A			
6. Annually acts on all findings from factor 5 for each delegate and implements quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	0	0	N/A			
<b>D. Opportunities for Improvement</b> - For delegation arrangements that have been in effect for more that 12 months, at least once in each of the past 2 years, the organization and followed up on opportunities for improvement, if applicable.	0	0	N/A			

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #3		
<b>Criteria</b>						
<b>A. Written delegation agreement:</b>  • Delegation agreements implemented on or after January 1, 2022, must include a description of the delegate’s system security controls. • Delegation Agreements in place prior to 1/1/2022, have until 7/1/2024 to update their agreements with the CR system control language. Prior to 7/1/2024, organizations may provide other documentation or the delegate’s system controls policies. • All delegation agreements effective July 1, 2024 must include a description of CR system security controls. (This is not applicable to entities that only store off-site files.)				Compliance	Delegation Agreement (Page / Section)	Comments
1. Is mutually agreed upon.	0	0	N/A	1/0/N/A		
2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. • Includes detailed language of specific credentialing activities	0	0	N/A			
3. Requires at least semiannual reporting of the delegated entity to the organization. • Information reported/activities delegated • How and to whom information is reported	0	0	N/A			
4. Describes the process by which the organization evaluates the delegated entity's performance. • The Agreement should, at a minimum, include the annual review of the delegate's policies and procedures and review of files, if applicable. • The delegation agreement describes: ○ The delegate's CR system, controls in place to protect data from unauthorized modification as outlined in CR 1, Element C, Factor 4. ○ How the delegate monitors its credentialing system security controls at least annually, as required in CR 8, Element C, Factor 5. ○ How the PO monitors the delegate's credentialing system controls at least annually.  <b>If not included in the Delegation Agreement, then:</b> Policies and procedures describe the process for: • Limiting physical access to the credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources. • Preventing unauthorized access, changes to and release of credentialing information. • Password-protecting electronic systems, including user requirements to: ○ Use strong passwords. ○ Discourage staff from writing down passwords. ○ User IDs and passwords unique to each other. ○ Change passwords when requested by staff or if passwords are compromised. ○ Disable or remove passwords of employees who leave the organization and alerting appropriate staff who oversee computer	0	0	N/A			
5. Specifies the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	0	0	N/A			
6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligation, including revocation of the delegation agreement.	0	0	N/A			

Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #3		
<b>CR 8. CMS Requirements/MediCal (DHCS)/CMC Delegation Agreement Requirements</b>						
<b>Criteria</b>				<b>Compliance</b> 1/0/N/A	<b>Delegation Agreement</b> (Page / Section)	<b>Comments</b>
1. Documentation in the agreement showing that sub-delegates must adhere to CMS regulations.	0	0	N/A			
2. The written delegation agreement must require at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			
3. Review of at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			
<b>CR 8.</b>				<b>Compliance</b> 1/0/N/A	<b>Evidence of Oversight</b>	<b>Comments</b>
<b>B. Pre-Delegation Evaluation</b> - For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began	0	0	N/A			
<b>C. Review of Credentialing Process - for delegation arrangements in effect for 12 months or longer the organization:</b>				<b>N/A</b>		
1. Annually audits credentialing policies and procedures. (Auto-credit does not apply. There must be evidence of review.)	0	0	N/A			
2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A			
3. Annually evaluated delegate performance against NCQA standards for delegated activities. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A			
4. Semi-annually evaluates regular reports, as specified in Element A. (Mark compliant for NCQA CVO's)	0	0	N/A			
5. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually.	0	0	N/A			
6. Annually acts on all findings from factor 5 for each delegate and implements quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	0	0	N/A			
<b>D. Opportunities for Improvement - For delegation arrangements that have been in effect for more that 12 months, at least once in each of the past 2 years, the organization and followed up on opportunities for improvement, if applicable.</b>	0	0	N/A			



Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #4		
<b>Criteria</b>						
<b>A. Written delegation agreement:</b>  • Delegation agreements implemented on or after January 1, 2022, must include a description of the delegate’s system security controls. • Delegation Agreements in place prior to 1/1/2022, have until 7/1/2024 to update their agreements with the CR system control language. Prior to 7/1/2024, organizations may provide other documentation or the delegate’s system controls policies. • All delegation agreements effective July 1, 2024 must include a description of CR system security controls. (This is not applicable to entities that only store off-site files.)				Compliance 1/0/N/A	Delegation Agreement (Page / Section)	Comments
1. Is mutually agreed upon.	0	0	N/A			
2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. • Includes detailed language of specific credentialing activities	0	0	N/A			
3. Requires at least semiannual reporting of the delegated entity to the organization. • Information reported/activities delegated • How and to whom information is reported	0	0	N/A			
4. Describes the process by which the organization evaluates the delegated entity's performance. • The Agreement should, at a minimum, include the annual review of the delegate's policies and procedures and review of files, if applicable. • The delegation agreement describes: ○ The delegate's CR system, controls in place to protect data from unauthorized modification as outlined in CR 1, Element C, Factor 4. ○ How the delegate monitors its credentialing system security controls at least annually, as required in CR 8, Element C, Factor 5. ○ How the PO monitors the delegate's credentialing system controls at least annually.  <b>If not included in the Delegation Agreement, then:</b> Policies and procedures describe the process for: • Limiting physical access to the credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources. • Preventing unauthorized access, changes to and release of credentialing information. • Password-protecting electronic systems, including user requirements to: ○ Use strong passwords. ○ Discourage staff from writing down passwords. ○ User IDs and passwords unique to each other. ○ Change passwords when requested by staff or if passwords are compromised. ○ Disable or remove passwords of employees who leave the organization and alerting appropriate staff who oversee computer	0	0	N/A			
5. Specifies the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	0	0	N/A			
6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligation, including revocation of the delegation agreement.	0	0	N/A			



Delegate: \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_

Review Date: \_\_\_\_\_

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #4		
<b>CR 8. CMS Requirements/MediCal (DHCS)/CMC Delegation Agreement Requirements</b>						
<b>Criteria</b>				<b>Compliance</b> 1/0/N/A	<b>Delegation Agreement</b> <b>(Page / Section)</b>	<b>Comments</b>
1. Documentation in the agreement showing that sub-delegates must adhere to CMS regulations.	0	0	N/A			
2. The written delegation agreement must require at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			
3. Review of at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			
<b>CR 8.</b>				<b>Compliance</b> 1/0/N/A	<b>Evidence of Oversight</b>	<b>Comments</b>
<b>B. Pre-Delegation Evaluation</b> - For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began	0	0	N/A			
<b>C. Review of Credentialing Process - for delegation arrangements in effect for 12 months or longer the organization:</b>				<b>N/A</b>		
1. Annually audits credentialing policies and procedures. (Auto-credit does not apply. There must be evidence of review.)	0	0	N/A			
2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A			
3. Annually evaluated delegate performance against NCQA standards for delegated activities. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A			
4. Semi-annually evaluates regular reports, as specified in Element A. (Mark compliant for NCQA CVO's)	0	0	N/A			
5. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually.	0	0	N/A			
6. Annually acts on all findings from factor 5 for each delegate and implements quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	0	0	N/A			
<b>D. Opportunities for Improvement - For delegation arrangements that have been in effect for more that 12 months, at least once in each of the past 2 years, the organization and followed up on opportunities for improvement, if applicable.</b>	0	0	N/A			



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Listed below are the items required for your Delegation Oversight Audit (DOA). We have identified when they should be available, by Department.

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

DESKTOP	VIRTUAL	DELEGATION OVERSIGHT
✓		Biographical Information
✓		Sub-Contracted Service by Facility/Agency
✓		<b>All sections</b> of the DOA tool documented with <b>road mapping</b> instructions for each element (see sample roadmap)
✓		Organizational chart(s) to include; CM, UM, Compliance and Credentialing
✓		Current job descriptions as relevant to the audit
✓		Delegation Agreements with any sub-delegated provider
✓		Ownership and Control Documentation (submitted annually)

DESKTOP	VIRTUAL	QUALITY MANAGEMENT (Look back period of 07/2021 to 06/2022)
✓		Program, Plan and Description (no submission required; reports were submitted February 2022)
✓		Quality Improvement Committee meeting minutes from the auditing period that identify the following occurred during the meeting
✓		- Recommendation of policy decisions
✓		- Review and evaluation of QI activities
✓		- Practitioner participation in the QI program through planning, design, implementation or review
✓		- Identification and follow up of needed actions
✓		Notification of Termination policy and evidence that members were notified of practitioner termination
✓		Continued Access to Practitioners policy and evidence that the delegate followed policy requirements
✓		Supportive documentation or materials such as studies, audits, and surveys completed during the reporting period



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<b>DESKTOP</b>	<b>VIRTUAL</b>	<b>UTILIZATION MANAGEMENT (Look back period of 07/2021 to 06/2022)</b>
✓		Program, Plan and Description (



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✓		Annual Work Plan
✓		Annual Program Evaluation
✓		Policies and Procedures
		Policies and Procedures of Denial System Controls standards.
		Policies and Procedures of Denial System Controls Oversight standards.
✓		Committee meeting minutes from last twelve (12) months for: -Board of Directors -Utilization Management Committee
✓		-
✓		-
✓		Subcommittee Meeting Minutes
✓		Annual Inter-rater Reliability Audit
✓		Semi-Annual Health Plan Reports for the last twelve (12) months;
✓		Two (2) examples that demonstrate the use of Board Certified consultants to assist with determinations
✓		Criteria for Length of Stay and Medical Necessity used during the past two (2) years
✓		Fifteen (15) referral files to include Denials, Modifications, Cancellations and Approvals; (conducted via webinar)
		Submission of request for UM Criteria Log
✓		Utilization Management statistics from the last twelve (12) months;
✓		Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions;
✓		Evidence, other than via a denial letter, that the providers have been notified that they may contact a physician reviewer to discuss denial decisions;
✓		Provider communications from last twelve (12) months
✓		Evidence of current license for Providers (MD/DO) and Employees (RN, LVN) who make UM Decisions
✓		Copies of most recent referral inventory reporting used to manage turnaround time requirements for processing of IEHP referrals.
✓		Copies of most recent mailroom policies



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DESKTOP	VIRTUAL	CARE MANAGEMENT (Look back period of 07/2021 to 06/2022)
✓		Program Plan and Description and CM applicable policies and procedures if different from UM; <b>(Desk Review) *</b>
	✓	10) CM files;
	✓	Five (5) sample cases with documentation of coordination of care with county mental health clinics for Member receiving specialty mental health services.

DESKTOP	VIRTUAL	CREDENTIALING (Look back period of 07/2021 to 06/2022)
✓		Credentialing Policies and Procedures
✓		Policies and Procedures of Credentialing System Controls standards.
✓		Policies and Procedures of Credentialing System Controls Oversight standards.
✓		Committee Meeting Minutes (i.e. Credentialing Committee, Quality Management Committee, Peer Review Committee), which include the following: <ul style="list-style-type: none"> <li>• Committee Date</li> <li>• Committee discussions for Practitioners who do not meet the organizations criteria</li> <li>• Attendees of voting members and their specialties to show range of practitioners.</li> </ul>
✓		Committee Structure. If an MSO is contracted with multiple organizations, has one set of policies and all of the organizations use the same Credentials Committee, then only one (1) file sample across all contracts organization will be used and apply the same score for CR 3 and CR 4 elements.



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DESKTOP	VIRTUAL	<b>CREDENTIALING</b> (Look back period of 07/2021 to 06/2022)
	✓	Credentialing Files in the order they are listed: Forty (40) files selected for Delegate must include evidence of: <ul style="list-style-type: none"> <li>• Current and valid license to practice</li> <li>• DEA/CDS or appropriate arrangements</li> <li>• Education and Training</li> <li>• Board Certification status</li> <li>• Work History</li> <li>• Malpractice Claims History</li> <li>• State Sanctions, restrictions on licensure and limitations on scope of practice</li> <li>• Medicare and Medicaid Sanctions</li> <li>• Application and Attestation with questions specific to:                             <ul style="list-style-type: none"> <li>○ Reasons for Inability to Perform</li> <li>○ Lack of present illegal drug use</li> <li>○ History of loss of license or felony convictions</li> <li>○ Current Malpractice Insurance coverage</li> <li>○ Current and signed attestation confirming the correctness and completeness of the application.</li> </ul> </li> <li>• Malpractice Insurance</li> </ul>



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DESKTOP	VIRTUAL	<b>CREDENTIALING</b> <b>(Look back period of 07/2021 to 06/2022)</b>
	✓	Recredentialing Files in the order they are listed: Forty (40) files selected for Delegate must include evidence of: <ul style="list-style-type: none"> <li>• Current and valid license to practice</li> <li>• DEA/CDS or appropriate arrangements</li> <li>• Board Certification status</li> <li>• Malpractice Claims History</li> <li>• State Sanctions, restrictions on licensure and limitations on scope of practice</li> <li>• Medicare and Medicaid Sanctions</li> <li>• Application and Attestation with questions specific to:                             <ul style="list-style-type: none"> <li>○ Reasons for Inability to Perform</li> <li>○ Lack of present illegal drug use</li> <li>○ History of loss of license or felony convictions</li> <li>○ Current Malpractice Insurance coverage</li> <li>○ Current and signed attestation confirming the correctness and completeness of the application.</li> </ul> </li> <li>• Malpractice Insurance</li> <li>• Recredentialing Cycle Length</li> </ul>
	✓	Credentialing and Recredentialing Files must also show evidence of: <ul style="list-style-type: none"> <li>• Hospital Affiliations or Admitting privileges at a participating hospital</li> <li>• Monitoring Physicians who have Opted Out</li> <li>• Review of Performance Monitoring (Recredentialing files only)</li> <li>• Review of OIG Exclusions</li> </ul> Review of Medi-Cal Suspended & Ineligible List



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<b>DESKTOP</b>	<b>VIRTUAL</b>	<b>CREDENTIALING (Look back period of 07/2021 to 06/2022)</b>
✓		Evidence of Ongoing Monitoring of Medicaid Sanctions review: <ul style="list-style-type: none"> <li>• Medi-Cal Suspended &amp; Ineligible List</li> <li>• OIG Exclusions List</li> </ul>
✓		Evidence of Ongoing Monitoring of Medicare Sanctions review: <ul style="list-style-type: none"> <li>• OIG Exclusions List</li> <li>• Medicare Opt-Out</li> <li>• Preclusions List</li> </ul>
✓		Evidence of Ongoing Monitoring of sanctions and limitations on licensure review
✓		Practitioner file(s) for those who were suspended and/or terminated due to quality of care
✓		Practitioner files that have appealed a decision





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DESKTOP	VIRTUAL	CREDENTIALING (Look back period of 07/2021 to 06/2022)
✓		Healthcare Delivery Organizational Provider Assessments via Spreadsheet/Log or Provider file, to include the following provider types: <ul style="list-style-type: none"> <li>• Hospitals</li> <li>• Home Health Agencies</li> <li>• Skilled Nursing Facilities</li> <li>• Free-standing Surgical Centers</li> <li>• Clinical Laboratories</li> <li>• Hospices</li> <li>• Comprehensive Outpatient Rehabilitation Facilities</li> <li>• Outpatient Physical Therapy</li> <li>• Speech Pathology Providers</li> <li>• Ambulatory Surgery Centers</li> <li>• Providers of end-stage renal disease services</li> <li>• Providers of outpatient diabetes self-management training</li> <li>• Portable X-ray Suppliers</li> <li>• Rural Health Clinics</li> <li>• Federally Qualified Health Center</li> </ul>
✓		Delegation Agreement(s) for all sub-delegate arrangements, to include but not limited to: <ul style="list-style-type: none"> <li>• MSO</li> <li>• CVO</li> <li>• PO</li> <li>• BH</li> </ul>
✓		Human Immunodeficiency Virus (HIV/AIDS) Annual Identification Process




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✓		a.

DESKTOP	ON-SITE	IT SECURITY
✓		The name of the medical management system(s) used for the utilization management, care management, and claims functions.



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<b>DESKTOP</b>	<b>ON-SITE</b>	<b>PROVIDER DIRECTORY</b>
✓		Report during the lookback period of the annual audit of identified/reported inaccuracies and the timeframe of the correction. (Applies to Kaiser Permanente and American Specialty Health (ASH))







**File Review Instructions:**

IEHP selects 30 Denials/Modifications for review from the IPA Delegated Monthly Referral Tracking Log. Each file will be reviewed against the elements listed below and noted as follows: "1" yes the file review element meets, "0" when the file review element does not meet. Each file reviewed has a maximum score of 8 possible points. Findings related to each file review will be listed within the comments for IPA review.

Data Dictionary			
Element	Element Description	Methodology	Regulatory Criteria/ Citation/ Policy
(a)	Denial Tracking #	<i>Element Not Scored:</i> The Denial/Modification reference number located on the referral form for tracking purposes.	IEHP Provider Policy and Procedure - Dual Choice MA_25E1: Utilization Management - Delegation Oversight & Monitoring
(b)	File Type Requested	<i>Element Not Scored:</i> The Denial/Modification type: Pre-Service Routine , Pre-Service Expedited, Post Service Retrospective Review, Concurrent Standard, Concurrent Expedited.  Review of documentation for a proper downgrade from an expedited determination request to a standard determination and for proper notification to the enrollee that explains that the organization will process the request using the 14-day timeframe for standard determinations, informs the enrollee of the right to file an expedited grievance, informs the enrollee of the right to resubmit a request for an expedited determination with any physician's support, and provides instructions about the grievance process and timeframes.	
(c)	Referral Received Date / Time	<i>Element Not Scored:</i> The date/time the request was received.	
(d)	Referral Decision Date / Time	<i>Element Not Scored:</i> The date/time the request was decided.	
(e)	Date Referral Deemed Necessary	<i>Element Not Scored:</i> The date/time the Provider deemed the referral necessary.	
(f)	Date receipt of information reasonably necessary to make the determination	<i>Element Not Scored:</i> The date the Plan or Delegate received information reasonably necessary to make the determination.	
(g)	Opportunity to Discuss	<i>Scored Element:</i> Review of written communication to the Provider of a denial or modification based on medical necessity must include the name and telephone number of the physician reviewer that may be contacted for any issues/concerns regarding the decision. Denial or modification based on non-medical necessity (non-benefits, carve-outs) must include the reviewing department name and telephone number that may be contacted for any issues/concerns regarding the decision.	IEHP Provider Policy and Procedure - Dual Choice MA_25E1: Utilization Management - Delegation Oversight & Monitoring
(h)	Physician Reviewed and Justification Documentation	<i>Scored Element:</i> Review of documentation must contain evidence that supports the denied or modified authorization determination and was conducted by a designated licensed physician with an unrestricted license. Documentation must include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based.	
(i)	Clinical Documentation	<i>Scored Element:</i> Review of supportive clinical information must support denial or modified authorization determination.	
(j)	Alternative Direction	<i>Scored Element:</i> Review of denied or modified authorization Member notification must include evidence that Member was provided alternative treatment information and instruction for additional follow-up care.	
(k)	Provider/Member Outreach	<i>Scored Element:</i> In the event initial request submitted by Provider does not include information reasonably necessary to make a determination of the authorization, evidence must demonstrate IPA outreach to the requesting Provider for additional clinical information.	
(l)	Denial Language	<i>Scored Element (sanctionable element):</i> Review of the denial or modification letter sent to the Member must be written in a manner, format, and language that can be easily understood and in the Member's appropriate threshold language.	
(m)	Appropriate use of Criteria	<i>Scored Element (sanctionable element):</i> Review of denial or modification authorization must demonstrate correct application of IEHP UM criteria hierarchy, as listed in the <i>IEHP Provider Policy &amp; Procedure</i> .	
(n)	Correct Template	<i>Scored Element (sanctionable element):</i> Review of the denial letter demonstrates the use of IEHP approved CMS template and attachments - Correct template with attachments can be found on the IEHP website at: iehp.org. Member authorization letter must be mailed in the Member's appropriate threshold language.	
(o)	Points Received	Each file reviewed has a maximum score of 8 possible points. Total points earned from letters (e)-(l) above.	N/A
(p)	Points Possible	Each file reviewed has a maximum score of 8 possible points. Total points possible from letters (e)-(l) above, excluding non applicable elements.	
(q)	Individual File Score	Total points earned from letters (e)-(l) above divided by total points possible from letters (e)-(l) above, excluding non applicable elements for each file reviewed.	



### Corrective Action Plan (CAP) Form

**COMPLETION INSTRUCTIONS**

Please complete the below form. Fields that are BOLD are required. (Root Cause Analysis, Action Plan and Monitoring Plan)  
 E-Sign at the "X" by double-clicking or right-clicking with your mouse in the space provided below.  
 \*If E-signature is not available, you may submit a signed and dated PDF copy along with this Microsoft Word version of this form.  
 This CAP is due to IEHP within 30 days from the date of request.  
 If you have any questions regarding this CAP, please contact Juan Ortega at Ortega-J2@iehph.org.

IPA: Choose an IPA  
 Original Date Sent to IPA: Click here to enter a date  
 CAP DUE DATE: Click here to enter a date

Finding #	File Month/Year	Type	Findings (As identified by IEHP audit)	Response Number (Initial response row #1, secondary response row #2)	Completed by IPA: Root Cause Analysis (Examples: policy, process, vendor, technology, reporting, staffing, training, etc. Was an Impact Analysis conducted on providers or impacted members? If so, provide those results.)	Completed by IPA: Action Plan (Clearly define the plan to remediate all deficiencies including impacted departments, required system updates, policy updates, staff training, member outreach, follow up or transition plans, implementation due dates, Committee Approvals or Board updates, Provider Updates, and monitoring plan)	Completed by IPA: Monitoring Plan (Identify what policy and work process updates will be put in place to monitor performance going forward. Include what actions will be taken to report deficiencies or trigger actions to address potential compliance risks.)	CAP received from IPA	CAP Status	Decision/Notification Date	Additional Documents Required / Comments
1				1							
				2							
				3							
				4							
2				1							
				2							
				3							
3				1							
				2							
				3							
				4							

**CAP Attestation:**  
 By signing below, I attest that the information in this Corrective Action Plan (CAP) including the Root Cause Analysis, Action Plan and Monitoring Plan will be implemented as stated in this form. **Please sign and date with each CAP submission.**

<b>First CAP Response:</b>	
<b>Printed Name of Signing Individual</b>	<b>Title of Signing Individual</b>
<b>Signature</b>	<b>Date</b>

<b>Second CAP Response:</b>	
<b>Printed Name of Signing Individual</b>	<b>Title of Signing Individual</b>
<b>Signature</b>	<b>Date</b>

<b>Third CAP Response:</b>	
<b>Printed Name of Signing Individual</b>	<b>Title of Signing Individual</b>
<b>Signature</b>	<b>Date</b>

**CAP Attestation Instructions:**  
 Please sign and date the form with each CAP submission, until the CAP form has been accepted. Initial Response, secondary response, etc.  
 Signature line: IPA to sign document using a scanned image with an approved document signer.  
 The CAP form will be returned if it is received without an approved signature for each response submission (see provided example).

**IPA Name:**  
**Reporting Period:**  
**Date of Submission:**  
**IPA Contact:**

**CA21 - The number of critical incident and abuse reports for Members receiving LTSS**

Element Letter	Element Name	Definition	Allowable Values
A	Total number of members receiving IHSS	Total number of members receiving IHSS services during the reporting period	Field Type: Numeric
B	Total number of members receiving CBAS	Total number of members receiving CBAS services during the reporting	Field Type: Numeric
C	Total number of members receiving MSSP services	Total number of members receiving MSSP services during the reporting	Field Type: Numeric
D	Total number of members receiving nursing facility (NF) services	Total number of members receiving NF services during the reporting period	Field Type: Numeric
E	Total number of critical incident and abuse reports among members receiving IHSS services	Of the total reported in A, the number of critical incident and abuse reports during the reporting period	Field Type: Numeric
F	Total number of critical incident and abuse reports among members receiving CBAS services	Of the total reported in B, the number of critical incident and abuse reports during the reporting period	Field Type: Numeric
G	Total number of critical incident and abuse reports among members receiving MSSP services	Of the total reported in C, the number of critical incident and abuse reports during the reporting period	Field Type: Numeric
H	Total number of critical incident and abuse reports among members receiving NF services	Of the total reported in D, the number of critical incident and abuse reports during the reporting period	Field Type: Numeric
I	Date of Occurrence	Date of the critical incident	Field Type: Date (YYYY/MM/DD)



J	Report Type	Type of Reporting	Field Type: Text (Domestic Violence, Suspected Child Abuse/Neglect, Suspected Elder/Dependent Abuse/Neglect)
K	Date Report was Filed	Date the critical incident was filed/reported	Field Type: Date (YYYY/MM/DD)
L	Report Reference Number	Critical incident report reference number	Field Type: Numeric
M	County	County critical incident reported	Field Type: Text (Riverside County, San Bernardino County, Other)
N	First Name of Contact at the Agency	First name of the contact at the agency	Field Type: Text
O	Last Name of Contact at the Agency	Last name of the contact at the agency	Field Type: Text
P	Contact Phone Number	Phone number of the contact at the agency	Field Type: Numeric (XXX-XXX-XXXX) & extension if applicable
Q	Brief Description of Reported Incident	Brief description of the reported incident	Field Type: Text



IPA ASM File Layout

Template Version 3

HEALTH_PLAN	MBR_HPID	MBR_LAST_NAME	MBR_FIRST_NAME	MBR_DOB	MBR_GENDER	MBR_MBI	DOS_FROM	DOS_THRU	PLACE_OF_SERVICE	CLAIM_TYPE	ICD_INDICATOR
Default value = IEHP (Required)	IEHP 14-digit Member Number (Required)	Member last name (Required)	Member first name (Required)	Member date of birth, format: dd/mm/yyyy (Required)	Member gender M = Male, F = Female (Required)	Member's MBI (Medicare Beneficiary Identifier) (Required)	Initial date of service for the claim (Required)	Final date of service for the claim (Required)	Place of Service Code (Required)	Professional or Institutional (Required)	Default value = 10 (Required)

ICD_CODE_1	ICD_CODE_2	ICD_CODE_3	ICD_CODE_4	ICD_CODE_47	ICD_CODE_48	ICD_CODE_49	ICD_CODE_50		BILL_PROV_TAXONOMY	BILL_PROV_NPI	BILL_PROV_LAST_NAME	BILL_PROV_FIRST_NAME	BILL_PROV_STREET_ADDRESS
For ICD_CODE_1 through ICD_CODE_50, list one ICD code in each column until all ICD codes are recorded, leaving the remaining columns blank (Required)	(Optional)	(Optional)	(Optional)	(Optional)	(Optional)	(Optional)	(Optional)	Billing Provider Tax ID Number (Required)	Billing Provider Taxonomy Code (Required)	Billing Provider NPI (Required)	Billing Provider Last Name (Required)	Billing Provider First Name (Required)	Billing Provider Street Address (Required)

BILL_PROV_CITY	BILL_PROV_STATE	BILL_PROV_ZIP_CODE	BILL_ENTITY_TYPE	REND_PROV_TAXID	REND_PROV_NPI	REND_PROV_LAST_NAME	REND_PROV_FIRST_NAME	REND_PROV_TAXONOMY_CODE	IEHP_CLAIM_ID
Billing Provider City (Required)	Billing Provider State (Required)	Billing Provider Zip Code (Required)	An indicator of if the billing provider is a person or an organization. 1 = Person, 2 = Non-person entity (organization) (Required)	Rendering Provider Tax ID Number (Required)	Rendering Provider NPI (Required)	Rendering Provider Last Name (Required)	Rendering Provider First Name (Required)	Rendering Provider Taxonomy Code (Highly Recommended)	Original IEHP Claim ID (Required for deletes only)

## IEHP Universe Expedited Service Authorization Request (MESAR) Data Dictionary

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First name of the member
B	Member Last Name	CHAR Always Required	50	Last name of the member
C	Member ID	CHAR Always Required	20	Medicare Beneficiary Identifier (MBI) used to identify the member. This is assigned by the MMP. Note : 11-digit identifier (contains uppercase alphabetic and numeric characters). This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	The contract number of the organization. Note: <b>H5355</b> identifies the CMC line of business.
E	Plan ID	CHAR Always Required	3	The plan number of the organization. Note: IEHP's assigned Plan ID is <b>001</b> .
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the MMP for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Who made the request?	CHAR Always Required	3	Indicate whether the pre-service request was made by a contract provider (CP), non-contract provider (NCP), member (M), member's representative (MR), or Service Coordinator/Care Coordinator (SC). Note: The term "provider" encompasses physicians and facilities.
H	Provider Type	CHAR Always Required	3	Indicate whether the provider performing the service is a contract provider (CP) or non-contract provider (NCP).
I	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Note-If the request was received as a standard service authorization request, but later expedited, enter the date of the request to expedite the service authorization request.
J	Time the request was received	CHAR Always Required	8	Provide the time the request was received by your organization. Submit in HH:MM:SS military time format (e.g., 23:59:59). Note: If the request was received as a standard service authorization request, but later expedited, enter the time of the request to expedite the service authorization.
K	Diagnosis	CHAR Always Required	100	Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC).

Column ID	Field Name	Field Type	Field Length	Description
L	Type of service	CHAR Always Required	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
M	Issue description	CHAR Always Required	2000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the service requested was denied.
N	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the MMP extended the timeframe to make the service authorization determination.
O	If an extension was taken, did the MMP notify the member of the reason(s) for the delay and of their right to file an expedited grievance?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the MMP notified the member of the delay. Answer NA if no extension was taken.
P	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. MMPs should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
Q	Date of MMP decision	CHAR Always Required	10	Date of the MMP decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). MMPs should answer NA for untimely cases that are still open.
R	Time of MMP decision	CHAR Always Requested	8	Time of the MMP decision (e.g., approved, denied). Submit in HH:MM:SS military time format (e.g., 23:59:59). MMPs should answer NA for untimely cases that are still open.
S	Was the request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.
T	Date oral notification provided to member	CHAR Always Required	10	Date oral notification provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no oral notification.
U	Time oral notification provided to member	CHAR Always Required	8	Time oral notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no oral notification.

Column ID	Field Name	Field Type	Field Length	Description
V	Date written notification provided to member	CHAR Always Required	10	Date written notification provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification was provided.
W	Time written notification provided to member	CHAR Always Required	8	Time written notification provided to member. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no written notification was provided.
X	Date service authorization entered/effectuated in the MMP's system	CHAR Always Required	10	Date service authorization entered in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials.
Y	Time service authorization entered/effectuated in the MMP's system	CHAR Always Required	8	Time service authorization entered in the MMP's system. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA for denials.
Z	AOR Receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.
AA	AOR Receipt time	CHAR Always Required	8	Time the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in HH:MM:SS military time format (e.g., 23:59:59). Answer NA if no AOR form was required.
AB	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the expedited service authorization request (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.



Universe Expedited Service Authorization Requests (MESAR) Template

A Member First Name	B Member Last Name	C Member ID	D Contract ID	E Plan ID	F Authorization or Claim Number	G Who Made the Request	H Provider Type	I Date the Request was Received	J Time the Request was Received	K Diagnosis	L Type of Service
<p>First name of the member.</p>	<p>Last name of the member.</p>	<p>Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes</p>	<p>The contract number of the organization. <i>Note: H5355 identifies the CMC line of business</i></p>	<p>The plan number of the organization. <i>Note: IEHP's assigned Plan ID Number is 001</i></p>	<p>The associated authorization number assigned by the MMP for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer <b>NA</b> if there is no authorization or other tracking number available.</p>	<p>Indicate whether the service authorization request was made by a contract provider (<b>CP</b>), non-contract provider (<b>NCP</b>), member (<b>M</b>), member's representative (<b>MR</b>), or Service Coordinator / Care Coordinator (<b>SC</b>)  <i>Note: the term "provider" encompasses physicians and facilities.</i></p>	<p>Indicate whether the provider performing the service is a contract provider (<b>CP</b>) or non-contract provider (<b>NCP</b>).</p>	<p>Provide the date the request was received by your organization. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01).  <i>Note: If the request was received as a standard service authorization request, but later expedited, enter the date of the request to expedite the service authorization request.</i></p>	<p>Provide the time the request was received by your organization. Submit in <b>HH:MM:SS</b> military time format (e.g., 23:59:59).  <i>Note: This is the original receipt of the request by the MMP or delegated entity and not the date that the request became valid via an AOR. Also-if the request was received as a standard service authorization request, but later expedited, enter the time of the request to expedite the service authorization.</i></p>	<p>Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.</p>	<p>Enter "BH" for Behavioral Health services, "LTSS" for Long Term Services and Supports, "SU" for Substance Use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.</p>



M	N	O	P	Q	R	S	T	U	V	W	X
Issue Description	Was a Timeframe Extension Taken?	If an Extension was taken, did the MMP notify the Member of the Reason(s) for the Delay and of their Right to file an Expedited Grievance?	Request Disposition	Date of MMP Decision	Time of MMP Decision	Was the Request Denied for Lack of Medical Necessity?	Date Oral Notification Provided to Member	Time Oral Notification provided to Member	Date Written Notification Provided to Member	Time Written Notification provided to Member	Date Service Authorization Entered / Effectuated in the MMP's System
<p>Provide Procedure Code followed directly by a dash (-) with no space, followed directly by the description. If there are multiple services, list them all here as specified above delimited by a comma. For denials, also provide an explanation of why the service request was denied.</p>	<p>Yes (Y) / No (N) indicator of whether the MMP extended the timeframe to make the service authorization decision.</p>	<p>Yes (Y) / No (N) indicator of whether the MMP notified the member of the delay. Answer <b>NA</b> if no extension was taken.</p>	<p>Status of the request. Valid values are: <b>Approved</b> or <b>Denied</b>. MMPs should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.</p>	<p>Date of the MMP decision. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). MMPs should answer <b>NA</b> for untimely cases that are still open.  <i>Note: This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.</i></p>	<p>Time of the MMP decision (e.g., approved, denied). Submit in <b>HH:MM:SS</b> military time format (e.g., 23:59:59). MMPs should answer <b>NA</b> for untimely cases that are still open.  <i>Note: This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.</i></p>	<p>Yes (Y) / No (N) indicator of whether the request was denied for lack of medical necessity. Answer <b>NA</b> if the request was approved. Answer <b>No</b> if the request was denied because it was untimely.</p>	<p>Date oral notification provided to member. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> if no oral notification.</p>	<p>Time oral notification provided to member. Submit in <b>HH:MM:SS</b> military time format (e.g., 23:59:59). Answer <b>NA</b> if no oral notification.</p>	<p>Date written notification provided to member. The term "provided" means when the letter left the MMP's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the MMP's organization. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> if no written notification was provided.</p>	<p>Time written notification provided to member. Submit in <b>HH:MM:SS</b> military time format (e.g., 23:59:59). Answer <b>NA</b> if no written notification was provided.</p>	<p>Date service authorization/approval was entered in the MMP'S system. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> for denials.  <i>Note: This is the point at which the member could obtain the service.</i></p>

Y	Z	AA	AB
<p align="center"><b>Time Service Authorization Entered / Effectuated in the MMP's System</b></p>	<p align="center"><b>AOR Receipt Date</b></p>	<p align="center"><b>AOR Receipt Time</b></p>	<p align="center"><b>First Tier, Downstream, and Related Entity.</b></p>
<p>Time service authorization/approval entered in the MMP'S system. Submit in <b>HH:MM:SS</b> military format (e.g., 23:59:59). Answer <b>NA</b> for denials.</p> <p><i>Note: This is the point at which the member could obtain the service.</i></p>	<p>Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> if no AOR form was required.</p>	<p>Time the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in <b>HH:MM:SS</b> military format (e.g., 23:59:59). Answer <b>NA</b> if no AOR form was required.</p>	<p>Insert the name of the First Tier, Downstream, and Related Entity that processed the expedited organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer <b>NA</b> if not applicable.</p>

**MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)  
Audit Process and Data Request**

**Table 3: MMP Provider Payment Requests (M\_Claims) Record Layout**

- Include all requests to the MMP processed as both contract and non-contract provider denied claims and paid claims from non-contract providers only.
- Exclude all requests processed as direct member reimbursements, dismissals, duplicate claims and payment adjustments to claims, reopenings, claims denied for invalid billing codes, denied claims for members who are not enrolled on the date of service, claims denied due to recoupment of payment. Submit provider payment requests (claims) based on the date the claim was paid or denied, or should have been paid or denied (the date the request was initiated may fall outside of the review period).
- If a claim has more than one line item, include all of the claim's line items in a single row and enter the multiple line items as a single claim.

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	Member ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	The contract number (e.g., H1234) of the organization.
E	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
F	Authorization or Claim Number	CHAR Always Required	40	The associated claim or payment request number assigned by the MMP for this request. If a claim or payment request number is not available, please provide your internal tracking or case number. Answer NA if there is no claim, payment request or other tracking number available.
G	Provider Type	CHAR Always Required	3	Indicate whether the provider who performed the service is a contract provider (CP) or non-contract provider (NCP).  Note, the term "provider" encompasses physicians and facilities.
H	Is this a clean claim?	CHAR Always Required	2	Yes/No indicator flag to indicate whether the claim is clean (Y) or unclean (N). Answer NA for untimely requests that are still open or if clean status has not been determined.

**MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)**

**Audit Process and Data Request**

Column ID	Field Name	Field Type	Field Length	Description
I	Date the request was received	CHAR Always Required	10	Provide the date the payment request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
J	Diagnosis	CHAR Always Required	100	Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC).
K	Type of service	CHAR Always Required	50	Enter “BH” for behavioral health services, “LTSS” for long term services and supports, “SU” for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.
L	Issue description	CHAR Always Required	2,000	Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the claim was denied.
M	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. MMPs should note any requests that are untimely and not yet resolved (still outstanding) as denied.  All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout’s fields.
N	Date the claim was paid or denied	CHAR Always Required	10	Date the claim was paid. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer DENIED for claims that were denied. Answer NA for untimely cases that are still open.
O	Was interest paid on the claim?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether interest was paid on the claim.
P	Was the request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.
Q	Date written notification provided to member	CHAR Always Required	10	Date written notification provided to member. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer Pending if written notification has not yet been provided, but is anticipated to be provided in a forthcoming EOB or IDN notice. Answer NA if no written notification provided to the member.

**MMP Service Authorization Requests, Appeals, and Grievances (MMP-SARAG)  
Audit Process and Data Request**

Column ID	Field Name	Field Type	Field Length	Description
R	Date written notification provided to provider	CHAR Always Required	10	Date written notification provided to the provider. Submit in CCYY/MM/DD format (e.g., 2015/01/01). Answer NA if no written notification was provided.
S	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the claim (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.



## Universe MMP Provider Payment Requests (M\_Claims) Template

A Member First Name	B Member Last Name	C Cardholder ID	D Contract ID	E Plan ID	F Authorization or Claim Number	G Provider Type	H Is this a Clean Claim?	I Date the Request was Received	J Diagnosis	K Type of Service
First name of the member.	Last name of the member.	Either the Medicare Beneficiary Identifier (MBI) of the enrollee or the IEHP 14 digit ID number.	The contract number of the organization.  <i>Note: H5355 identifies the CMC line of business</i>	The plan number of the organization.  <i>Note: IEHP's assigned Plan ID Number is 001</i>	The associated claim or payment request number assigned by the MMP for this request. If a claim or payment request number is not available, please provide your internal tracking or case number. Answer <b>NA</b> if there is no claim, payment request or other tracking number available.	Indicate whether the provider who performed the service is a contract provider ( <b>CP</b> ) or non-contract provider ( <b>NCP</b> ).  <i>Note: the term "provider" encompasses physicians and facilities.</i>	Yes/No indicator flag to indicate whether the claim is clean ( <b>Y</b> ) or unclear ( <b>N</b> ). Answer <b>NA</b> for untimely requests that are still open or if clean status has not been determined.	Provide the date the payment request was received by your organization. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01).	Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.	Enter <b>"BH"</b> for Behavioral Health services, <b>"LTSS"</b> for Long Term Services and Supports, <b>"SU"</b> for Substance Use services. Other service types might include, but are not limited to <b>DME, SNF care, dental, vision</b> , etc.

L	M	N	O	P	Q	R	S
Issue Description	Request Disposition	Date the Claim was Paid or Denied	Was Interest Paid on the Claim?	Was the Request Denied for Lack of Medical Necessity?	Date Written Notification Provided to Member	Date Written Notification Provided to Provider	First Tier, Downstream, and Related Entity.
Provide a description of the service, medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the Claim was denied.	<p>Status of the request. Valid values are: <b>Approved</b> or <b>Denied</b>. MMPs should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.</p> <p><b>Please note that for audit purposes, partially favorable decisions are treated as denials.</b></p>	Date the Claim was paid. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>DENIED</b> for claims that were denied. Answer <b>NA</b> for untimely cases that are still open.	Yes (Y) / No (N) indicator of whether interest was paid on the claim.	Yes (Y) / No (N) indicator of whether the request was denied for lack of medical necessity. Answer <b>NA</b> if the request was approved. Answer <b>No</b> if the request was denied because it was untimely.	Date written notification provided to member. The term "provided" means when the letter left the MMP's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the MMP's organization. If no proof of mailing is available, populate based on worst case scenario according to policies in place. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> if no written notification provided to the member.	Date written notification provided to enrollee. The term "provided" means when the EOB, IDN or letter left the sponsor's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the sponsor's organization. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> if no written notification provided to the enrollee.	Insert the name of the First Tier, Downstream, and Related Entity that processed the claim (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.

T
Date of Service
The beginning Date of Service for this Claim.





Universe Standard and Expedited Service Authorization Requests (M\_SAR) Template

A	B	C	D	E	F	G	H	I	J	K	L	M
Enrollee First Name	Enrollee Last Name	Enrollee ID	Contract ID	Plan Benefit Package (PBP)	First Tier, Downstream, and Related Entity	Authorization or Claim Number	Date the Request was Received	Time the Request was Received	Part B Drug Request	AOR/Equivalent notice Receipt Date	AOR/Equivalent notice Receipt Time	Request Determination
First name of the enrollee.	Last name of the enrollee.	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.	The contract number of the organization. <i>Note: H5355 identifies the CMC line of business</i>	Enter the PBP. <i>Note: IEHP's assigned PBP is 001</i>	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the MMP to provide administrative or health care services to an enrollee under the MMP program) that processed the request. Enter None if the MMP processed the request.	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available	Enter the date the request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01). If a standard request was upgraded to expedited, enter the date the request was upgraded.	For all expedited requests and standard Part B drug requests, enter the time the request was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). If a standard request was upgraded to expedited, enter the time the request was upgraded. Enter None for standard service requests and dismissed requests.	Enter: Y for Yes, N for No	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no AOR or equivalent written notice was received or required.	For all expedited requests and standard Part B drug requests, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in HH:MM:SS format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no AOR or equivalent written notice was received or required.	Valid values are <b>Approved</b> , <b>Denied</b> , or <b>Dismissed</b>

N	O	P	Q	R	S	T	U	V	W	X	R
Was the request processed as Standard or Expedited	Was a Timeframe Extension Taken?	Date of Determination	Time of Determination	Date Oral Notification Provided to Enrollee	Time Oral Notification Provided to Enrollee	Date Written Notification Provided to Enrollee	Time Written Notification Provided to Enrollee	Who made the request?	Issue Description and Type of Service	Was an expedited request made but processed as standard?	Was the Request Denied for Lack of Medical Necessity?
<p>Enter the manner by which the request was processed: <b>S</b> for Standard <b>E</b> for Expedited</p>	<p>Yes (<b>Y</b>) / No (<b>N</b>) indicator of whether the MMP extended the timeframe to make the service authorization decision.</p>	<p>For all expedited requests and standard Part B drug requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard and dismissed requests.</p>	<p>For all expedited requests and standard Part B drug requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard and dismissed requests.</p>	<p>Enter the date oral notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no oral notification was provided.</p>	<p>For all expedited requests and standard Part B drug requests, enter the time oral notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no oral notification was provided.</p>	<p>Enter the date written notification of determination was provided to enrollee. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no written notification was provided.</p>	<p>For all expedited requests and standard Part B drug requests, enter the time written notification of determination was provided to enrollee. Do not enter the time a letter was generated or printed. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no written notification was provided.</p>	<p>Enter who made the request:: Enter <b>E</b> for enrollee, <b>ER</b> for enrollee's representative or purported representative, <b>CP</b> for requests by a contract provider/ facility, <b>NCP</b> for requests by a noncontract provider/ facility</p>	<p>Provide Procedure Code followed directly by a dash (-) with no space, followed directly by the description. If there are multiple services, list them all here as specified above delimited by a comma. For denials, also provide an explanation of why the preservice request was denied. For dismissed requests, provide the reason for dismissal. If describing behavioral health services, long-term services and supports (LTSS), or substance use disorder services, include the terms behavioral health, LTSS, and substance use disorder service in this field, as applicable.</p>	<p>Enter <b>Y</b> for Yes if an expedited request was received but downgraded to standard. Enter <b>None</b> for all other requests (e.g. the request was received as expedited and processed as expedited, the request was received as standard)</p>	<p>Enter <b>Y</b> for Yes, <b>N</b> for No, and <b>None</b> if the request was approved or dismissed.</p>



Payment Organization Determinations and Reconsiderations (PYMT\_C)

A Enrollee First Name	B Enrollee Last Name	C Enrollee ID	D Contract ID	E Plan Benefit Package (PBP)	F First Tier, Downstream, and Related Entity.	G Authorization or Claim Number	H Date the Request was Received	I AOR/Equivalent notice Receipt Date	J Waiver of Liability (WOL) Receipt Date	K Was it a Clean Claim?	L Was the request processed as an OD or Recon?
First name of the enrollee.	Last name of the enrollee.	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.	The contract number of the organization.  <i>Note: H5355 identifies the CMC line of business</i>	Enter the PBP.  <i>Note: IEHP's assigned PBP is 001</i>	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the sponsoring organization to provide administrative or health care services to an enrollee under the Part C or D program) that processed the request. Enter None if the sponsoring organization processed the request.	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available.	Enter the date the payment request was received. If the sponsoring organization obtained good cause after the 60-day filing timeframe, enter the date the MMP received the information establishing good cause. Submit in CCYY/MM/DD format (e.g., 2020/01/01).	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the Sponsoring organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for dismissed requests or if no AOR or equivalent written notice was received or required.	Enter the date the WOL form was received for noncontracted provider payment appeals. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None for ODs, enrollee submitted requests, or if a WOL was never received.	Enter <b>Y</b> for clean claim, <b>N</b> for unclean claim, or <b>None</b> for payment reconsiderations.	The manner by which the request was processed. Enter <b>OD</b> or <b>Recon</b>

M	N	O	P	Q	R	S	T
Request Determination	Date of Determination	Date Claim/Reconsideration was paid	Date Written Notification Provided to Enrollee	Date Written Notification Provided to Provider	Date forwarded to IRE	Who made the request?	Issue Description and Type of Service
Status of the request. Valid values are: <b>Approved, Denied or Dismissed</b>	Enter the date of the determination. Submit in CCYY/MM/DD format (e.g., 2020/01/01). This is the date the determination was entered in the system and may be the same as the date claim was paid. For dismissed requests, enter the date the Sponsoring organization dismissed the request.	Enter the date the claim/reconsideration was paid. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter <b>None</b> if payment was not provided, if the request was denied, or if the request was dismissed.	Enter the date written notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter <b>None</b> if no written notification was provided.	Enter the date written notification was provided to provider. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter <b>None</b> if no written notification was provided or if the enrollee submitted the request.	Enter the date the payment appeal was forwarded to the IRE. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter <b>None</b> for organization determination requests, or if the reconsideration request was approved, dismissed, or not forwarded to the IRE	Who made the request. Enter <b>E</b> for enrollee, <b>ER</b> for enrollee's representative or purported representative, or <b>NCP</b> for requests by a non-contract provider/pharmacy.	Provide Procedure Code followed directly by a dash (-) with no space, followed directly by the description. If there are multiple services, list them all here as specified above delimited by a comma. For denials, also provide an explanation of why the determination or request was denied. For dismissed requests, provide the reason for dismissal.

<b>U</b>
<b>Was the initial Organization Determination request denied for lack of medical necessity?</b>
Enter <b>Y</b> for Yes, <b>N</b> for No or <b>None</b> if the request was approved or dismissed.

## IEHP Universe Standard Service Authorization Request (MSSAR) Data Dictionary

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First name of the member
B	Member Last Name	CHAR Always Required	50	Last name of the member
C	Member ID	CHAR Always Required	20	Medicare Beneficiary Identifier (MBI) used to identify the member. This is assigned by the MMP. Note : 11-digit identifier (contains uppercase alphabetic and numeric characters). This number must be submitted excluding hyphens or dashes.
D	Contract ID	CHAR Always Required	5	The contract number of the organization. Note: <b>H5355</b> identifies the CMC line of business.
E	Plan ID	CHAR Always Required	3	The plan number of the organization. Note: IEHP's assigned Plan ID is <b>001</b> .
F	Authorization or Claim Number	CHAR Always Required	40	The associated authorization number assigned by the sponsor for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer NA if there is no authorization or other tracking number available.
G	Who made the request?	CHAR Always Required	3	Indicate whether the pre-service request was made by a contract provider (CP), non-contract provider (NCP), member (M), member's representative (MR), or Service Coordinator/Care Coordinator (SC). Note: The term "provider" encompasses physicians and facilities.
H	Provider Type	CHAR Always Required	3	Indicate whether the provider performing the service is a contract provider (CP) or non-contract provider (NCP).
I	Date the request was received	CHAR Always Required	10	Provide the date the request was received by your organization. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
J	Diagnosis	CHAR Always Required	100	Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC).
K	Type of service	CHAR Always Required	50	Enter "BH" for behavioral health services, "LTSS" for long term services and supports, "SU" for substance use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.

Column ID	Field Name	Field Type	Field Length	Description
L	Issue description	CHAR Always Required	2,000	Provide a description of the service medical supply or drug requested and why it was requested (if known). For denials, also provide an explanation of why the service request was denied.
Column ID	Field Name	Field Type	Field Length	Description
M	Was the request made under the expedited timeframe, but processed by the plan under the standard timeframe?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the request was made under an expedited timeframe, but was processed under the standard timeframe.
N	Was a timeframe extension taken?	CHAR Always Required	1	Yes (Y)/No (N) indicator of whether the MMP extended the timeframe to make the service authorization decision.
O	If an extension was taken, did the MMP notify the member of the reason(s) for the delay and of their right to file an expedited grievance?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the MMP notified the member of the delay. Answer NA if no extension was taken.
P	Request Disposition	CHAR Always Required	8	Status of the request. Valid values are: approved, or denied. MMPs should note any requests that are untimely and not yet resolved (still outstanding) as denied.  All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.
Q	Date of MMP decision	CHAR Always Required	10	Date of the MMP decision. Submit in CCYY/MM/DD format (e.g., 2020/01/01). MMPs should answer NA for untimely cases that are still open.
R	Was the request denied for lack of medical necessity?	CHAR Always Required	2	Yes (Y)/No (N) indicator of whether the request was denied for lack of medical necessity. Answer NA if the request was approved. Answer No if the request was denied because it was untimely.
S	Date oral notification provided to member	CHAR Always Required	10	Date oral notification provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no oral notification.
T	Date written notification provided to member	CHAR Always Required	10	Date written notification provided to member. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no written notification.

Column ID	Field Name	Field Type	Field Length	Description
U	Date service authorization entered/effectuated in the MMP's system	CHAR Always Required	10	Date service authorization entered in the MMP's system. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA for denials.
Column ID	Field Name	Field Type	Field Length	Description
V	AOR Receipt date	CHAR Always Required	10	Date the Appointment of Representative (AOR) form received by the MMP. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Answer NA if no AOR form was required.
W	First Tier, Downstream, and Related Entity	CHAR Always Required	70	Insert the name of the First Tier, Downstream, and Related Entity that processed the standard service authorization request (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer NA if not applicable.





Universe Standard Service Authorization Requests (MSSAR) Template

A Member First Name	B Member Last Name	C Member ID	D Contract ID	E Plan ID	F Authorization or Claim Number	G Who Made the Request	H Provider Type	I Date the Request was Received	J Diagnosis	K Type of Service	L Issue Description
First name of the member.	Last name of the member.	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.	The contract number of the organization.  <i>Note: H5355 identifies the CMC line of business</i>	The plan number of the organization.  <i>Note: IEHP's assigned Plan ID Number is 001</i>	The associated authorization number assigned by the MMP for this request. If an authorization number is not available, please provide your internal tracking or case number. Answer <b>NA</b> if there is no authorization or other tracking number available.	Indicate whether the service authorization request was made by a contract provider ( <b>CP</b> ), non-contract provider ( <b>NCP</b> ), member ( <b>M</b> ), member's representative ( <b>MR</b> ), or Service Coordinator / Care Coordinator ( <b>SC</b> ).  <i>Note: the term "provider" encompasses physicians and facilities.</i>	Indicate whether the provider performing the service is a contract provider ( <b>CP</b> ) or non-contract provider ( <b>NCP</b> ).	Provide the date the request was received by your organization. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01).  <i>Note: This is the original receipt of the request by the MMP or delegated entity and not the date that the request became valid via an AOR.</i>	Provide the member diagnosis/diagnoses ICD-10 codes related to this request. If the ICD codes are unavailable, provide a description of the diagnosis, or for drugs provide the 11-digit National Drug Code (NDC) as well as the ICD-10 code related to the request.	Enter "BH" for Behavioral Health services, "LTSS" for Long Term Services and Supports, "SU" for Substance Use services. Additionally, enter types of services other than BH, LTSS, and SU, such as DME, SNF care, dental, vision, etc. Responses other than BH, LTSS and SU are unspecified, but should reflect the description in the Issue Description field.	Provide Procedure Code followed directly by a dash (-) with no space, followed directly by the description. If there are multiple services, list them all here as specified above delimited by a comma. For denials, also provide an explanation of why the service request was denied.

M	N	O	P	Q	R	S	T	U	V	W
<p><b>Was Request made under the Expedited timeframe, but Processed by the plan under the Standard Timeframe?</b></p>	<p><b>Was a Timeframe Extension Taken?</b></p>	<p><b>If an Extension was taken, did the MMP notify the Member of the Reason(s) for the Delay and of their Right to file an Expedited Grievance?</b></p>	<p><b>Request Disposition</b></p>	<p><b>Date of MMP Decision</b></p>	<p><b>Was the Request Denied for Lack of Medical Necessity?</b></p>	<p><b>Date Oral Notification Provided to Member</b></p>	<p><b>Date Written Notification Provided to Member</b></p>	<p><b>Date Service Authorization Entered / Effectuated in the MMP's System</b></p>	<p><b>AOR Receipt Date</b></p>	<p><b>First Tier, Downstream, and Related Entity.</b></p>
<p>Yes (Y) / No (N) indicator of whether the request was made under an expedited timeframe, but was processed under a standard timeframe.</p>	<p>Yes (Y) / No (N) indicator of whether the MMP extended the timeframe to make the service authorization decision.</p>	<p>Yes (Y) / No (N) indicator of whether the MMP notified the member of the delay. Answer <b>NA</b> if no extension was taken.</p>	<p>Status of the request. Valid values are: <b>Approved</b> or <b>Denied</b>. MMPs should note any requests that are untimely and not yet resolved (still outstanding) as denied. All untimely and pending cases should be treated as denials for the purposes of populating the rest of this record layout's fields.</p>	<p>Date of the MMP decision. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). MMPs should answer <b>NA</b> for untimely cases that are still open.  <i>Note: This is separate from effectuation, notice, etc. This is the determination to approve/deny and may not be a captured field but rather a field to be populated from notes.</i></p>	<p>Yes (Y) / No (N) indicator of whether the request was denied for lack of medical necessity. Answer <b>NA</b> if the request was approved. Answer <b>No</b> if the request was denied because it was untimely.</p>	<p>Date oral notification provided to member. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> if no oral notification.</p>	<p>Date written notification provided to member. The term "provided" means when the letter left the MMP's establishment by US Mail, fax, or electronic communication. Do not enter the date a letter is generated or printed within the MMP's organization. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> if no written notification.</p>	<p>Date service authorization entered in the MMP'S system. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> for denials.  <i>Note: This is the point at which the member could obtain the service.</i></p>	<p>Date the Appointment of Representative (AOR) form or other appropriate documentation received by the MMP. Submit in <b>CCYY/MM/DD</b> format (e.g., 2017/01/01). Answer <b>NA</b> if no AOR form was required.</p>	<p>Insert the name of the First Tier, Downstream, and Related Entity that processed the standard organization determination (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator). Answer <b>NA</b> if not applicable.</p>



Universe Standard and Expedited Service Authorization Requests (M\_SAR) Template

A Enrollee First Name	B Enrollee Last Name	C Enrollee ID	D Contract ID	E Plan Benefit Package (PBP)	F First Tier, Downstream, and Related Entity	G Authorization or Claim Number	H Date the Request was Received	I Time the Request was Received	J Part B Drug Request	K AOR/Equivalent notice Receipt Date	L AOR/Equivalent notice Receipt Time	M Request Determination
First name of the enrollee.	Last name of the enrollee.	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.	The contract number of the organization. <i>Note: H5355 identifies the CMC line of business</i>	Enter the PBP. <i>Note: IEHP's assigned PBP is 001</i>	Enter the name of the First Tier, Downstream, and Related Entity (which is any party that enters into a written arrangement, acceptable to CMS, with the MMP to provide administrative or health care services to an enrollee under the MMP program) that processed the request. Enter None if the MMP processed the request.	Enter the associated authorization or claim number for this request. If an authorization or claim number is not available, enter the internal tracking or case number. Enter None if there is no authorization, claim or other tracking number available	Enter the date the request was received. Submit in CCYY/MM/DD format (e.g., 2020/01/01). If a standard request was upgraded to expedited, enter the date the request was upgraded.	For all expedited requests and standard Part B drug requests, enter the time the request was received. Submit in HH:MM:SS military time format (e.g., 23:59:59). If a standard request was upgraded to expedited, enter the time the request was upgraded. Enter None for standard service requests and dismissed requests.	Enter: Y for Yes, N for No	Enter the date the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no AOR or equivalent written notice was received or required.	For all expedited requests and standard Part B drug requests, enter the time the Appointment of Representative (AOR) form or equivalent written notice was received by the MMP. Submit in HH:MM:SS format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no AOR or equivalent written notice was received or required.	Valid values are <b>Approved</b> , <b>Denied</b> , or <b>Dismissed</b>

N	O	P	Q	R	S	T	U	V	W	X	R
Was the request processed as Standard or Expedited	Was a Timeframe Extension Taken?	Date of Determination	Time of Determination	Date Oral Notification Provided to Enrollee	Time Oral Notification Provided to Enrollee	Date Written Notification Provided to Enrollee	Time Written Notification Provided to Enrollee	Who made the request?	Issue Description and Type of Service	Was an expedited request made but processed as standard?	Was the Request Denied for Lack of Medical Necessity?
<p>Enter the manner by which the request was processed: <b>S</b> for Standard <b>E</b> for Expedited</p>	<p>Yes (<b>Y</b>) / No (<b>N</b>) indicator of whether the MMP extended the timeframe to make the service authorization decision.</p>	<p>For all expedited requests and standard Part B drug requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard and dismissed requests.</p>	<p>For all expedited requests and standard Part B drug requests, enter the time of the determination. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard and dismissed requests.</p>	<p>Enter the date oral notification was provided to enrollee. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no oral notification was provided.</p>	<p>For all expedited requests and standard Part B drug requests, enter the time oral notification was provided to enrollee. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no oral notification was provided.</p>	<p>Enter the date written notification of determination was provided to enrollee. Do not enter the date a letter is generated or printed. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter None if no written notification was provided.</p>	<p>For all expedited requests and standard Part B drug requests, enter the time written notification of determination was provided to enrollee. Do not enter the time a letter was generated or printed. Submit in HH:MM:SS military time format (e.g., 23:59:59). Enter None for standard service requests, dismissed requests, or if no written notification was provided.</p>	<p>Enter who made the request: Enter <b>E</b> for enrollee, <b>ER</b> for enrollee's representative or purported representative, <b>CP</b> for requests by a contract provider/ facility, <b>NCP</b> for requests by a noncontract provider/ facility</p>	<p>Provide Procedure Code followed directly by a dash (-) with no space, followed directly by the description. If there are multiple services, list them all here as specified above delimited by a comma. For denials, also provide an explanation of why the preservice request was denied. For dismissed requests, provide the reason for dismissal. If describing behavioral health services, long-term services and supports (LTSS), or substance use disorder services, include the terms behavioral health, LTSS, and substance use disorder service in this field, as applicable.</p>	<p>Enter <b>Y</b> for Yes if an expedited request was received but downgraded to standard. Enter <b>None</b> for all other requests (e.g. the request was received as expedited and processed as expedited, the request was received as standard)</p>	<p>Enter <b>Y</b> for Yes, <b>N</b> for No, and <b>None</b> if the request was approved or dismissed.</p>



**Inland Empire Health Plan  
2023 IPA Delegation Oversight Audit Tool  
Biographical Information**

<b>Date of Review:</b>	<b>Surveyor:</b>
<b>Name of IPA:</b>	<b>IPA Code</b>
<b>Address:</b>	
<b>City/State</b>	
<b>Phone:</b>	<b>FAX:</b>
<b>Name of Management Company (if applicable)</b>	
<b>Address:</b>	
<b>City/State:</b>	
<b>Phone:</b>	<b>FAX:</b>
<b>Name of Parent Company (if applicable)</b>	
<b>Address:</b>	
<b>City/State:</b>	
<b>Phone:</b>	<b>FAX:</b>

IPA Contact Personnel	Phone	FAX	E-Mail
IPA Administrator:			
Medical Director:			
QM Chairperson:			
QM Contact/Title:			
UM Chairperson:			
UM Contact/Title:			
CM Contact/Title:			
Credentialing Contact/Title:			
Provider Relations Contact/Title:			
Compliance Officer:			
Privacy Officer:			
Case Management Contact/Title:			
<b>HEALTH PLAN CONTRACTS/ENROLLMENT</b>			
<b>IPA Total Enrollment in all participating health plans:</b>			
<b>IPA total enrollment for each of the following:</b>			
<b>Commercial:</b>	<b>MediCare:</b>	<b>MediCal:</b>	
<b>IPA Enrollment for ( insert health plan) for each of the following:</b>			
<b>Commercial:</b>	<b>MediCare:</b>	<b>MediCal:</b>	





Element	Regulatory Criteria & Policy	Methodology	Scope	Benchmark	Look-back Period	Data Source	Frequency
Documentation of review of the HRA	<i>IEHP Provider Policy and Procedure Manual - MA_12A2</i>	<p>Review of case notes to show evidence of case manager review of completed HRA with Member Each identified risk in the HRA is addressed within the clinical documentation system including Member's Threshold Language preference and needs.</p> <p>Must demonstrate that HRA was retrieved from either the Provider Portal or SFTP. For example, automatically loaded or manually retrieved.</p>	Dual Choice members with an initial or a reassessment HRA completed within the past 90 calendar days as identified on the Care Management Logs submitted by the IPA and/or other data sources generated by IEHP.	≥ 90%	13 Months	Care management clinical documentation	Monthly
If no HRA is available for review, an assessment is completed with Member in effort to complete/update an ICP	<i>IEHP Provider Policy and Procedure Manual - MA_12A2</i>	<p><b>For newly enrolled/eligible Members:</b></p> <p>(1) The IPA must continue to outreach to the Member for ICP completion within ninety (90) calendar days of the Member's enrollment date.</p> <p><b>For annual reassessments:</b></p> <p>(1) The IPA must utilize the completed reassessment HRA to update the ICP</p> <p><b>If the Member agrees to an assessment by the IPA, the assessment should include, but not be limited to the following:</b></p> <p>(1) Medi-Cal services the member currently accesses.</p> <p>(2) Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided DHCS or similar questions.</p> <p>(3) Populations that may need additional screening or services specific to that population, including dementia and Alzheimer's disease.</p> <p>(4) If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the assessment process. Assessments must directly inform the development of member's Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT).</p> <p>IPA must document review of Provider Portal and/or SFTP to review HRA availability to determine that there was none available.</p> <p>Each identified risk in the assessment is addressed within the clinical documentation system with plans to mitigate within care management plans.</p>	Dual Choice members without a completed HRA within the lookback period.	≥ 90%	13 Months	Care management clinical documentation	Monthly
Member is re-stratified for enrollment into the appropriate level of CM program	<i>IEHP Provider Policy and Procedure Manual - MA_12A2</i>	<p>Based on their completed HRA, and additional information provided by the Member/Caregiver, data, or Providers, the Member is re-stratified as High, Rising, or Low Risk</p> <p>The IPA must have a process in place to stratify the Members without an HRA by using data that is available to them. If no additional data is available to the IPA, then the IPA should use the stratification level that was assigned to the Member on the daily HRA data transmission on the Provider portal, and/or other IEHP risk stratification designation.</p> <p>If a Member is re-stratified to a lower risk level by the IPA then supporting documentation is required</p>	Dual Choice members within the lookback period.	≥ 90%	13Months	Care management clinical documentation	Monthly
Care Plan developed with Member, and/or authorized representatives within 90 days of initial enrollment	<i>IEHP Provider Policy and Procedure Manual - MA_12A3</i> <i>D-SNP Policy Guide Oct 2022 Updates</i>	<p>Review of case notes to identify opportunity to utilize HRA, clinical information, other available assessments and/or utilization and pharmacy data in development of ICP. If data available, reviewer to ensure there is documentation to support within ICP or there is a documented plan to discuss/address at a future date.</p> <p>Care Plan developed with Member and/or authorized representatives are included in the ICP process per Members preference and approval.</p> <p>In the event there is an IEHP-developed ICP, the IPA is expected to retrieve and review the posted ICP on the secure IEHP Provider Portal to complete and/or update with the Member, and/or authorized representative, making every attempt to complete the ICP within ninety (90) calendar days of enrollment date</p> <p>Successful Member outreach attempt must align with the date of ICP development or documentation must support discrepancies in dates.</p> <p>Has self-management goals according to Member preference.</p> <p>Care Plan must include the name and contact information of Member's current assigned care manager, PCP, any specialists and county workers, complete and current list of medications, measurable objectives and timetables to meet needs, barriers, timeframes for reassessment and updates to care plan, care coordination needs and consultation with the Member, PCP, and other members of the ICT, as appropriate.</p> <p>The ICP must identify any carved-out services the member needs and how the IPA will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to:</p> <p>Community Based Organizations such as those serving members with disabilities (e.g. independent living centers) and those serving members with dementia (e.g. Alzheimer's organizations)</p> <p>County mental health and substance use disorder services</p> <p>Housing and homelessness providers</p> <p>Community Supports (formerly ILOS) providers in the aligned MCP network</p> <p>1915(c) waiver programs, including MSPP</p> <p>LTSS programs, including IHSS and Community-Based Adult Services (CBAS)</p>	Newly enrolled Dual Choice members with an initial care plan developed or required within lookback period.	≥ 90%	13 Months	Care management clinical documentation	Monthly



ICP updated based on Member's needs and/or condition	IEHP Provider Policy and Procedure Manual - MA_12A3	Review of clinical documentation that demonstrates the ICP is updated at least annually, and in the following instances, at minimum: A change in the Member's health condition, including but not limited to a change in the level of care; A new problem has been identified with the Member; A goal has changed priority, has been met or is no longer applicable; and ☐ ICP is closed or completed	Dual Choice members with a care plan developed or updated within lookback period.	≥ 90%	13 Months	Care management clinical documentation	Monthly
Care plan developed if a Member is unable to be contacted and/or declined to participate in the care management program or ICP process	IEHP Provider Policy and Procedure Manual - MA_12A3	If the Member is not successfully contacted, ICPs can be developed without a completed HRA, utilizing data such as utilization and pharmacy data, and/or any other available assessments.  The ICP must identify any carved-out services the member needs and how the IPA will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to: Community Based Organizations such as those serving members with disabilities (e.g. independent living centers) and those serving members with dementia (e.g. Alzheimer's organizations) County mental health and substance use disorder services Housing and homelessness providers Community Supports (formerly ILOS) providers in the aligned MCP network 1915(c) waiver programs, including MSSP LTSS programs, including IHSS and Community-Based Adult Services (CBAS) Medi-Cal transportation to access Medicare and Medi-Cal services	Unable to Contact Dual Choice members with a care plan developed, required or updated within lookback period.	≥ 90%	13 Months	Care management clinical documentation	Monthly
Member and/or their authorized representative must have the opportunity to review and sign the care plan and any amendments	IEHP Provider Policy and Procedure Manual - MA_12A3	Review of clinical documentation demonstrates the Member and/or representative was allowed to review and sign the ICP, ensure that ICP was provided in Member preferred preference and/or alternative formats, including Member's Threshold Language preference.	Dual Choice members with a care plan developed or updated within lookback period.	≥ 90%	13 Months	Care management clinical documentation	Monthly
Member has an Interdisciplinary Care Team based on Member's needs and preferences	IEHP Provider Policy and Procedure Manual - MA_12A4 D-SNP Policy Guide October 2022	ICT participants are documented within the Medical Management system. At a minimum, the Care Team will consist of the Member and/or Caregiver, Care Manager, and Primary Care Provider, providers of any Medi-Cal services the member is receiving, including LTSS and Community Supports.  The ICT must include the member's caregiver and a trained dementia care specialist to the extent possible and as consistent with the member's preferences, as applicable.	Dual Choice within lookback period.	≥ 90%	13 Months	Care management clinical documentation	Monthly
ICT case conference completed, per Member need.	IEHP Provider Policy and Procedure Manual - MA_12A4	Should a need for a formal interdisciplinary case conference be identified, the Member/Caregiver are invited and encouraged to participate. Informally, the Member/Caregiver are informed of ICT participant recommendation during follow-up calls and/or in writing if requested.  The ICT reviews Member health care outcomes to determine if adjustments to the ICP should be made to support health care needs. The Care Manager communicates with the appropriate ICT participants when the expected outcomes are not achieved, allowing the ICT participants to recommend changes or adjustments	Dual Choice within lookback period.	≥ 90%	13 Months	Care management clinical documentation	Monthly
ICT case conference documentation includes the dates, participants, notes and actions discussed during the ICT including any Member discussions	IEHP Provider Policy and Procedure Manual - MA_12A4	Review of notes to ensure documentation of ICT meeting has the discussion of the meeting and attendees. Notes should include follow-up and action items should be addressed until need is met.  If the Member does not demonstrate the need for an ICT, there is documentation to support.  Documentation must also reflect Member's request to exclude any ICT Members.	Dual Choice members with ICT conducted within lookback period.	≥ 90%	13 Months	Care management clinical documentation	Monthly
If the Member does not demonstrate the need for an ICT case conference, there is documentation to support	IEHP Provider Policy and Procedure Manual - MA_12A4	Review of notes to ensure documentation is noted when there is no identified need for ICT meeting.	Dual Choice members with a care plan developed or updated within lookback period.	≥ 90%	13 Months	Care management clinical documentation	Monthly
Documentation of 3 attempts (different dates and times) for Member outreach prior to determining Member(s) is unable to reach	Core 3.2 Requirement IEHP Provider Policy and Procedure Manual - MA_12A3	Review of case notes to identify 3 outreach attempts were made to the Member/Member representative prior to determining Member is unable to reach.  All contact attempts of the same type on the same day are considered one attempt.	Dual Choice members with an initial or a reassessment HRA completed within the past 90 calendar days as identified on the Care Management Logs submitted by the IPA and/or other data sources.	≥ 90%	13 Months	Care management clinical documentation	Monthly

TOC ELEMENTS ONLY							
Upon admission notification, appropriate outreach attempts were completed to notify Member of the care transition process	IEHP Provider Policy and Procedure Manual - MA_12A5	Documentation of evidence that supports IPAs communication with the Member and/or Member caregiver about the care transition process within 1-2 business days, not to exceed three (3) business days post notification of hospital or skilled nursing facility admission	Dual Choice member with an admission/care transition during the lookback period	≥ 90%	13 Months	Care management clinical documentation	Monthly
Member was notified of the care transition process and provided with the care management central point of contact information	IEHP Provider Policy and Procedure Manual - MA_12A5	Documentation of evidence that supports IPAs communication with the Member and/or Member's caregiver about changes to the Member's health status and plan of care, and to provide the Member or caregiver with a central point of contact within 1-2 business days, not to exceed three (3) business days of notification of a hospital or skilled nursing facility admission;	Dual Choice member with an admission/care transition during the lookback period	≥ 90%	13 Months	Care management clinical documentation	Monthly
Upon discharge notification, appropriate outreach attempts were made to contact Member or Caregiver for at least 30 days post transition to assist with TOC needs	IEHP Provider Policy and Procedure Manual - MA_12A5	Review of case notes to identify upon discharge notification, all appropriate outreach attempts were completed to Member or Caregiver during the TOC process. If needs were identified, they were addressed and captured in the documentation system. This includes closing the loop (lookback) to ensure all needs were met or a plan is in place to address. IPA is required to follow up with the Member at least thirty (30) days post-transition and upon Member's agreed cadence of contact.	Dual Choice member with an discharge/care transition during the lookback period	≥ 90%	13 Months	Care management clinical documentation	Monthly
Member's identified care coordination needs addressed	IEHP Provider Policy and Procedure Manual - MA_12A5	Review of case notes and assessment to ensure change of condition reassessment was completed post discharge. All needs identified in assessment are addressed and captured within documentation system.  Assess Member's need for all environmental adaptations, equipment, and/or technology (i.e., walker with seat, shower chair, or ramp for wheelchair) needed for a successful care setting transition or any other adaptive equipment or technology necessary for a successful transition back to their usual setting; d. Discuss options available to the Member such as sub-acute, skilled nursing or acute rehabilitation, after discharge from acute setting, when skilled level of care cannot be provided in Member's usual setting and assist with scheduling appointments or needed educational activities; and e. Notify the Members' PCP to inform of the admission and discharge.	Dual Choice member with an discharge/care transition during the lookback period	≥ 90%	13 Months	Care management clinical documentation	Monthly
Coordinated with appropriate team discipline for medication reconciliation to be completed within 30 days of discharge	IEHP Provider Policy and Procedure Manual - MA_12A5	Medication reconciliation documented within the medical management system demonstrating the IPAs will collaborate with IEHP's Pharmaceutical Services department to assist with medication reconciliation and medication management, and ensure that the medication list is included on the plan of care  Clinical Pharmacists: Complex/high-risk post-discharge Pharmacy technicians: Non-complex post discharge	Dual Choice member with an discharge/care transition during the lookback period	≥ 90%	13 Months	Care management clinical documentation	Monthly



**IPA DELEGATION AGREEMENT – IEHP DUALCHOICE (HMO D\_SNP)**

The purpose of the following grid is to specify the activities delegated by Inland Empire Health Plan (IEHP) under the Delegation Agreement with respect to: (i) Quality Management and Improvement, (ii) Continuity and Coordination of Care, (iii) Utilization Management, (iv) Care Management, (v) Credentialing and Recredentialing, (vi) Encounter Data, (vii) Claims Adjudication and (viii) Compliance. All Delegated activities are to be performed in accordance with currently applicable NCQA accreditation standards, DHCS regulatory requirements, DMHC regulatory requirements, and IEHP standards, as modified from time to time. Delegate agrees to be accountable for all responsibilities delegated by IEHP and oversight of any sub-delegated activities, except as outlined in the Delegation Agreement. Delegate will submit the reports to IEHP as described in the Required Reporting Elements of the Delegation Agreement to the Delegation Oversight Department through IEHP Secure File Transfer Protocol (SFTP) by no later than the due date specified. The IPA will provide notice of report submission via email to the Provider Services designated contacts. IEHP will oversee the delegate by performing annual audits. In the event deficiencies are identified through this oversight, Delegate will provide a specific corrective action plan acceptable to IEHP. If Delegate does not comply with the corrective action plan within the specified time frame, IEHP will take necessary steps up to and including revocation of delegation in whole or in part. Delegate is free to collect data as needed to perform delegated activities. IEHP will provide Member experience and clinical performance data, upon request.

In accordance, the Health Insurance Portability and Accountability Act, IPA/Medical group shall comply with the following provisions:

- The IPA has a list of the allowed uses of protected health information. The IPA may only use PHI associated with performing functions outlined in this agreement. It may only be disclosed to the member, their authorized representative, IEHP, and other authorized healthcare entities.
- The IPA has a process in place for ensuring that Members and Practitioners information will remain protected. Protections must include oral, written, and electronic forms of PHI.
- The IPA has a description of the safeguarding of the protected health information from inappropriate use or further disclosure.
- The IPA has a written description stipulating that the IPA will ensure that sub-delegates have similar safeguards when applicable.
- The IPA has a written description stipulating that the delegate will provide individuals with access to their protected health information. The delegate will have procedures to receive, analyze and resolve Members' requests for access to their PHI.
- The IPA will ensure that its organization will inform the organization if inappropriate uses of information occur. The IPA will have policies and procedures to identify and report unauthorized access, use, disclosure, modification or destruction of PHI and the systems used to access or store PHI.
- The IPA will ensure that the protected health information is returned, destroyed or protected if the delegation agreement ends.



**IPA DELEGATION AGREEMENT – IEHP DUALCHOICE (HMO D\_SNP)**

**REQUIRED REPORTING ELEMENTS**

Department	Required Documentation/Materials	Frequency	Submission Deadline	IEHP Contact
Quality Management and Improvement	Semi-Annual: QM Work Plan Update/ Evaluation	Semi-Annual and Annual	Aug 15/Feb 15	SFTP Server
	Annual QM Program Description Annual QM Program Evaluation Annual QM Work Plan		Feb 28	
	Chronic Care Improvement Program (CCIP) Planning & Reporting Document	Semi-Annual	Mar 15/Sept 15	



**IPA DELEGATION AGREEMENT – IEHP DUALCHOICE (HMO D\_SNP)**

**REQUIRED REPORTING ELEMENTS**

Department	Required Documentation/Materials	Frequency	Submission Deadline	IEHP Contact
Utilization Management	Monthly Denials and Partial Approvals (Modifications) Monthly Approval File Review Monthly Long-Term Care (LTC) Data Sheet Monthly Second Opinion Tracking Log Monthly MESAR Monthly MSSAR Monthly Care Transition Cases Log	Monthly	15th of each month	SFTP Server
	Part C Organization Determinations-Authorizations	Quarterly	May 15 Aug 15 Nov 15 Feb 09	
	Quarterly UM Annual Evaluation/HICE Report Quarterly UM Workplan Update	Quarterly	May 15 August 15 November 15 February 15	
	Annual UM Program Description Annual UM Workplan/Initial ICE Report Annual UM Program Evaluation	Annual	Feb 28	



**IPA DELEGATION AGREEMENT – IEHP DUALCHOICE (HMO D\_SNP)**

**REQUIRED REPORTING ELEMENTS**

Department	Required Documentation/Materials	Frequency	Submission Deadline	IEHP Contact
Care Management	Monthly Medicare Care Management Log Monthly Medicare Care Plan Outreach Log  Number of critical incident and abuse reports for members receiving LTSS  Annual Care Coordinator Training for Supporting Self-Direction  Annual Guidelines for Care Management Provider and Internal Staff Training Completion records  CM Data System Validation	Monthly   Quarterly   Semi-Annual	15 <sup>th</sup> of each month  May 13 Aug 15 Nov 15 Jan 15  Feb 28  Month of June	SFTP Server
HCI	Annual HCC WorkPlan  MMP Provider Payment Requests (M_Claims) Record Layout/Universe	Annual  Monthly	Feb 15  15 <sup>th</sup> of each month	SFTP Server



**IPA DELEGATION AGREEMENT – IEHP DUALCHOICE (HMO D\_SNP)**

**REQUIRED REPORTING ELEMENTS**

<b>Department</b>	<b>Required Documentation/Materials</b>	<b>Frequency</b>	<b>Submission Deadline</b>	<b>IEHP Contact</b>
Health Services Regulatory Governance (HSRG)	Care Coordinator to Member Ratio	Annual	Jan 15	SFTP Server
Credentialing and Recredentialing	Monthly Credentialing and Recredentialing Report	Monthly	15th of each month	SFTP server and email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a>
Credentialing and Recredentialing	Written and approved Credentialing, Recredentialing, Peer Review policies and Procedures	As Required	Within 30 days of the Credentialing Committee approval or prior to onsite and/or desktop DOA audit	SFTP server and email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a>
Credentialing and Recredentialing	Approved Delegated practitioners requesting to participate in the IEHP network must be submitted to IEHP, by submitting a current profile, contract (1 <sup>st</sup> and signature pages and any applicable addendums) and W-9.	As Required	After Credentialing Approval	SFTP Server and email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a>
Credentialing and Recredentialing	Credentialing and Recredentialing activities for approved and terminated practitioners must be submitted to IEHP via IEHP Excel Recred Template identified in the IEHP Provider Manual, 05B – Practitioner Credentialing Requirements.	Monthly	By the 15 <sup>th</sup> of the following month, after Committee approval	SFTP Server and email to <a href="mailto:CredentialingProfileSubmission@iehp.org">CredentialingProfileSubmission@iehp.org</a>



**IPA DELEGATION AGREEMENT – IEHP DUALCHOICE (HMO D\_SNP)**

**REQUIRED REPORTING ELEMENTS**

<b>Department</b>	<b>Required Documentation/Materials</b>	<b>Frequency</b>	<b>Submission Deadline</b>	<b>IEHP Contact</b>
Encounter Data	5010 / Encounters	Monthly	1 <sup>st</sup> of each month	SFTP Server
Claims Adjudication	Monthly Claims Timeliness Reports Monthly MMP Provider Payment Request (M_Claims Template & Universe M_claims Data Dictionary)	Monthly	15 <sup>th</sup> of each month	SFTP Server
	Quarterly Provider Payment Dispute Resolution	Quarterly	April 29 July 29 October 31 January 31	
Compliance	Compliance Program Description and copies of Compliance Training	Annual	Annually as required for DOA	SFTP Server
	Fraud Waste and Abuse (FWA) Program Description and copies of FWA Training	Annual	Annually as required for DOA	
	Sanction/Exclusions Screening Process policies and procedure	Annual	Annually as required for DOA	
	Standards/Code of Conduct	Annual	Annually as required for DOA	
	Compliance Committee Meeting minutes from the last 12 months to include agenda and sign in sheet (attendance)	Annual	Annually as required for DOA	





**IPA DELEGATION AGREEMENT – IEHP DUALCHOICE (HMO D\_SNP)**

**REQUIRED REPORTING ELEMENTS**

Department	Required Documentation/Materials	Frequency	Submission Deadline	IEHP Contact
	Annual Compliance Work Plan	Annual	Annually as required for DOA	
	Annual Audit and Monitoring Plan	Annual	Annually as required for DOA	
	Annual Risk Assessment Report	Annual	Annually as required for DOA	
	Employee Universe Report	Annual	Annually as required for DOA	
	Downstream Entity/Subcontractors Universe Report	Annual	Annually as required for DOA	
	HIPAA Privacy Program Description and copies of HIPAA Training	Annual	Annually as required for DOA	
	Confidentiality Statement	Annual	Annually as required for DOA	
	Privacy Incident Universe Report	Annual	Annually as required for DOA	



**IPA DELEGATION AGREEMENT – IEHP DUALCHOICE (HMO D\_SNP)**

**REQUIRED REPORTING ELEMENTS**

<b>Department</b>	<b>Required Documentation/Materials</b>	<b>Frequency</b>	<b>Submission Deadline</b>	<b>IEHP Contact</b>
Financial Analysis	Balance Sheet Income Statement, Cash Flow Statement, Supporting Worksheets for IBNR	Quarterly	May 15 Aug 15 Nov 15 Feb 15	SFTP Server
	Organizational Informational Disclosures			
	Annual Audited Financial Statements, Including IBNR Certification Financial Statements, Including IBNR Certification	Annual	5 months after end of IPAs Fiscal year	



**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>Quality Improvement Program Structure (NCQA QI 1 Elements A, B, C, D and E and MA Manual Ch. 5 Section 20)</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The IPA has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members and to oversee the QI program.</p> <p>A. The QI program description specifies:</p> <ol style="list-style-type: none"> <li>1. The QI program structure               <ol style="list-style-type: none"> <li>a. The QI program’s functional areas and their responsibilities.</li> <li>b. Reporting relationships of QI Department staff, QI Committee and any subcommittee.</li> <li>c. Resources and analytical support.</li> <li>d. QI activities.</li> <li>e. Collaborative QI activities, if any.</li> <li>f. How the QI and population health management (PHM) programs are related in terms of operations and oversight.</li> </ol> </li> <li>2. Involvement of a designated physician in the QI program.</li> <li>3. Oversight of QI functions of the organization by the QI Committee.               <ol style="list-style-type: none"> <li>a. The program description defines the role, function and reporting relationships of the QI Committee and subcommittees, including committees associated with oversight of delegated activities.</li> </ol> </li> </ol>	<p>Semi-Annual and Annual</p>	<p>IPA is not delegated for this function, however IEHP will review the IPA’s Policies and Procedures.</p> <p>Semi-Annual review and Annually as part of the DOA</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



<p>Quality Improvement Program Structure (NCQA QI 1 Elements A, B, C, D and E and MA Manual Ch. 5 Section 20 continued)</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>B. The IPA documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses:</p> <ol style="list-style-type: none"> <li>1. Yearly planned QI activities and objectives that address:             <ol style="list-style-type: none"> <li>a. Quality of clinical care.</li> <li>b. Safety of clinical care.</li> <li>c. Quality of service.</li> <li>d. Members' experience.</li> </ol> </li> <li>2. Time frame for each activity's completion.</li> <li>3. Staff responsible for each activity.</li> <li>4. Monitoring previously identified issues.</li> <li>5. Evaluation of the QI program.</li> </ol> <p>C. The IPA conducts an annual written evaluation of the QI program that includes the following information:</p> <ol style="list-style-type: none"> <li>1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.</li> <li>2. Trending of measures of performance in the quality and safety of clinical care and quality of service.</li> <li>3. Evaluation of the overall effectiveness of the QI program and its progress toward influencing networkwide safe clinical practices with a summary addressing:             <ol style="list-style-type: none"> <li>a. Adequacy of QI program resources.</li> <li>b. QI Committee and subcommittee structure.</li> <li>c. Practitioner participation and leadership involvement in the QI program.</li> <li>d. Need to restructure or change the QI program for the subsequent year.</li> </ol> </li> </ol> <p>D. QI Committee Responsibilities:</p> <ol style="list-style-type: none"> <li>1. Recommends policy decisions.</li> <li>2. Analyzes and evaluates the results of QI activities.</li> </ol>	<p>Semi-Annual and Annual</p>	<p>IPA is not delegated for this function, however IEHP will review the IPA's Policies and Procedures.</p> <p>Semi-Annual review and Annually as part of the DOA</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Quality Improvement Program Structure (NCQA QI 1 Elements A, B, C, D and E and MA Manual Ch. 5 Section 20 continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	<ol style="list-style-type: none"> <li>3. Ensures practitioner participation in the QI program through planning, design, implementation or review.</li> <li>4. Identifies needed actions.</li> </ol> E. The IPA promotes Organizational Diversity, Equity and Inclusion: <ol style="list-style-type: none"> <li>1. Promotes diversity in recruiting and hiring.</li> <li>2. Offers training to employees on cultural competency, bias or inclusion.</li> </ol>	Semi-Annual and Annual	IPA is not delegated for this function, however IEHP will review the IPA's Policies and Procedures.  Semi-Annual review and Annually as part of the DOA	See Corrective Action Plan (CAP) Requirements in MA_25A3.



**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>Continuity and Coordination of Medical Care and Continued Access to Care (NCQA QI 3 Element D and NET 4 Elements A and B)</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The IPA helps with members’ transition to other care when their benefit ends, if necessary.</p> <p>The IPA uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system.</p> <p>A. The IPA notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner.</p> <p>B. If a practitioner’s contract is discontinued, the IPA allows affected members continued access to the practitioner, as follows:</p> <ol style="list-style-type: none"> <li>1. Continuation of treatment through the current period of active treatment, or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.</li> <li>2. Continuation of care through the postpartum period for the members in their second or third trimester of pregnancy.</li> </ol>	<p>Monthly through UM Logs</p>	<p>Annual audit of IPA Policies and Procedures and sample cases</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>

**ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT**



<p>Utilization Management Program Structure (NCQA UM 1 Elements A and B and MA Manual Ch.5)</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The IPA has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial, and consistent manner.</p> <p>A. The IPA’s UM program description includes the following:</p> <ol style="list-style-type: none"> <li>1. A written description of the program structure: <ol style="list-style-type: none"> <li>a. UM Staff’s assigned activities.</li> <li>b. UM staff who have the authority to deny coverage.</li> <li>c. Involvement of a designated physician.</li> <li>d. The process for evaluating, approving and revising the UM program, and the staff responsible for each step.</li> <li>e. The UM program’s role in the QI program, including how the organization collects UM information and uses it for it for QI activities.</li> <li>f. The IPA’s process for handling appeals and making appeal determinations (if applicable).</li> </ol> </li> <li>2. Involvement of a designated senior-level physician in UM program implementation, supervision, oversight and evaluation of the UM program.</li> <li>3. The program scope and process used to determine benefit coverage and medical necessity including: <ol style="list-style-type: none"> <li>a) How the IPA develops and selects criteria.</li> <li>b) How the IPA reviews, updates and modifies criteria.</li> </ol> </li> <li>4. Information sources used to determine benefit coverage and medical necessity.</li> </ol>	<p>Semi-Annual and Annually.</p>	<p>Annual audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Utilization Management Program Structure (NCQA UM 1 Elements A and B and MA Manual Ch.5 continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	B. The IPA annually evaluates and updates the UM Program, as necessary. <ul style="list-style-type: none"> <li>• Must meet applicable IEHP Standards and are consistent with NCQA, State and Federal Health Care Regulatory Agencies Standards.</li> </ul>	Semi-Annual and Annually.	Annual audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings	See Corrective Action Plan (CAP) Requirements MA_25A3
Clinical Criteria for UM Decisions (NCQA UM 2 Elements A, B and C)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the health appropriateness of health care services. <p>A. The IPA:</p> <ol style="list-style-type: none"> <li>1. Has written UM decision-making criteria that are objective and based on medical evidence.</li> <li>2. Has written policies for applying the criteria based on individual needs; considers at least the following individual characteristics when applying criteria:</li> </ol>	Monthly UM Logs	Annual Audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings.  Monthly log and focused denial file selection review.	See Corrective Action Plan (CAP) Requirements in MA_25A3.





**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>Clinical Criteria for UM Decisions (NCQA UM 2 Elements A, B and C continued)</p> <p>California Health &amp; Safety Code §1363.5</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<ul style="list-style-type: none"> <li>a. Age.</li> <li>b. Comorbidities.</li> <li>c. Complications.</li> <li>d. Progress of treatment.</li> <li>e. Psychosocial situation.</li> <li>f. Home environment, when applicable.</li> </ul> <ul style="list-style-type: none"> <li>3. Has written policies for applying the criteria based on an assessment of the local delivery system.</li> <li>4. Involves appropriate practitioners in developing, adopting &amp; reviewing criteria.</li> <li>5. Annually reviews the UM criteria and the procedures for applying them and updates the criteria when appropriate.</li> </ul> <p>B. The IPA:</p> <ul style="list-style-type: none"> <li>1. States in writing how practitioners and Members can obtain UM criteria.</li> <li>2. Makes the UM criteria available to its practitioners and Members upon request.</li> </ul> <p>C. At least annually, the IPA:</p> <ul style="list-style-type: none"> <li>1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making.</li> <li>2. Acts on opportunities to improve consistency, if applicable.</li> </ul>	<p>Monthly UM Logs</p>	<p>Annual Audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings.</p> <p>Monthly log and focused denial file selection review.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Communication Services (NCQA UM 3 Element A)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>Members and practitioners can access staff to discuss UM issues.</p> <p>A. The IPA provides the following communication services for members and practitioners.</p> <ol style="list-style-type: none"> <li>1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.</li> <li>2. Staff can receive inbound communication regarding UM issues after normal business hours.               <ol style="list-style-type: none"> <li>a. Telephone</li> <li>b. Email</li> <li>c. Fax</li> </ol> </li> <li>3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.</li> <li>4. TDD/TTY services for members who need them.</li> <li>5. The IPA refers members to IEHP who need language assistance to discuss UM issues.</li> </ol>	N/A	Annual Audit of IPA Policies and Procedures and Annual Appointment Availability and Access Study Survey	See Corrective Action Plan (CAP) Requirements in MA_25A3.



**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>Appropriate Professionals (NCQA UM 4 Elements A, B, C*and F, MED 9 Element -E, MA Manual Chapter 5, 6, and 11)</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p> <p>IEHP will provide IPA with guidelines</p>	<p>UM decisions are made by qualified health professionals.</p> <p>A. The IPA has written procedures:</p> <ol style="list-style-type: none"> <li>1. Requiring appropriately licensed professionals to supervise all medical necessity decisions.</li> <li>2. Specifying the type of personnel responsible for each level of UM decision making.</li> </ol> <p>B. The IPA has a written job description with qualifications for practitioners who review denials for care based on medical necessity. Practitioners are required to have:</p> <ol style="list-style-type: none"> <li>1. Education, training, or professional experience in medical or clinical practice</li> <li>2. A current clinical license to practice or an administrative license to review UM cases.</li> </ol> <p>C. The IPA uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity*.</p> <p>D. Use of Board-Certified Consultants</p> <ol style="list-style-type: none"> <li>1. The IPA has written procedures for using board-certified consultants to assist in making medical necessity determinations.</li> <li>2. The IPA provides evidence that it uses board-certified consultants for medical necessity determinations. <b>CRITICAL FACTOR.</b></li> </ol>	<p>Monthly UM Logs</p> <p>Monthly UM Logs</p>	<p>Annual audit of IPA Policies and Procedures, Workplan, Program, Committee Meetings and Ownership and Control documentation.</p> <p>Monthly log and focused denial and approval file selection review.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>Appropriate Professionals (NCQA UM 4 Elements A, B, C*and F, MED 9 ElementE, MA Manual Chapter 5, 6, and 11 continued)</p>	<p>for Policies and Procedures via IEHP Provider Manual</p>	<p>E The IPA distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following:</p> <ol style="list-style-type: none"> <li>1. UM decision making is based only on appropriateness of care and service and existence of coverage.</li> <li>2. The IPA does not specifically reward practitioners or other individuals for issuing denials of coverage.</li> <li>3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.</li> </ol>		<p>Annual audit of IPA Policies and Procedures, Workplan, Program, Committee Meetings and Ownership and Control documentation.</p> <p>Monthly log and focused denial and approval file selection review.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3</p>



**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>Timeliness of UM Decisions (NCQA UM 5 Element A* and 42 CFR 422.568 and 42 CFR 422.572)</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The IPA makes UM decisions in a timely manner to minimize any disruption in the provision of health care.</p> <p>A. The IPA adheres to the following time frames for notification of non-behavioral healthcare UM decisions*:</p> <ol style="list-style-type: none"> <li>1. Urgent Concurrent Decisions: The IPA gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request.</li> <li>2. Urgent Pre-Service Decisions: The IPA makes decisions within seventy-two (72) hours from receipt of the request.</li> <li>3. Non-Urgent Pre-Service Decisions: The IPA gives electronic or written notification of the decision to members and practitioners within fourteen (14) calendar days of the request.</li> <li>4. Post-Service Decisions: The IPA gives electronic or written notification of the decision to practitioners and members and written notification to the member within 14 calendar days calendar days of the request.</li> </ol>	<p>Monthly</p>	<p>Annual audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings.</p> <p>Monthly log and focused denial and approval file selection review.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Clinical Information (NCQA UM 6 Element A)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>The IPA uses all information relevant to a member’s care when it makes coverage decisions.</p> <p>A. There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.</p>	Monthly	<p>Annual audit of IPA Policies and Procedures, Workplan, Program, and Committee Meetings.</p> <p>Monthly log and focused denial and approval file selection review.</p>	See Corrective Action Plan (CAP) Requirements in MA_25A3.



<p>Denial Notices (NCQA UM 7 Elements A, B*, and C*)</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>Members and practitioners receive enough information to help them understand a decision to deny care or coverage and to decide whether to appeal the decision.</p> <ul style="list-style-type: none"> <li>A. The IPA gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer.</li> <li>B. The IPA’s written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information*:             <ul style="list-style-type: none"> <li>1. The specific reasons for the denial, in easily understandable language.</li> <li>2. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based.</li> <li>3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request.</li> </ul> </li> <li>C. The IPA’s written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information*:             <ul style="list-style-type: none"> <li>1. A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.</li> <li>2. An explanation of the appeal process, including members’ rights to representation and appeal time frames.                 <ul style="list-style-type: none"> <li>a. Includes a statement that members may be represented by anyone they choose, including an attorney.</li> </ul> </li> </ul> </li> </ul>	<p>Monthly</p>	<p>Monthly log and focused denial file review and Annual DOA</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Denial Notices (NCQA UM 7 Elements A, B*, and C*)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	<ul style="list-style-type: none"> <li>b. Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsperson, if applicable.</li> <li>c. States the time frame for filing an appeal.</li> <li>d. States the organization’s time frame for deciding the appeal.</li> <li>e. States the procedure for filing an appeal, including where to direct the appeal and information to include in the appeal.</li> </ul> <p>3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. The denial notification states:</p> <ul style="list-style-type: none"> <li>a. The time frame for filing an expedited appeal.</li> <li>b. The IPA’s time frame for deciding the expedited appeal.</li> <li>c. The procedure for filing an expedited appeal, including where to direct the appeal and information to include in the appeal.</li> </ul> <p>4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.</p>	Monthly	Monthly log and focused denial file review and Annual DOA	See Corrective Action Plan (CAP) Requirements in MA_25A3.





<p>UM System Controls (NCQA UM 12, Element A*)</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The IPA has policies and procedures describing its system controls specific to UM denial notification dates that:</p> <ol style="list-style-type: none"> <li>1. Define the date of receipt consistent with NCQA requirements.</li> <li>2. Define the date of written notification consistent with NCQA requirements.</li> <li>3. Describe the process for recording dates in systems.</li> <li>4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when notification is appropriate. The IPA's policies and procedures identify:             <ol style="list-style-type: none"> <li>a. All Staff titles or roles authorized to modify dates.</li> <li>b. The circumstances when modification is appropriate.</li> </ol> </li> <li>5. Specify how the system tracks modified dates. The IPA's policies and procedures describe how the system tracks:             <ol style="list-style-type: none"> <li>a. Date modifications.</li> <li>b. When the date was modified.</li> <li>c. The staff who modified the date.</li> <li>d. Why the date was modified.</li> </ol> </li> <li>6. Describe system security controls in place to protect data from unauthorized modification. The IPA's policies and procedures describe the process for:             <ol style="list-style-type: none"> <li>a. Limiting physical access to the operating environment that houses utilization management data.</li> </ol> </li> </ol>	<p>Annually, at minimum during DOA.</p>	<p>Focused denial file review and Annual DOA.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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		<ul style="list-style-type: none"><li>b. Preventing unauthorized access and changes to system data.</li><li>c. Password protecting electronic systems, including requirements to: use strong passwords, discourage staff from writing down passwords, User IDs and passwords unique to each user, change passwords when requested by staff or if passwords are compromised.</li><li>d. Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.</li></ul> <p>7. Describe how the IPA monitors its compliance with the policies and procedures for Factors 1-6 at least annually and takes appropriate action,</p>			
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		<p>when applicable. At a minimum, the description includes:</p> <ul style="list-style-type: none"><li>a. The method used to monitor compliance with the organization’s policies and procedures described in factors 1-6.<ul style="list-style-type: none"><li>• If the UM system does not allow date modifications under any circumstances, the description includes the functionality of the system that ensures compliance with established policy.</li><li>• If the UM system allows date modifications only under specific circumstances established by policy, the description includes the process for monitoring compliance with established policy.</li><li>• If the IPA uses system alerts or flags to identify noncompliance, the description indicates how this process is conducted and monitored.</li><li>• If the IPA conducts auditing, sampling is not an allowable method.</li><li>• The description specifies the staff roles or department involved in the audit and the audit frequency.</li></ul></li><li>b. The staff titles or roles responsible for oversight of the monitoring process.</li><li>c. The organization’s process for taking actions if it identifies date modifications that do not meet its established policy, including:<ul style="list-style-type: none"><li>• A quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three (3) consecutive quarters.</li></ul></li></ul>			
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**ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		<ul style="list-style-type: none"> <li>• The staff roles or department responsible for the actions.</li> <li>• The process for documenting and reporting date modifications that do not meet its established policy.</li> </ul>			



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
UM Denial System Controls Oversight (NCQA UM 12 Element B)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	At least annually, the IPA demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by: <ol style="list-style-type: none"> <li>1. Identifying all modifications to receipt and decision notification dates that did not meet the IPA’s policies and procedures for date modifications.</li> <li>2. Analyzing all instances of date modifications that did not meet the IPA’s policies and procedures for date modifications.</li> <li>3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters.</li> </ol>			



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Emergency Services (NCQA MED 9 Element D)		<p>The IPA’s policies and procedures require coverage of emergency services in the following situations:</p> <ol style="list-style-type: none"> <li>1. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.</li> <li>2. If an authorized representative, acting for the organization, authorized the provision of emergency services.</li> <li>3. To provide post-stabilization care services for the member.</li> </ol>			
Second Opinions AB 12	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>Assembly Bill 12 (AB 12) states that there must be a written process to obtain Second Opinion from PCP and Specialist.</p> <ol style="list-style-type: none"> <li>1. The IPA allows for a second opinion consultation, when a Member has questions/concerns regarding a diagnosis or plan of treatment, with an appropriately qualified health care provider if requested by the Member, or a health care provider who is treating the Member. The second opinion shall be with one of the IPA’s contracted Providers unless the IPA does not have the appropriately qualified health care provider in-network. In the event that the services cannot be provided in-network, the IPA must arrange for second opinion out-of-network with the same or equivalent Provider seen in-network.</li> </ol>	Monthly	Monthly review of Second Opinion Logs and Annual Audit of IPA Policies and Procedures	See Corrective Action Plan (CAP) Requirements in MA_25A3.



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Discharge Planning	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	<ul style="list-style-type: none"> <li>▪ Develop and document program to perform discharge planning functions for</li> <li>▪ Acute and Skilled Nursing Facility meeting all regulatory and IEHP standards.</li> <li>▪ Issue timely and appropriate acute facility Detailed Notice of Discharge (DND) letter.</li> <li>▪ Issue timely and appropriate Skilled Nursing Facility (SNF) and Home Health Agency (HHA) Notice of Medicare Non-coverage (NOMNC) letter.</li> </ul>	Monthly	<p>Annual Audit of IPA Policies and Procedures.</p> <p>Monthly log and focused file review.</p>	See Corrective Action Plan (CAP) Requirements in MA_25A3.



**ATTACHMENT IV: DELINEATION OF CARE MANAGEMENT**

<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
Guidelines for Care Management	IEHP will provide IPA with guidelines for Policies and Procedures, and guidelines for Care Management Training via IEHP Provider Manual.	<p>The IPA must develop and implement guidelines for Care Management that provides the structure for care management processes and systems that will enable them to provide coordinated care for special needs individuals. The Guidelines for Care Management must include the following elements:</p> <ul style="list-style-type: none"> <li>▪ Description of Target Population</li> <li>▪ Care Management for the Most Vulnerable Subpopulations</li> <li>▪ Staff structure and Care Management Roles</li> <li>▪ Use of Health Risk Assessment Tool (HRAT) (Provided by Health Plan)</li> <li>▪ Development and essential components of Individualized Care Plan (ICP)</li> <li>▪ Interdisciplinary Care Team (ICT)</li> <li>▪ Care Transition Protocols</li> <li>▪ Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols</li> <li>▪ Guidelines for Care Management</li> </ul> <p><b>Training for Personnel and Provider Network</b></p> <ul style="list-style-type: none"> <li>▪ Guidelines for Care Management Quality Performance Improvement Plan</li> <li>▪ Measurable Goals and Health Outcomes</li> <li>▪ Measuring Patient Experience of Care (Member Satisfaction)</li> <li>▪ Ongoing Performance Improvement Evaluation; and</li> <li>▪ Dissemination of Quality Improvement Performance</li> </ul>	Annually	<p>IPA must demonstrate guidelines for Care Management trainings are conducted annually for personnel and provider network.</p> <p>Submission of documents for training include:</p> <ul style="list-style-type: none"> <li>▪ Guidelines for Care Management presentation</li> <li>▪ Sign in sheet or attestations</li> </ul>	See Corrective Action Plan (CAP) Requirements in MA_25A3.





<p>CM 1: Care Management</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>IPAs must submit a monthly care management log that includes the following:</p> <ol style="list-style-type: none"> <li>1. Member name (First, Last)</li> <li>2. Member ID number</li> <li>3. Date of Birth</li> <li>4. Case Status (Open or Closed)</li> <li>5. Case Level</li> <li>6. Case Open Date</li> <li>7. Name of Care Coordinator</li> <li>8. Date of HRA Review</li> <li>9. Date ICP Created</li> <li>10. Date ICP Updated</li> <li>11. Care plan developed/Updated with Member/Authorized Rep Participation</li> <li>12. Date ICP sent to PCP</li> <li>13. Date Care Goals Discussed with Member</li> <li>14. Date of Member Reassessment</li> <li>15. Last Date of Member Contract</li> <li>16. Date ICT was Assigned</li> <li>17. Date ICT was completed</li> <li>18. Appropriate parties invited</li> <li>19. PCP Attended ICT Meeting</li> <li>20. Specialist Attended ICT Meeting</li> <li>21. MSSP SW Attended ICT Meeting</li> <li>22. IHSS SW Attended ICT Meeting</li> </ol> <p>IPAs must submit a monthly care plan outreach log that includes the following:</p> <ol style="list-style-type: none"> <li>1. Member name (First, Last)</li> <li>2. Member ID number</li> <li>3. Date of Birth</li> <li>4. Date of Outreach Attempt</li> <li>5. Outreach Method</li> <li>6. Outreach Disposition</li> <li>7. Care Team Member Title</li> <li>8. Clinical Care Team Member</li> </ol> <p>All Members must have activity that aligns with their assigned stratification.(Sources:</p>	<p>Monthly</p>	<p>Annual Audit of IPA Policies and Procedures.</p> <p>Monthly CM log and targeted case file review.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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**ATTACHMENT IV: DELINEATION OF CARE MANAGEMENT**

<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
		Medicare CM Log V2.0 and Att 12- CM Outreach Log V1.0)			



<p>Care Management</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<ul style="list-style-type: none"> <li>▪ Delegate should demonstrate a care management policy and Program Description that evidence used to develop the program, criteria for identifying Members who are eligible, services offered to Member's, defined program goals, and how case management services are integrated with the services of others involved in the member's care.</li> <li>▪ Annually assess the characteristics and needs of its member population and relevant subpopulations, Reviews and updates its care management processes to address Member needs, and Reviews and updates its care management resources to address member needs.</li> </ul> <p>Delegates must have a policy that describes how D-SNP risk stratification of Member's will account for identified member needs covered by Medi-Cal. At a minimum, this process must include a review of: any available utilization data, including data from the member's CMC plan (for members transitioning from CMC to D-SNP); any other relevant and available data from delivery systems outside of the managed care plans such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), other 1915(c) and home-and community based waiver programs, behavioral health (both mental health and substance use disorder data, if available), and pharmacy data; the results of previously administered CMC or Medi-Cal Health Risk Assessments (HRAs),</p>	<p>Monthly</p>	<p>Annual Audit of IPA Policies and Procedures.</p> <p>Monthly CM log review and targeted case file review.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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		<p>including those completed by IEHP and shared with the Delegate, when available; and any data and risk stratification available through the DHCS Population Health Management Platform (when it becomes available).</p> <p>(DHCS-CalAIM-D-SNP-Policy Guide)</p> <p>IEHP is responsible for completing initial and annual reassessment HRAs, however, in the event the Delegate will need to complete an assessment, the assessment must have the following elements:</p> <ul style="list-style-type: none"><li>• Medi-Cal services the member currently accesses.</li><li>• Any Long-Term Services and Supports (LTSS) needs the member may have or potentially need, utilizing the LTSS questions provided the D-SNP Policy Guide or similar questions.</li><li>• Populations that may need additional screening or services specific to that population, including dementia and Alzheimer’s disease.</li></ul> <p>If a member identifies a caregiver, assessment of caregiver support needs should be included as part of the assessment process. HRAs must directly inform the development of member’s Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT), per federal requirements.</p>			
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		<p>Policy and procedures to demonstrate ICP components that include but are not limited to: Member self-management goals and objectives; the Member’s personal healthcare preferences; description of services specifically tailored to the Member’s needs; roles of the Members’ caregiver(s); and identification of goals met or not met. (CMS Model of Care Chapter 5)</p> <p>When the Member’s goals are not met, provide a detailed description of the process employed to reassess the current ICP and determine appropriate alternative actions. (CMS Model of Care Chapter 5)</p> <p>Policy and procedures that demonstrate how both the ICP and ICT meeting will include, to the extent possible, services and providers from the Medi-Cal managed care and carved-out delivery systems, as appropriate for the member and consistent with their preferences. Delegates must encourage participation of both members and primary care providers in development of the ICP and ICT activities. The ICP should be person-centered and informed by the member’s HRA and past utilization of both Medicare and Medi-Cal services. One ICP should be used to meet both Medicare and Medi-Cal ICP requirements. (DHCS-CalAIM-D-SNP-Policy Guide)</p> <p>Policies and procedures that demonstrate how initial ICPs will be developed within the first 90 days of enrollment, with Member and/or Caregiver(s) participation. If unable to develop</p>			
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		<p>ICP within the first 90 days of enrollment due to Member being unwilling or unable to contact, Delegate must clearly document the reason and three (3) outreach attempts to engage, if unable to contact. (Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements, Core 3.2)</p> <p>Policies and procedures that demonstrate how the ICP must identify any carved-out services the member needs and how the Delegate will facilitate access and document referrals (including at least three (3) outreach attempts), including but not limited to referrals and connections to:</p> <ul style="list-style-type: none"> <li>• Community Based Organizations</li> <li>• County mental health and substance use disorder services</li> <li>• Housing and homelessness providers</li> <li>• Community Supports providers in the aligned MCP network</li> <li>• 1915(c) waiver programs, including MSSP</li> <li>• LTSS programs, including IHSS and Community-Based Adult Services (CBAS)</li> <li>• Medi-Cal transportation to access Medicare and Medi-Cal services.</li> </ul> <p>(DHCS-CalAIM-D-SNP-Policy Guide)</p> <p>Policies that explain how D-SNP care coordinators/care managers participating in the ICT must be trained to identify and understand the full spectrum of Medicare and Medi-Cal LTSS programs, including home- and</p>			
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		<p>community-based services and long-term institutional care.</p> <p>How the ICT will include providers of any Medi-Cal services the member is receiving, including LTSS and Community Supports.</p> <p>(DHCS-CalAIM-D-SNP-Policy Guide)</p> <p>Irrespective of having a formal Alzheimer’s or dementia diagnosis, if the member has documented dementia care needs, including but not limited to: wandering, home safety concerns, poor self-care, behavioral issues, issues with medication adherence, poor compliance with management of co-existing conditions, and/or inability to manage ADLs/IADLs, the ICT must include the member’s caregiver and a trained dementia care specialist to the extent possible and as consistent with the member’s preferences.</p> <p>Policies and procedures that demonstrate how dementia care specialists are trained in understanding Alzheimer’s Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees and caregivers. D-SNPs should leverage available training content from community-based organizations with expertise in serving people with dementia when developing training content for dementia care specialists.</p>			
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**ATTACHMENT IV: DELINEATION OF CARE MANAGEMENT**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		<p>Delegate must identify individuals to serve as liaisons for the LTSS provider community to help facilitate member care transitions. These staff must be trained to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules.</p> <p>Liaisons for the LTSS provider community should be engaged in the ICT, as appropriate for members accessing those services. It is not required that an LTSS liaison be a licensed position. Delegate must identify these individuals and their contact information in materials for providers and beneficiaries.</p> <p>These ICT members must be included in the development of the member’s ICP to the extent possible and as consistent with the member’s preference.</p> <p>(DHCS-CalAIM-D-SNP-Policy Guide)</p>			





**ATTACHMENT IV: DELINEATION OF CARE MANAGEMENT**

<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
Care Management	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	<ul style="list-style-type: none"> <li>▪ Annually measures the effectiveness of its care management program by using three (3) measures to identify a relevant process or outcome; uses valid methods that provide quantitative results; Sets a performance goal; Clearly identifies measure specifications; Analyzes results; Identifies opportunities for improvement; Implements at least one intervention for each of the three (3) opportunities identified and develops a plan for evaluation of the intervention and re-measurement.</li> </ul>	Monthly	Annual Audit of IPA Policies and Procedures.  Monthly CM log review and targeted file review.	See Corrective Action Plan (CAP) Requirements in MA_25A3.



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<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
<p>Care Management  Care Transitions</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The IPA makes a special effort to coordinate care when members move from one setting to another, such as when they are discharged from a hospital.</p> <ul style="list-style-type: none"> <li>▪ The IPA facilitates safe transitions by identifying transitions, sharing the sending setting’s care plan with the receiving setting within one business day of notification of the transition, and notifying the patient’s usual practitioner of the transition within twenty-four (24) hours.</li> <li>▪ The IPA facilitates safe transitions by communicating with the members or responsible party about the care transition process, about the changes to the health status and plan of care within 1-2 business days, not to exceed three business days of notification of a hospital or skilled nursing facility admission and provides a consistent person or unit within the organization who is responsible for supporting the member through transitions.</li> <li>▪ The IPA annually analyzes its performance on the entire process of managing all care transitions.</li> <li>▪ The IPA identifies unplanned transitions by reviewing hospital admissions within one business day of admission reports and long-term care facilities within one business day of admission reports.</li> <li>▪ The IPA minimizes unplanned transitions and works to maintain members in the least restrictive</li> </ul>	<p>Monthly</p>	<p>Annual Audit of IPA Policies and Procedures.</p> <p>Monthly CM log review and targeted file review.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



**ATTACHMENT IV: DELINEATION OF CARE MANAGEMENT**

<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
Care Management  Care Transitions		<p>setting possible by analyzing data at least monthly and analyzing rates at least annually of all member admissions to hospitals and ED visits to identify areas for improvement. The IPA also implements at least one intervention related to the opportunities identified during the analysis of all member admissions to hospitals and ED visits.</p> <ul style="list-style-type: none"> <li>▪ Based on the findings from its monthly analysis of data to identify individual members at risk of a transition, the IPA works to reduce unplanned transitions and to maintain members in the least restrictive setting possible by coordinating services for members at high risk of having a transition and educating members or responsible parties about transitions and how to prevent unplanned transitions.</li> </ul>			



**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>Credentialing Policies (NCQA CR 1 Element A)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>Delegate has policies and procedures that specify:</p> <ol style="list-style-type: none"> <li>1. The types of practitioners it credentials and recredentials.</li> <li>2. The verification sources it uses.</li> <li>3. The criteria for credentialing and recredentialing.</li> <li>4. The process for making credentialing and recredentialing decisions.</li> <li>5. The process for managing credentialing files that meet the organizations established criteria.</li> <li>6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.</li> <li>7. The process for notifying practitioners if information obtained during the organization’s credentialing process varies substantially from the information they provided to the organization.</li> </ol>	<p>Annually, at minimum</p>	<p>Annual Audit of Delegate’s Policies and Procedures.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>Credentialing Policies (NCQA CR 1 Element A continued)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<ol style="list-style-type: none"> <li>8. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee’s decision.</li> <li>9. The Medical Director or other designated physician’s direct responsibility and participation in the credentialing program.</li> <li>10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.</li> <li>11. The process for confirming listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.</li> </ol>	<p>Annually, at minimum</p>	<p>Annual Audit of Delegate’s Policies and Procedures.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
<p>Practitioner Rights (NCQA CR 1 Element B)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>Delegate notifies practitioners about their right to:</p> <ol style="list-style-type: none"> <li>1. Review information submitted to support their credentialing application.</li> <li>2. Correct erroneous information.</li> <li>3. Receive the status of their credentialing or recredentialing application, upon request.</li> </ol>	<p>Annually, at minimum</p>	<p>Annual Audit of Delegate’s Policies and Procedures.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



<p>Credentialing System Controls (NCQA CR 1 Element C*)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The Delegates credentialing process describes*:</p> <ol style="list-style-type: none"> <li>1. How primary source verification information is received, dated and stored.</li> <li>2. How modified information is tracked and dated from its initial verification.             <ol style="list-style-type: none"> <li>a. When the information was modified.</li> <li>b. How the information was modified.</li> <li>c. Staff who made the modification.</li> <li>d. Why the information was modified.</li> </ol> </li> <li>3. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.</li> <li>4. The security controls in place to protect the information from unauthorized modification             <ol style="list-style-type: none"> <li>a. Limiting physical access to the operating environment that houses credentialing information, to protect the accuracy of information gathered from primary sources &amp; NCQA-approved sources. Physical access may include, but is not limited to, the Delegate’s computer servers, hardware &amp; physical records &amp; files. Physical access does not refer to the Delegate’s building or office location.</li> <li>b. Preventing unauthorized access, changes to and release of credentialing information.</li> <li>c. Password-protecting electronic systems, including user requirements to: Use strong passwords, Discourage staff from writing down passwords, Use IDs and passwords unique to each</li> </ol> </li> </ol>	<p>Annually, at minimum</p>	<p>Audit of Delegate’s policies and procedures</p>	<p>See Corrective Action Plan (CAP) Requirements in MC_25D 3.</p>
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Credentialing System Controls (NCQA CR 1 Element C* continued)		<p>user, Change passwords when requested by staff or if passwords are compromised, Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.</p> <p>5. How the Delegate monitors its compliance with the policies and procedures in factors 1-4 at least annually and takes appropriate action when applicable. At a minimum, the description includes:</p> <ul style="list-style-type: none"><li>a. The method used to monitor compliance with the Delegate's policies and procedures described in factors 1-4.</li><li>b. The staff titles or roles responsible for oversight of the monitoring process.</li><li>c. The Delegate's process for taking actions if it identifies modifications that do not meet its established policy, including: A quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three (3) consecutive quarters. The staff roles or department responsible for the actions. The process for documenting and reporting modifications that do not meet established policy.</li></ul>			
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<p>Credentialing System Controls Oversight (NCQA CR 1 Element D)</p>	<p>IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual</p>	<p>Delegate's, at least annually must demonstrate that it monitors compliance with its credentialing controls, by:</p> <ol style="list-style-type: none"> <li>4. Identifying all modifications to credentialing and recredentialing information that did not meet the Delegates policies and procedures for modifications.</li> <li>5. Analyzing all instances of modifications that did not meet the Delegate's policies and procedures for modification.</li> <li>6. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.</li> </ol>	<p>Annually, at minimum</p>	<p>Review of Reports</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>CMS/DHCS</p> <p>Performance Monitoring for Recredentialing</p> <p>(Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>Delegate’s recredentialing policies and procedures require information from quality improvement activities and member complaints in the recredentialing decision making process.</p> <p>(Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD 02-03 and Exhibit A, Attachment 4 of Plan Contract)</p>	<p>Annually, at minimum</p>	<p>Annual Audit of IPA Policies and Procedures.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
<p>CMS</p> <p>Contracts – Opt-Out Provisions</p> <p>(Medicare Managed Care Manual, Chapter 6 § 60.2)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>Delegate has policies and procedures to ensure that it only contracts with physicians who have not opted out.</p> <p>(Source: Medicare Managed Care Manual; Chapter 6 § 60.2)</p>	<p>Annually, at minimum</p>	<p>Annual Audit of Delegate’s Policies and Procedures.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>CMS/DHCS Medicare – Exclusions/Sanctions  (Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>Delegate must have policies and procedures that prohibit employment or contracting with practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (practitioners or entities found on OIG Report)</p> <p>(Source: Medicare Managed Care Manual, Chapter 6 § 60.2)</p>	<p>Annually, at minimum</p>	<p>Annual Audit of Delegate’s Policies and Procedures.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
<p>Credentialing Committee (NCQA CR 2 Element A)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The Delegate’s Credentialing Committee:</p> <ol style="list-style-type: none"> <li>1. Uses participating practitioners to provide advice and expertise for credentialing decisions.</li> <li>2. Reviews credentials for practitioners who do not meet established thresholds.</li> <li>3. Ensures that files that meet established criteria are reviewed and approved by a Medical Director, designated physician or Credentialing Committee.</li> </ol>	<p>Annually, at minimum</p>	<p>Audit of Delegate’s Policies and Procedures and Credentialing Committee Meeting Minutes</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



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<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
Verification of Credentials (NCQA CR 3 Element A*, DHCS, CMS)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate verifies that the following are within the prescribed time limits*: 1. A current and valid license to practice. 2. A valid DEA or CDS certificate, if applicable. 3. Education and training as specified in the explanation. 4. Board Certification status, if applicable. 5. Work history. 6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner.	Annually, at minimum	IEHP reviews verification of credentials within a random sample of up to 40 initial credentialing files and 40 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MA_25A3.



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<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
Sanction Information (NCQA CR 3 Element B*, DHCS, CMS)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>The Delegate verifies the following sanction information for credentialing*:</p> <ol style="list-style-type: none"> <li>1. State sanctions, restrictions on licensure or limitations on scope of practice.</li> <li>2. Medicare and Medicaid sanctions               <ol style="list-style-type: none"> <li>a. Medicare and Medicaid Sanctions, OIG must be the verification source.</li> <li>b. Medicaid Sanctions, the Medi-Cal Suspended and Ineligible List must be the verification source.</li> </ol> </li> </ol>	Annually, at minimum	IEHP reviews verification of credentials within a random sample of up to 40 initial credentialing files and 40 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MA_25A3.



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<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
<p>Credentialing Application (NCQA CR 3 Element C*)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The Delegate verifies that applications for credentialing include the following*:</p> <ol style="list-style-type: none"> <li>1. Reasons for inability to perform the essential functions of the position.</li> <li>2. Lack of present illegal drug use.</li> <li>3. History of loss of license and felony convictions.</li> <li>4. History of loss or limitation of privileges or disciplinary actions.</li> <li>5. Current malpractice insurance coverage.</li> <li>6. Current and signed attestation confirming the correctness and completeness of the application.</li> </ol>	<p>Annually, at minimum</p>	<p>IEHP reviews application and attestation within a random sample of up to 40 initial credentialing files and 40 recredentialing files from the decision made during the look-back period.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



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<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
<p>Practitioner must have clinical privileges in good standing.</p> <p>CMS/DMHC/DHCS</p> <p>(Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>Delegate verifies the practitioner has privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital.</p> <p>(Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD Policy Letter 02-03 and DMHC TAG 10/11)</p>	<p>Annually, at minimum</p>	<p>IEHP reviews verification of credentials within a random sample of up to 40 initial credentialing files and 40 recredentialing files from the decision made during the look-back period.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>CMS Contracts – Opt-Out Provisions  (Medicare Managed Care Manual, Chapter 6 § 60.2)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>Delegate monitors its credentialing files to ensure that it only contracts with practitioners who have not opted out.  (Source: Medicare Managed Care Manual, Chapter 6 § 60.2)</p>	<p>Annually, at minimum</p>	<p>IEHP reviews verification of credentials within a random sample of up to 40 initial credentialing files and 40 recredentialing files from the decision made during the look-back period.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
<p>CMS/DHCS Review of Performance Information  (Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter APL 19-004)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>Delegate includes information from quality improvement activities and member complaints in the recredentialing decision-making process.  (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD 02-03 and Exhibit A: Attachment 4 of Plan Contract)</p>	<p>Annually, at minimum</p>	<p>IEHP reviews verification of credentials within a random sample of up to 40 recredentialing files from the decision made during the look-back period.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



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<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
<p>Recredentialing Cycle Length (NCQA CR 4 Element A*)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The Delegate conducts timely recredentialing. The length of the recredentialing cycle is within the required thirty-six (36) month time frame*.</p>	<p>Annually, at minimum</p>	<p>IEHP reviews verification of credentials within a random sample of up to 40 initial credentialing files and 40 recredentialing files from the decision made during the look-back period.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>





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<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
Performance Standards and Thresholds (NCQA MED 3 Element A)	IEHP sets site performance standards and thresholds for: <ol style="list-style-type: none"> <li>1. Accessibility equipment.</li> <li>2. Physical accessibility.</li> <li>3. Physical appearance.</li> <li>4. Adequacy of waiting and examining room space.</li> <li>5. Adequacy of medical/treatment medical record keeping.</li> </ol>	The Delegate is responsible for ensuring the providers are compliant with IEHP Facility Site Review and Medical Record Audits.	Not Applicable	Not Applicable	Not Applicable



<p>Site Visits and Ongoing Monitoring (NCQA MED 3 Element B)</p>	<p>IEHP implements appropriate interventions by:</p> <ol style="list-style-type: none"> <li>1. Continually monitoring member complaints for all practitioner sites.</li> <li>2. Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met.</li> <li>3. Instituting actions to improve offices that do not meet thresholds.</li> <li>4. Evaluating the effectiveness of the actions at least every six months, until deficient offices meet the site standards and thresholds.</li> <li>5. Documenting follow-up visits for offices that had subsequent deficiencies.</li> </ol>	<p>The Delegate is responsible for ensuring the providers are compliant with IEHP Facility Site Review and Medical Record Audits.</p>	<p>Not Applicable</p>	<p>Not Applicable</p>	<p>Not Applicable</p>
<p>Ongoing Monitoring and Interventions (NCQA CR 5 Element A)</p>	<p>IEHP will provide Delegate with guidelines for</p>	<p>The Delegate develops and implements policies and procedures for ongoing monitoring of practitioner sanctions,</p>	<p>Annually, at minimum</p>	<p>IEHP reviews the organization's policies and</p>	<p>See Corrective Action Plan (CAP)</p>



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
	Policies and Procedures via IEHP Provider Manual.	<p>complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality by:</p> <ol style="list-style-type: none"> <li>1. Collecting and reviewing Medicare and Medicaid sanctions.</li> <li>2. Collecting and reviewing sanctions or limitations on licensure.</li> <li>3. Collecting and reviewing complaints.</li> <li>4. Collecting and reviewing information from identified adverse events.</li> <li>5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4.</li> </ol>		<p>procedures, monitoring reports, and documentation of interventions.</p> <p>Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan's Credentialing Manager, with the delegate's plan of action for the identified provider and date it was reviewed by their Credentialing/Peer Review Committee.</p>	Requirements in MA_25A3.



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>CMS Contracts – Opt-Out Provisions  (Medicare Managed Care Manual, Chapter 6 § 60.2)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The Delegate maintains a documented process for monitoring whether network physicians have opted out of participating in the Medicare Program.  (Source: Medicare Managed Care Manual, Chapter 6 § 60.3)</p>	<p>Annually, at minimum</p>	<p>IEHP reviews the Delegate’s Policies and Procedures, Monitoring Reports, and Documentation of Interventions  The Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan, with the Delegate’s plan of action for the identified provider.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>DHCS Monitoring Medi-Cal Suspended and Ineligible Provider Reports  (DHCS All Plan Letter APL 19-004)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The Delegate verifies that their contracted providers have not been terminated as a Medi-Cal provider or have not been placed on the Suspended and Ineligible Provider List  (Source: Exhibit A: Attachment 4, Plan Contract)</p>	<p>Annually, at minimum</p>	<p>IEHP reviews the Delegate’s Policies and Procedures, Monitoring Reports, and Documentation of Interventions  The Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan, with the IPA’s plan of action for the identified provider.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>CMS Monitoring Preclusions List</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p> <p>IEHP will provide Delegate with Preclusions List through the SFTP portal</p>	<p>The Delegate maintains a documented process for monitoring providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare Beneficiaries.</p> <p>Delegates are responsible for reviewing these reports within thirty (30) days of its release and notify IEHP of any providers identified, to include the delegate’s plan of action.</p>	<p>Annually, at minimum</p>	<p>IEHP reviews the Delegate’s Policies and Procedures, Monitoring Reports, and Documentation of Interventions</p> <p>The Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan, with the Delegate’s plan of action for the identified provider.</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>CMS Monitoring Death Master File  (DHCS All Plan Letter APL19-004)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p> <p>IEHP maintains a documented process for monitoring providers who are identified on the Death Master File</p>	<p>The Delegate is required to submit SSN for all new and existing providers to screen against the Death Master File.</p> <p>(Source: Department of Health Care Services (DHCS) All Plan Letter (APL) APL 17-019 supersedes APL 16-012, “Provider Credentialing/Rec credentialing and Screening/Enrollment)</p>	<p>Ongoing</p>	<p>Not Applicable</p>	<p>Not applicable</p>



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>DHCS – Monitoring the Restricted Provider Database.</p> <p>(DHCS All Plan Letter APL 19-004)</p>	<p>IEHP will review the Restricted Provider Database, on a monthly basis, and notify the Delegate of any identified practitioners.</p>	<p>Delegated Practitioners identified with payment suspensions, reimbursements for Medi-Cal covered services will be withheld. If the Delegate continues to continue their contractual relationship with practitioners who are placed on payment suspensions, the Delegate must allow out-of-network access to members currently assigned to the practitioner by approving the request.</p> <p>Delegated Practitioners placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations. Delegates must terminate their contract and submit appropriate documentation.</p>	<p>As needed</p>	<p>As needed</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>





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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Notification to Authorities and Practitioner Appeal Rights - Actions Against Practitioners (NCQA CR 6 Element A)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>Delegates that have taken action against a practitioner for quality reasons reports the action to the appropriate authorities and offers the practitioner a formal appeal process.</p> <p>The Delegate has policies and procedures for:</p> <ol style="list-style-type: none"> <li>1. The range of actions available to the organization.</li> <li>2. Making the appeal process known to practitioners.</li> </ol>	Annually, at minimum	<p>IEHP reviews evidence that the organization reports to authorities and the health plan’s Credentialing Manager, Information may be de-identified for confidentiality purposes.</p> <p>IEHP reviews the organization’s policies and procedures.</p>	See Corrective Action Plan (CAP) Requirements in MA_25D 3.
CMS– Appeals Process for Termination/ Suspension	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>The Delegate’s policies and procedures regarding suspension or termination of a participating physician require the organization to ensure that the majority of the hearing panel members are peers of the affected physician.</p> <p>(Source: Medicare Managed Care Manual, Chapter 6 § 60.4)</p>	Annually, at minimum	IEHP reviews the information sent to practitioners.	See Corrective Action Plan (CAP) Requirements in MA_25A3.



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Review and Approval of Providers (NCQA CR 7 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>The Delegate’s policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it:</p> <ol style="list-style-type: none"> <li>1. Confirms that the provider is in good standing with state and federal regulatory bodies.</li> <li>2. Confirms that the provider has been reviewed and approved by an accrediting body.</li> <li>3. Conducts an onsite quality assessment if the provider is not accredited.</li> </ol>	Annually, at minimum	IEHP reviews Delegate’s policies and procedures	See Corrective Action Plan (CAP) Requirements in MA_25D 3.
Medical Providers (NCQA CR 7 Element B)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>The Delegate includes at least the following medical providers in its assessment:</p> <ol style="list-style-type: none"> <li>1. Hospitals (CRITICAL FACTOR).</li> <li>2. Home health agencies.</li> <li>3. Skilled nursing facilities.</li> <li>4. Free-standing surgical centers.               <ul style="list-style-type: none"> <li>• Clinical Laboratories (IEHP Requirement)</li> </ul> </li> </ol>	Annually, at minimum	IEHP reviews Delegate’s policies and procedures	See Corrective Action Plan (CAP) Requirements in MA_25D 3.



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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Assessing Medical Providers (NCQA CR 7 Element D)	1. IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>The Delegate assesses contracted medical health care providers against the requirements and within the time frame in Element A .</p> <p>The Delegate maintains a checklist, spreadsheet, or other record that it assessed providers against the requirements.</p>	Annually, at minimum	IEHP reviews evidence that the organization assessed the providers in NCQA CR7 Element A	See Corrective Action Plan (CAP) Requirements in MA_25D 3.
Accreditation/Certification of Free-Standing Surgical Centers in California - CH & SC  (California Health and Safety Code § 1248.1)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegate has documentation of assessment of free-standing surgical centers to ensure that if the organization is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program, in compliance with California Health and Safety Code § 1248.1	Annually, at minimum	IEHP reviews evidence that the organization assessed the providers	See Corrective Action Plan (CAP) Requirements in MA_25A3.



**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Written Delegation Agreement (NCQA CR 8 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>The Delegate remains responsible for credentialing and recredentialing its practitioners, even if its delegates all or part of these activities.</p> <p>The written delegation agreement:</p> <ol style="list-style-type: none"> <li>1. Is mutually agreed upon.</li> <li>2. Describes the delegated activities and the responsibilities of IEHP and the Delegate.</li> <li>3. Requires at least semiannual reporting of the delegate to IEHP.</li> <li>4. Describes the process by IEHP evaluates the Delegate’s performance.</li> <li>5. Specifies that IEHP retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if IEHP delegates decision making.</li> </ol>	Annually, at minimum	IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MA_25D 3.



**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Written Delegation Agreement (NCQA CR 8 Element A continued)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual	6. Describes the remedies available to IEHP if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement	Annually, at minimum	IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MA_25D 3.
Written Delegation Agreement (NCQA CR 8 Element A continued)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegate retains the right to approve, suspend and terminate individual practitioners, providers, and sites in situation where it has delegated decision making. This right is reflected in the delegation document	Annually, at minimum	IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MA_25D 3.



**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
<p>CMS Adherence to Medicare Advantage (MA) requirements</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>All Delegation agreements include a statement that Delegate’s must adhere to MA requirements.  (Source: Medicare Managed Care Manual, Chapter 11 § 110.2)</p>	<p>Annually, at minimum</p>	<p>IEHP reviews Delegation Agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
<p>Review of Credentialing Activities (NCQA CR 8 Element C)</p>	<p>IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>For delegation agreements in effect for 12 months or longer, the organization:</p> <ol style="list-style-type: none"> <li>1. Annually reviews the Delegate’s credentialing policies and procedures.</li> <li>2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.</li> <li>3. Annually evaluates the Delegate’s performance against NCQA standards for delegated activities.</li> <li>4. Semi-annually evaluates regular reports as specified in Element A.</li> <li>5. Annually monitors the IPA’s credentialing system security controls to ensure that the IPA monitors its compliance with the delegation agreement or with the IPA’s policies and procedures.</li> <li>6. Annually acts on all findings from factor 5 for each IPA and implements a quarterly monitoring process until each IPA demonstrates improvement for one finding over three (3) consecutive quarters.</li> </ol>	<p>Annually, at minimum</p>	<p>IEHP reviews a sample of up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>



**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Opportunities for Improvement (NCQA CR 8 Element D)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.	Annually, at minimum	IEHP reviews reports for opportunities for improvement if applicable and appropriate actions to resolve issues from up to or four randomly selected delegates, or all delegates if the organization has fewer than four delegates	See Corrective Action Plan (CAP) Requirements in MA_25A3.
Identification of HIV/AIDS Specialists – Written Process  (CA H&SC §1374.16; DMHC TAG QM-004). (DHCS MMCD All-Plan Letter 01001)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegate has a written policy and procedure describing the process that the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist, according to California State regulations on an annual basis	N/A	IEHP reviews Delegate Policies and Procedures	See Corrective Action Plan (CAP) Requirements in MA_25A3.





**ATTACHMENT V: DELINEATION OF CREDENTIALING and RECREDENTIALING**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Evidence of Implementation  (CA H&SC §1374.16; DMHC TAGQM-004). (DHCS MMCD All-Plan Letter 01001)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	On an annual basis, the Delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS, specialist according to California State Regulations	Annually, at minimum	IEHP reviews evidence that the organization identified or reconfirmed the appropriate qualified physicians	See Corrective Action Plan (CAP) Requirements in MA_25A3.
Distribution of Findings  (CA H&SC §1374.16; DMHC TAG QM-004). (DHCS MMCD All-Plan Letter 01001)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider P=Manual.	The Delegate is to provide the list of identified qualifying physicians to the department responsible for authorizing standing referrals.	Annually, at minimum	IEHP reviews evidence that the organization provided the list of identified qualifying physicians to the department responsible for authorizing standing referrals.	See Corrective Action Plan (CAP) Requirements in MA_25A3.



**ATTACHMENT VI: DELINEATION OF ENCOUNTER DATA**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
ENC 1: Encounter Data Reporting		<p>The Delegate is required by DMHC, CMS and DHCS to submit Encounter Data for the effective management of IEHP health care delivery system.</p> <ul style="list-style-type: none"> <li>A. Data must be submitted using the HIPAA compliant 5010 837 file format.</li> <li>B. The Encounter Data must be complete and accurate.</li> <li>C. Submit complete Encounter data within ninety (90) days after each month of service.</li> </ul>	Submit Encounter Data within ninety (90) days after each month of service	<p>Initial Onsite Assessment</p> <p>Monthly assessment of encounter data submission rates</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25D 3.</p> <p>IEHP may withhold no more than one percent (1%) of the monthly Capitation Payment for failure to submit complete and accurate Encounter Data within ninety (90) days after each month of service.</p>



**ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Correct Claim Determination (CMS MA Manual Ch. 4 Section 10)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>The Delegate must make correct claim determinations, which include developing the claim for additional information, when necessary, for:</p> <ul style="list-style-type: none"> <li>A. Services obtained from a non-contracting Provider when the services were authorized by the IPA.</li> <li>B. Ambulance services dispatched through 911.</li> <li>C. Emergency services</li> <li>D. Urgently needed services.</li> <li>E. Post-stabilization care services</li> <li>F. Renal dialysis services that Medicare members obtain while temporarily out of the service area.</li> </ul>	See Attachment IPA Reporting Requirements Schedule in Section 25	<p>Initial Onsite Assessment</p> <p>Monthly Assessment</p> <p>Annual Oversight Assessment</p>	May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D.
Reasonable Reimbursement for Covered Services (CMS MA Manual Ch. 4 Section 110.1.3)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>The Delegate must provide reasonable reimbursement for:</p> <ul style="list-style-type: none"> <li>A. Services obtained from a non-contracting Provider when the services were authorized by the IPA.</li> <li>B. Ambulance services dispatched through 911.</li> <li>C. Emergency services</li> <li>D. Urgently needed services.</li> <li>E. Post-stabilization care services</li> <li>F. Renal dialysis services that Medicare members obtain while temporarily out of the service area.</li> </ul>	See Attachment IPA Reporting Requirements Schedule in Section 25	<p>Initial Onsite Assessment</p> <p>Monthly Assessment</p> <p>Annual Oversight Assessment</p>	May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D.



**ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION**

<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
Reasonable Reimbursement for Covered Services (CMS MA Manual Ch. 4 Section 110.1.3 (continued))	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	G. Services for which coverage has been denied by the Delegate but found to be services the member was entitled to upon appeal. H. The Delegate must use the appropriate fee-for-service payment mechanisms when determining amounts to pay non-contracted Providers. Note: if the IPA has negotiated lower amounts or if a Provider bills lower amounts than is possible under fee-for-service, paying non-contracted Providers these lower amounts is appropriate.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment Monthly Assessment Annual Oversight Assessment	May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D.
Timely Payment of Non-Contracting Provider Clean Claims (CMS MA Manual Ch. 11 Section 100.2 and CMS MA Manual Ch. 13 Section 40.10)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegate must pay 95 percent of “clean” claims from non-contracting Providers within thirty (30) calendar days of the earliest receipt date.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment Monthly Assessment Annual Oversight Assessment	May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D.
Interest on Clean Claims Paid Late (CMS MA Manual Ch. 11 Section 100.2)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	If the Delegate pays clean claims from non-contracting Providers in over thirty (30) calendar days, it must pay interest in accordance with 1816 (c)(2)(B) and 1842(c)(2)(B)	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment Monthly Assessment Annual Oversight Assessment	May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D.



**ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION**

<b>Delegated Activity</b>	<b>IEHP Responsibilities</b>	<b>Delegate Responsibilities</b>	<b>Frequency of Reporting</b>	<b>Process for Evaluating Delegates Performance</b>	<b>Corrective Actions if Delegate Fails to Meet Responsibilities</b>
Timely Adjudication of Non-Clean Claims (CMS MA Manual Ch. 11 Section 100.2 and CMS MA Manual Ch. 13 Section 40.10)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegate must pay all non-contracted claims that do not meet the definition of “clean claims” within sixty (60) calendar days of the earliest receipt date.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment  Monthly Assessment  Annual Oversight Assessment	May result in Request for Corrective Action (CAP) or Focused Audit as defined in MA_20D.
Claim Denials (Notice Content). (CMS MA Manual Ch. 13 Section 40.12.1).	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	If an Delegate denies payment resulting in Member liability, a written denial notice must be sent to the member. The written denial must clearly state the service denied and the specific denial reason. The notice must also inform the beneficiary of his or her right to a standard reconsideration and describe the appeal process.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment  Monthly Assessment  Annual Oversight Assessment	See Corrective Action Plan (CAP) Requirements in MA_20D.
Medicare Secondary Payer (CMS MA Manual 4 Section 130)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegate must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.  The Delegate must have written policies and procedures which ensure that claims involving coordination of benefits are identified and paid correctly.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment  Monthly Assessment  Annual Oversight Assessment	See Corrective Action Plan (CAP) Requirements in MA_20D.



**ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Submission Standards	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegate must allow: A. Contracted Providers ninety (90) days to submit claims. B. Non-contracted Providers three hundred and sixty-five (365) days to submit claims. C. Claims denied for untimely submission to be considered for adjudication upon receipt of a Provider’s request for a redetermination and demonstration of good cause for delay.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment  Monthly Assessment  Annual Oversight Assessment	See Corrective Action Plan (CAP) Requirements in MA_20D.
Misdirected Claims	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	95% of misdirected claims must be forwarded to the appropriate financially responsible entity within ten (10) calendar days.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment  Monthly Assessment  Annual Oversight Assessment	See Corrective Action Plan (CAP) Requirements in MA_20D.



**ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Denials	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	A. 100% of member denial notices are written and include the denied service and give a specific reason for the denial which is not confusing and/or misleading to the member. B. 100% of member denial notices for payment use the CMS approved format and language. C. 100% of provider denial determinations include a valid explanation on the remittance advice (RA) which includes language for non-participating providers stating to submit all appeals to IEHP. 100% of all claim denials must be mailed to the member and/or Provider within 60 calendar days of the earliest receipt date.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment  Monthly Assessment  Annual DOA	See Corrective Action Plan (CAP) Requirements in MA_25A3.
Overpayments (CMS MFM Manual Ch. 3 & 4)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	100% of requests for overpayments must: A. Clearly identify the claim, the name of the member, the date of service and a clear explanation of the basis upon which the payor believes the overpayment occurred. B. Be made following federal guidelines and no retractions can be made prior to forty-one (41) calendar days after the overpayment was identified. C. Not recover overpayments after December 31 of the 3 <sup>rd</sup> calendar year in which the overpayment was identified.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment  Monthly Assessment  Annual Oversight Assessment	See Corrective Action Plan (CAP) Requirements in MA_25A3.



**ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Contract Standards (CMS MA Manual Ch. 11 Section 100)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	A. All written contracts with downstream entities and providers of service contain a prompt payment provision. B. All written contracts with downstream entities and providers of service contain a provision that Medicare members are held harmless for payment.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment  Monthly Assessment  Annual Oversight Assessment	See Corrective Action Plan (CAP) Requirements in MA_25A3.
Provider Payment Disputes	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	A. Provider Payment Disputes must be filed within one hundred and twenty (120) calendar days after the notice of initial determination. B. Provider Payment Disputes may be accepted after one hundred and twenty (120) calendar days if a written request for an extension of the timeframe is for good cause. C. Provider Payment Disputes must be resolved with a valid determination, and written determination is sent to the Provider within thirty (30) calendar days. D. Provider Payment disputes in which additional information is requested allows the provider fourteen (14) calendar days to respond.	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment   Quarterly Assessment  Annual Oversight Assessment	See Corrective Action Plan (CAP) Requirements in MA_25A3.





**ATTACHMENT VII: DELINEATION OF CLAIMS ADJUDICATION**

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Effectuation of Third-Party Claims Reconsideration Reversals (42 CFR 422.618)	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	<p>If the Delegate’s determination is reversed in whole or in part by the health plan, the IPA must pay for the service no later than seven (7) calendar days from the date it receives the notice reversing the organization determination. The IPA must also inform the health plan that the organization has effectuated the decision.</p> <p>If the Delegate’s determination is reversed in whole or in part by an administrative law judge (ALJ), or at a higher level of appeal, the IPA must authorize or provide the service under dispute as expeditiously as the member’s health requires, but no later than sixty (60) calendar days from the date it received notice of the reversal.</p>	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Onsite Assessment  Monthly Assessment  Annual Oversight Assessment	See Corrective Action Plan (CAP) Requirements in MA_25A3.



**ATTACHMENT VIII: REQUIREMENTS OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND HIPAA PRIVACY PROGRAM**

Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
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<p>Compliance Program (CMS Managed Care Manual Ch. 21 and DHCS Two Plan Contract Exhibit E, Attachment 2)</p>	<p>IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The Delegate has developed and implemented an Effective Compliance Program which includes the following structural components:</p> <ul style="list-style-type: none"> <li>A. Written Policies, Procedures and Standards of Conduct that articulate a commitment to comply with all applicable Federal and State requirements;</li> <li>B. Designation of a Compliance Officer who reports directly to the CEO and Board of Directors, Compliance Committee at the Board of Directors and/or Senior Leadership level charged with overseeing the compliance program;</li> <li>C. Has an effective Compliance training program for its employees to receive within 90 days of hire and annually thereafter or as updates/changes occur;</li> <li>D. Distribute Standards/Code of Conduct within 90 days of hire and annually thereafter.</li> <li>E. Effective Lines of Communication between the Compliance Officer, Compliance Committee and employees;</li> <li>F. Well-Publicized Disciplinary Standards;</li> <li>G. Provides guidance on how to report issues of non-compliance that includes non- intimidation and non-retaliation for good faith participation.</li> </ul>	<p>Precontractual Assessment and Annually as part of the DOA</p>	<p>Initial Assessment Annual DOA</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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**ATTACHMENT VIII: REQUIREMENTS OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND HIPAA PRIVACY PROGRAM**

Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		<p>H. Establishment and implementation of an Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks; and</p> <p>I. Implementation of Procedures and System for prompt response to Compliance issues as they are raised, investigation of potential compliance problems as identified through the course of self-evaluation and audits, correction of such problems promptly and thoroughly.</p>			



<p>Fraud, Waste and Abuse Program (CMS Managed Care Manual Ch. 21 and DHCS Two Plan Contract Exhibit E, Attachment 2)</p>	<p>IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The Delegate has developed and implemented an Effective Fraud, Waste and Abuse (FWA) program that is designed to deter, identify, investigate, and resolve potentially fraudulent activities that may occur in daily operations, both internally and with contracted providers.</p> <p>IPA provides monitoring and oversight, both internally and externally, of daily operational activities to detect and/or deter fraudulent behavior. Such activities include, but are not limited to:</p> <ul style="list-style-type: none"> <li>A. Provider grievances</li> <li>B. Claims activity</li> <li>C. Financial Statements</li> <li>D. Utilization management monitoring</li> <li>E. Chart audits</li> <li>F. Clinical Audits</li> <li>G. Internal auditing and monitoring process</li> <li>H. Risk assessment</li> </ul> <p>The Delegate has a FWA training program and requires training within ninety (90) days of hire/contracting and annually thereafter or as updates/changes occur.</p> <p>The Delegate has a process in place, where needed, for reporting suspected fraudulent behavior to appropriate federal, state, local authorities, and IEHP.</p>	<p>Precontractual Assessment and Annually as part of the DOA</p>	<p>Initial Assessment Annual DOA</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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**ATTACHMENT VIII: REQUIREMENTS OF COMPLIANCE PROGRAM, FRAUD, WASTE, AND ABUSE, HIPAA PRIVACY PROGRAM**



Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
	IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegate has a process in place to notify IEHP of suspected fraudulent behavior and cooperating with IEHP in the investigation to the extent permitted by law.		Initial Assessment  Annual DOA	See Corrective Action Plan (CAP) Requirements in MA_25A3.



<p>HIPAA/Privacy Title 45 CFR; HITECH Act ARRA COMIA</p>	<p>IEHP will provide the Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.</p>	<p>The Delegate maintains policies and procedures required by HIPAA and ARRA.</p> <ul style="list-style-type: none"> <li>A. Uses and disclosures of PHI and PII</li> <li>B. Confidentiality of Member Information</li> <li>C. Auditing/Monitoring of Business Associates, Downstream/Subcontracted and Related Entities</li> <li>D. General Security controls of Facilities and Information Systems</li> <li>E. Record Retention</li> <li>F. Paper Document Controls</li> <li>G. Non-retaliation for exercising rights provided by the Privacy Rule.</li> <li>H. Reporting incidents of HIPAA non-compliance to IEHP</li> </ul> <p>A privacy officer has been designated by the IPA.</p> <p>The Delegate has a HIPPA Privacy training program and requires training prior to access it PHI is given and annually thereafter or as updates/changes occur.</p> <p>The Delegate has implemented a risk assessment process to assess privacy incidents and determine breach or breach exception.</p> <p>Has policies and procedures to ensure that all persons who work with PHI/ePHI sign a confidentiality statement, prior to access to PHI is given and annually thereafter.</p> <p>There are appropriate administrative, technical and physical safeguards to</p>	<p>See Attachment IPA Reporting Requirements Schedule in Section 25</p>	<p>Initial Assessment Annual DOA</p>	<p>See Corrective Action Plan (CAP) Requirements in MA_25A3.</p>
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		prevent intentional or unintentional use or disclosure of PHI			
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## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Claims Timeliness Reports	Monthly	1/1-1/31	February 15, 2023	MA 20F - Claims and Payment Appeal Reporting	Claims	IPACode_MTR_MM_2023	Claims Timeliness / Month	42 CFR Part 422.520 & Social Security Act Sections 1876(g)(6)(A), 1816(2)(A)
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Table 3 Payment Organization Determinations and Reconsiderations (PYMT_C)	Monthly	1/1-1/31	February 15, 2023	MA 21F - Medicare MMP Reporting Requirements - IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan)	Claims	IPACode_Universe_PYMTC_MM_2023	IPA Oversight / Year / Month	CMS Program Audit, Universe Submissions for Random File Reviews
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Table 1 Standard and Expedited Pre-Service Organization Determinations	Monthly	1/1-1/31	February 15, 2023	MA 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_Universe_OD_MM_2023	IPA Oversight / Year / Month	CMS Program Audit, Universe Submissions for Random File Reviews
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight-Monthly Denial Files	Monthly	1/1-1/31	February 15, 2023	MA 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_DenFiles_MM_2023	IPA Oversight / Year / Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
IPA Oversight-Monthly Approval File Review	Monthly	1/1-1/31	February 15, 2023	MA 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_App_File_Rv_MM_2023	IPA Oversight / Year / Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
IPA Oversight-Monthly Care Transition Cases Log	Monthly	1/1-1/31	February 15, 2023	Pending Policy TBD	UM	IPACode_TOC_MM_2023	IPA Oversight / Year / Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
IPA Oversight-Monthly Long Term Care (LTC) Data Sheet	Monthly	1/1-1/31	February 15, 2023	MA 14F - Long-Term Care (LTC)	UM	IPACode_LTC_Data_MM_2023	FAX to IEHP's Long Term Care fax line at (909) 912-1045	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight-Monthly Second Opinion Log	Monthly	1/1-1/31	February 15, 2023	MA 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_Second Opinion Log_MM_2023	IPA Oversight / Year/ Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Encounter Data	Monthly	1/1-1/31	February 15, 2023	MA 21A - Medicare Dual Choice Encounter Data Submission Requirements IEHP Provider EDI Manual- IV-4	EDI	IPACode_ENC_MM_2023	5010 / Encounters	Encounter Data Submission Requirement
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Care Management Log Version 2.3	Monthly	1/1-1/31	February 15, 2023	MA 25C2 - Care Management Requirements - Reporting Requirements	CM	IPACode_CM_MM_2023	IPA Oversight / Year / Month	Guidelines for Care Management California- Specific Reporting - CA1.5, CA1.6, CA1.12 Care Coordination and CMS/DHCS CA Demonstration Three-Way Contract 1-1-2018, section 2.5.2.8
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Care Plan Outreach Log Version 1.1	Monthly	1/1-1/31	February 15, 2023	MA 25C2 - Care Management Requirements - Reporting Requirements	CM	IPACode_Outreach_MM_2023	IPA Oversight / Year / Month	DHCS Policy Guide 12-2022
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Interdisciplinary Care Team Log	Monthly	1/1-1/31	February 15, 2023	MA 25C2 - Care Management Requirements - Reporting Requirements	CM	IPACode_ICT_MM_2023	IPA Oversight / Year / Month	DHCS Policy Guide 12-2022
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
11/1-11/30	December 15, 2023							
12/1-12/31	January 15, 2024							
Credentialing and Recredentialing Report	Quarterly	1/1-3/31	May 15, 2023	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPACode - YYYY-Q1 - Credentialing and Recredentialing Activities Report	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
		4/1-6/30	August 15, 2023			IPACode - YYYY-Q2 - Credentialing and Recredentialing Activities Report		
		7/1-9/30	November 15, 2023			IPACode - YYYY-Q3 - Credentialing and Recredentialing Activities Report		
		10/1-12/31	February 15, 2024			IPACode - YYYY-Q4 - Credentialing and Recredentialing Activities Report		
Review of Recred Report provided by IEHP (by the 5th of each month)	Quarterly	1/1-3/31	May 15, 2023	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPA - YYYY-Q1 - Recredentialing Report (IEHP to IPA Code)	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
		4/1-6/30	August 15, 2023			IPA - YYYY-Q2 - Recredentialing Report (IEHP to IPA Code)		
		7/1-9/30	November 15, 2023			IPA - YYYY-Q3 - Recredentialing Report (IEHP to IPA Code)		
		10/1-12/31	February 15, 2024			IPA - YYYY-Q4 - Recredentialing Report (IEHP to IPA Code)		
Current Profile, Contract and W-9 (to include any applicable attachments i.e. Attachment I, Practice	As needed	Not Applicable	As required for Initial Credentialing Applications	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates		IPA Code_Last Name, First Name_YYYY_MM_DD (YYYY_MM-DD = Date submitted to IEHP)	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
Provider Submission via Excel Spreadsheet	As needed	Not Applicable	As required for Initial Credentialing Applications	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates		IPA_Code_Provider Profile Additions_YYYY_MM_DD (YYYY_MM-DD = Date submitted to IEHP)	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
Written and approved Credentialing, Recredentialing, Peer Review Policies and Procedures	As needed	1/1-12/31	Within thirty (30) days following Credentialing Committee approval or prior to on-site and/or desktop audit	MA	Credentialing	N/A	IPA Oversight/Credentialing	

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Claims Quarterly Provider Payment Dispute Resolution Report	Quarterly	1/1-3/31	April 29, 2023	MA 20F - Claims and Payment Appeal Reporting	Claims	IPACode_PDR_Q1_2023	Claims Timeliness / Year / Month	42 CFR Part 422.214, 417.558 and 422.520 & Social Security Act Sections 1852(k), 1894(b)(3)
		4/1-6/30	July 29, 2023			IPACode_PDR_Q2_2023		
		7/1-9/30	October 31, 2023			IPACode_PDR_Q3_2023		
		10/1-12/31	January 31, 2024			IPACode_PDR_Q4_2023		
Balance Sheet, Income Statement, Cash flow Statement,	Quarterly	1/1-3/31	May 15, 2023	MA 19A1 - Financial Viability	Financial Analysis	IPAName_Quarterly_IBNR_LOB_Q1_2023	Financial Statements	California Code of Regulations: 1300.75.4.2
		4/1-6/30	August 15, 2023			IPAName_Quarterly_IBNR_LOB_Q2_2023		
		7/1-9/30	November 15, 2023			IPAName_Quarterly_IBNR_LOB_Q3_2023		
		10/1-12/31	February 15, 2024			IPAName_Quarterly_IBNR_LOB_Q4_2023		
Organizational Informational Disclosures	Quarterly	1/1-3/31	May 15, 2023	MA 19A1 - Financial Viability	Financial Analysis	IPAName_Quarterly_Financial_Info_Disc_LOB_Q1_2023	Financial Statements	California Code of Regulations: 1300.75.4.2
		4/1-6/30	August 15, 2023			IPAName_Quarterly_Financial_Info_Disc_LOB_Q2_2023		
		7/1-9/30	November 15, 2023			IPAName_Quarterly_Financial_Info_Disc_LOB_Q3_2022		
		10/1-12/31	February 15, 2024			IPAName_Quarterly_Financial_Info_Disc_LOB_Q4_2023		

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Part C Organization Determinations/Reconsiderations - Claims	Quarterly	1/1-3/31	May 15, 2023	MA 25 - Delegation and Oversight	Claims	IPACode_PartC_Claims_Q1_2023	IPA Oversight / Year / Month	Part C Reporting - Organization Determinations/Reconsiderations
		4/1-6/30	August 15, 2023			IPACode_PartC_Claims_Q2_2023		
		7/1-9/30	November 15, 2023			IPACode_PartC_Claims_Q3_2023		
		10/1-12/31	February 9, 2024			IPACode_PartC_Claims_Q4_2023		
Part C Organization Determinations/Reconsiderations - Authorizations	Quarterly	1/1-3/31	May 15, 2023	MA 25 - Delegation and Oversight	UM	IPACode_PartC_Auths_Q1_2023	IPA Oversight / Year / Month	Part C Reporting - Organization Determinations/Reconsiderations
		4/1-6/30	August 15, 2023			IPACode_PartC_Auths_Q2_2023		
		7/1-9/30	November 15, 2023			IPACode_PartC_Auths_Q3_2023		
		10/1-12/31	February 9, 2024			IPACode_PartC_Auths_Q4_2023		
IPA Oversight-Quarterly UM Program Evaluation /HICE Report	Quarterly	1/1-3/31	May 15, 2023	MA 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_UM Program Evaluation_HICE_Q1_2023	IPA Oversight / Year / Quarterly	FDR Oversight
		4/1-6/30	August 15, 2023			IPACode_UM Program Evaluation_HICE_Q2_2023		
		7/1-9/30	November 15, 2023			IPACode_UM Program Evaluation_HICE_Q3_2023		
		10/1-12/31	February 15, 2024			IPACode_UM Program Evaluation_HICE_Q4_2023		

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight- Quarterly UM Work plan Update / Evaluation /HICE Report	Quarterly	1/1-3/31	May 15, 2023	MA 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_UM Program Evaluation_HICE_Q1_2023	IPA Oversight / Year / Quarterly	FDR Oversight
		4/1-6/30	August 15, 2023			IPACode_UM Program Evaluation_HICE_Q2_2023		
		7/1-9/30	November 15, 2023			IPACode_UM Program Evaluation_HICE_Q3_2023		



## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Report		10/1-12/31	February 15, 2024			IPACode_UM Program Evaluation_HICE_Q4_2023		
IPA Oversight-Semi-Annual Chronic Care Improvement Program Activity (CCIP)	Semi-Annual (Q1 Plan)	1/1-2/30	March 15, 2023	MA 13E - Chronic Care Improvement Program (CCIP)	QM	IPACode_CCIP_Q1 Plan_2023	IPA Oversight / Year / Semi Annual	FDR Oversight
	Semi-Annual (Progress Update)	3/1-8/31	September 15, 2023			IPACode_CCIP_Progress Update_2023	IPA Oversight / Year / Semi Annual	
IPA Oversight-Semi-Annual QM Work plan Update / Evaluation	Semi-Annual	1/1-6/30	August 15, 2023	MA 25D1 - Quality Management Reporting Requirements	QM	IPACode_QM_Workplan Eval_Q1-Q2_2023	IPA Oversight / Year / Semi Annual	FDR Oversight
	Semi-Annual	7/1-12/31	February 15, 2024			IPACode_QM_Workplan Eval_Q3-Q4_2023	IPA Oversight / Year / Semi Annual	
Care Coordinator to Member Ratio Report	Annual	1/1-12/31	January 15, 2024	MA 25 - Section V - Organizational Structure and Staffing	CM	IPACode_CareCoord_2024	IPA Oversight / Care Coordinator Ratio	MMP Reporting 5.1 - Care Coordinator to Member Ratio
IPA Oversight-Annual UM Program Description	Annual	1/1-12/31	February 15, 2023	MA 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_UM Program Description_2023	IPA Oversight / Year / Annual	FDR Oversight
IPA Oversight-Annual UM Work plan / Initial /HICE Report	Annual	1/1-12/31	February 15, 2023	MA 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_Initial UM Workplan_ICE Report_2023	IPA Oversight / Year / Annual	FDR Oversight
IPA Oversight-Annual QM Program Description	Annual	1/1-12/31	February 28, 2023	MA 25D1 - Quality Management Reporting Requirements	QM	IPACode_QM Program Description_2023	IPA Oversight / Year / Annual	FDR Oversight

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight-Annual QM Work plan / Initial	Annual	1/1-12/31	February 28, 2023	MA 25D1 - Quality Management Reporting Requirements	QM	IPACode_QM_Workplan_2023	IPA Oversight / Year / Annual	FDR Oversight
IPA Oversight-Annual QM Program Evaluation	Annual	1/1-12/31	February 28, 2024	MA 25D1 - Quality Management Reporting Requirements	QM	IPACode_QM_Evaluation_2022	IPA Oversight / Year / Annual	FDR Oversight
Compliance-Annual Guidelines for Care Management Provider and Internal Staff Training Completion Records	Annual	1/1-12/31	February 28, 2023	MA 12A7 Coordination of Care	CM	IPACode_Model_Care_Trmg_2023	IPA Oversight / Year / Annual	Guidelines for Care Management
IPA Oversight-Annual HCC Workplan	Annual	1/1-12/31	February 15, 2023	MA 21C – Medicare Risk Adjustment and Hierarchical Condition Categories (HCC)	HCI	IPACode_HCC_Workplan_2023	IPA Oversight / Year / Annual	FDR Oversight
Care Coordinator training for supporting self-direction under the demonstration	Annual	1/1-12/31	January 15, 2023	MA 21F - Medicare MMP Reporting Requirements - IEHP DualChoice Cal MediConnect Plan (Medicare - Medicaid Plan)	CM	IPACode_Care_Coordinator_Trmg_2023	IPA Oversight / Year / Annual	California-Specific Reporting - CA3.2 Organizational Structure & Staffing
Credentialing and Recredentialing- Written and Approved Credentialing, Recredentialing, Peer Review Policies and Procedures	Precontractual and Annual DOA	1/1-12/31	As required for Precontractual Assessment and Annual DOA	MA 13G - Delegation Oversight Audit	Credentialing	IPA Name_Policy Name_MMDDYY	Audits / 2022 DOA Audit	FDR Oversight
Compliance- Compliance Program policies and procedures	Annual	1/1-12/31	As required for Precontractual Assessment and Annual DOA	MA 23B Compliance Reporting Requirements	Compliance	N/A	IPA Oversight / Compliance / Year	MMCM Chapter 21
Compliance-FWA Program policies and procedures	Annual	1/1-12/31	As required for Precontractual Assessment and Annual DOA	MA 23B Compliance Reporting Requirements	Compliance	N/A	IPA Oversight / Compliance / Year	Code of Federal Regulations, Title 42, Part 422 and 423; Code of Federal Regulations, Title 42, §438.608 and §455.2; Federal False Claims Act, US Code, Title 31; Health & Safety Code §1348; Welfare & Institutions Code, §14043.1

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Compliance-Sanction and Exclusion Screenings policies and procedures and evidence activity was conducted prior to hire and monthly thereafter.	Annual	1/1-/12/31	As required for Precontractual Assessment and Annual DOA	MA 23B Compliance Reporting Requirements	Compliance	N/A	Audits / 2022 DOA Audit	MMCM Chapter 21
Compliance - Standards/Code of Conduct and evidence of distribution to New Hires and Annually thereafter	Annual	1/1-/12/31	As required for Precontractual Assessment and Annual DOA	MA 24E Compliance Program Description	Compliance	N/A	Audits / 2022 DOA Audit	Code of Federal Regulations, Title 42 § 422.503(b)(4)(vi)(A)
Compliance - Copies of Compliance and FWA Trainings and evidence of completion records for New Hires and Annually thereafter.	Annual	1/1-/12/31	As required for Precontractual Assessment and Annual DOA	MA 23B Compliance Reporting Requirements	Compliance	N/A	Audits / 2022 DOA Audit	MMCM Chapter 21
Compliance - Compliance Committee Meeting Minutes and Sign Ins	Annual	1/1-/12/31	As required for Precontractual Assessment and Annual DOA	MA 24E Compliance Program Description	Compliance	N/A	Audits / 2022 DOA Audit	Code of Federal Regulations, Title 42 §438.608(a)(iii)
Compliance - Annual Compliance Work Plan	Annual	1/1-/12/31	As required for Precontractual Assessment and Annual DOA	MA 24E Compliance Program Description	Compliance	N/A	Audits / 2022 DOA Audit	Code of Federal Regulations, Title 42 §§ 422.503(b)(4)(vi)(F)and §§ 423.504(b)(4)(vi)(F)
Compliance - Annual Audit and Monitoring Plan	Annual	1/1-/12/31	As required for Precontractual Assessment and Annual DOA	MA 24E Compliance Program Description	Compliance	N/A	Audits / 2022 DOA Audit	Code of Federal Regulations, Title 42 §§ 422.503(b)(4)(vi)(F)and §§ 423.504(b)(4)(vi)(F)
Compliance - Annual Risk Assessment Report	Annual	1/1-/12/31	As required for Precontractual Assessment and Annual DOA	MA 24E Compliance Program Description	Compliance	N/A	Audits / 2022 DOA Audit	Code of Federal Regulations, Title 42 §§ 422.503(b)(4)(vi)(F)and §§ 423.504(b)(4)(vi)(F)

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Compliance - Employee Universe including temporary, interns, volunteers and Governing Board	Annual	1/1-/12/31	As required for Annual DOA	MA 23B Compliance Reporting Requirements	Compliance	N/A	Audits / 2022 DOA Audit	MMCM Chapter 21
Compliance - List of Downstream Entity/Subcontractors	Annual	1/1-/12/31	As required for Precontractual Assessment and Annual DOA	MA 24E Compliance Program Description	Compliance	N/A	Audits / 2022 DOA Audit	Code of Federal Regulations, Title 42 §§ 422.503(b)(4)(vi)(F)
Compliance- HIPAA Privacy Program policies and procedures	Annual	1/1-12/31	As required for Precontractual Assessment and Annual DOA	MA 23B Compliance Reporting Requirements	Compliance	N/A	Audits / 2022 DOA Audit	Code of Federal Regulations, Title 45, Part 160, 162, and 164; U.S. Dept. of Health and Human Services (DHHS), section 13402(h)(2) of Public Law 111-5 (HITECH ACT).
Compliance - Copies of HIPAA Privacy Training and evidence of completion records for New Hires and Annually thereafter.	Annual	1/1-/12/31	As required for Precontractual Assessment and Annual DOA	MA 23B Compliance Reporting Requirements	Compliance	N/A	Audits / 2022 DOA Audit	MMCM Chapter 21
Compliance- Confidentiality Statement and evidence of completion records for New Hires and Annually thereafter.	Annual	1/1-/12/31	As required for Annual DOA	MA_23B HIPAA Privacy and Security	Compliance	N/A	Audits / 2022 DOA Audit	Code of Federal Regulations, Title 45 §164.530(b)(1)
Compliance- HIPAA Privacy Incident Universe Report	Annual	1/1-/12/31	As required for Annual DOA	MA_23B HIPAA Privacy and Security	Compliance	N/A	Audits / 2022 DOA Audit	Code of Federal Regulations, Title 45 §164.530(i)(1) and §164.530(b)(1)

## Medicare Provider Reporting Requirements Schedule

IPA Medicare Calendar Year Reporting Period: 2023



IPA Deliverable	Report Frequency	CY 2023 Reporting Period	IEHP Due Date	IEHP Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Annual Audited Financial Statements, Including IBNR Certification Financial Statements, Including IBNR Certification	Annual	Fiscal Year	5 Months after end of your IPA's Fiscal Year	MC 19A - Financial Viability	Financial Analysis	IPACode_Annual Financial Statement_2022	Financial Statements	

*Version: November 2, 2020*

**MEDICARE-MEDICAID  
CAPITATED FINANCIAL ALIGNMENT MODEL  
REPORTING REQUIREMENTS**

Effective as of January 1, 2021; Issued November 2, 2020

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## INTRODUCTION

The Medicare-Medicaid Financial Alignment Initiative is designed to test innovative models to better align Medicare and Medicaid financing and the services provided to Medicare-Medicaid enrollees.

The purpose of this document is to provide Medicare-Medicaid Plans (MMPs) with the reporting requirements for the capitated financial alignment model. It provides technical specifications to help assure a common understanding of the data to be reported by MMPs, to assist MMPs in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to the Centers for Medicare & Medicaid Services (CMS) and the states, and to reduce the need for MMPs to correct and resubmit data.

The reporting requirements document is divided into three sections. The first section lists all Medicare Part C Reporting Requirements the MMPs are responsible for submitting via the Health Plan Management System (HPMS). The second section lists all Medicare Part D Reporting Requirements the MMPs are responsible for submitting via HPMS. Upon Office of Management and Budget (OMB) approval, MMPs are required to report these measures according to the existing specifications and must comply with the Part C and Part D data validation requirements.

The third section consists of the MMP-specific Core Reporting Requirements for the capitated financial alignment model. Specifications for these demonstration measures indicate their reporting frequency and due dates. MMPs are also required to comply with validation requirements for MMP-specific measures.

Measures should be reported at the contract level, unless otherwise indicated.

## Definitions

The following terms are used throughout the document:

Medicare-Medicaid Plan (MMP): An MMP is a managed care plan that has entered into a three-way contract with CMS and the state in which the plan will operate. Note: some demonstrations might use different terms to refer to their plans, such as One Care plans in Massachusetts.

State: The state with which the MMP has contracted.

Health Plan Management System (HPMS): The CMS centralized information system used by MMPs to submit Part C, Part D, and MMP-specific core measure data.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year are defined as follows: January 1 to March 31, April 1 to June 30, July 1 to September 30, and October 1 to December 31.

Calendar Year: All annual measures are reported on a calendar year basis. For example, CY 2021 represents January 1, 2021 through December 31, 2021.



## **Passive Enrollment and Stopping Enrollment**

Under the capitated financial alignment model, demonstrations may allow for passive enrollment. During passive enrollment, MMPs must demonstrate adequate performance across a range of measures to remain eligible to receive passive enrollment of beneficiaries. Failure to adequately meet any single measure or set of measures may result in CMS and the state ceasing enrollment. CMS and each state, through the Contract Management Team (CMT), will have the option to discontinue passive enrollment for MMPs for various reasons, including for MMPs failing to completely and accurately report measures or to adequately meet performance standards.

## **Quality Withhold Measures**

CMS and each state established a set of quality withhold measures, and MMPs are required to meet established thresholds. Throughout this document, CMS core quality withhold measures are marked with the following symbol for Demonstration Year 1: (i) and the following symbol for Demonstration Years 2 through 8: (ii). Note that additional CMS core quality withhold measures are reported through other vehicles or venues, such as HEDIS<sup>®</sup> and CAHPS<sup>®</sup>.<sup>1</sup> Any state-specific exceptions to the CMS core quality withhold measures, along with definitions of Demonstration Years, are noted in the state-specific quality withhold appendices. Additional information on the withhold methodology can be found at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html>.

## **Reporting on Passively Enrolled and Opt-In Enrolled Members**

When reporting all measures, MMPs should include all members who meet the criteria for inclusion in the measure, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

## **Reporting on Disenrolled and Retro-disenrolled Members**

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMP. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each MMP-specific core measure.

Due to retro-disenrollment of members, there may be instances where there is a lag between a member's effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data

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<sup>1</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA). CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and therefore was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are *not* required to re-submit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member's enrollment status.

### **Data Submission**

All MMPs will submit core measure data in accordance with the guidance in these reporting requirements. Submission requirements vary by measure, but most core measures are reported through HPMS.

Please note, late submissions may result in compliance action from CMS.

### **Resubmission of MMP-Specific Core Measure Data to HPMS**

MMPs must comply with the following steps to resubmit data for MMP-specific core measures after an established due date:

1. Email the applicable NORC HelpDesk to request resubmission.
  - a. Specify in the email which measure(s) need resubmission;
  - b. Specify for which reporting period(s) the resubmission is needed; and
  - c. Provide a brief explanation for why the data need to be resubmitted.
2. After review of the request, the NORC HelpDesk will notify the MMP that the resubmission can be completed.
3. Resubmit data through HPMS.
4. Notify the NORC HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.

## **MEDICARE PART C REPORTING REQUIREMENTS**

MMPs are required to report the following Part C reporting sections according to existing reporting requirements and technical specifications, which can be found on the CMS website at: <https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html>

Section VI. Rewards and Incentives Programs

Section VII. Payments to Providers

## **MEDICARE PART D REPORTING REQUIREMENTS**

MMPs are required to report the following Part D reporting sections according to existing reporting requirements and technical specifications, which can be found on the CMS website at: [https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting\\_ReportingOversight.html](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html)

Section II. Medication Therapy Management Programs

Section III. Grievances

Section IV. Improving Drug Utilization Review Controls

Section V. Coverage Determinations, Redeterminations, and Reopenings

## MMP-SPECIFIC CORE REPORTING REQUIREMENTS

### Introduction

The Core Reporting Requirements section consists of measures developed for all capitated financial alignment demonstrations. State-specific appendices capture the reporting requirements specific to each state's demonstration. The core and state-specific measures supplement existing Medicare Part C and Part D Reporting Requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS<sup>®</sup>, HOS, CAHPS<sup>®</sup> and state Medicaid agencies.<sup>2</sup> In addition, CMS and the states will track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

### Value Sets

The measure specifications in this section refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The Core Value Sets Workbook includes all value sets and codes needed to report certain MMP-specific measures included in the Core Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Core Value Sets Workbook can be found on the CMS website at the following address:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

### Reporting Phases

There are three distinct types of reporting phases for demonstration measures: "Implementation," "Ongoing," and "Continuous Reporting."

The Implementation phase corresponds with the initial months of the demonstration and will be further defined in the Introduction section of each state-specific appendix. Monitoring will be more intensive during this phase to allow CMS and the state to quickly become aware of any performance or access issues. MMPs will report measures on the Implementation reporting timeline during the Implementation phase only.

The Ongoing phase begins at the inception of the demonstration and continues for the life of the demonstration. MMPs will report measures on the Ongoing reporting timeline during the Ongoing phase. Note: Measures that have both an Implementation and Ongoing phase should be reported concurrently (e.g., Core Measure 2.1, Members with

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<sup>2</sup> HEDIS<sup>®</sup> is a registered trademark of NCQA. CAHPS<sup>®</sup> is a registered trademark of AHRQ.

an assessment completed within 90 days of enrollment). MMPs will cease reporting on the Implementation reporting timeline once the Implementation phase is complete. Some measures do not include an Ongoing phase, meaning data are collected only during the Implementation phase.

Continuous Reporting measures will be reported at the same frequency for the duration of the demonstration. The first reporting period for these measures coincides with the first reporting period of the Ongoing and Implementation phases.

Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for any core measure falls on a weekend or a federal holiday, MMPs may submit data on the following business day. Table 1 and Table 2 below are examples of reporting timelines that will be found throughout this section. The introduction of each state-specific appendix provides tables describing each state's Implementation, Ongoing, and Continuous Reporting periods.

**Table 1. Sample Implementation and Ongoing Reporting Timeline**

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
Example	Monthly, beginning after 90 days	Contract	Current Calendar Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
Example	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

**Table 2. Sample Continuous Reporting Timeline**

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
Example	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

**Measure Specifications**

Each measure specification includes information regarding the following subjects:

- A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.
- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- D. Analysis – how CMS will evaluate reported data, as well as how other data sources may be monitored.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.

## Section I. Access

- 1.1 Claims (excluding pharmacy point-of-sale [POS]) denied during the first 90 days of enrollment with the MMP, by reason for denial. – **Retired**
- 1.2 Pharmacy point-of-sale (POS) claims denied during passive enrollment, by reason for denial.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
1. Access	Every 14 days during the first month of a wave of passive enrollment (subsequent submissions may be necessary for MMPs that meet or exceed the threshold or have an insufficient sample size)	Contract	14 days Ex: 12:00a.m. on January 1st through 11:59p.m. on January 14th and 12:00a.m. on January 15th through 11:59p.m. on January 28th.	5:00p.m. ET three days following the end of the reporting period  Ex: Data is due by 5:00p.m. ET on January 17th for the reporting period that ends at 11:59p.m. ET on January 14th. Data is due by 5:00p.m. ET on January 31st for the reporting period that ends at 11:59p.m. ET on January 28th.

The list of pharmacy POS denied claims will be limited to claims denied for the following reasons: non-formulary, prior authorization, and step therapy. A template for providing these claims is located on the CMS website: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

- A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.
- Required file format is Microsoft Excel file.
  - The file name extension should be “.xlsx”
  - File name= RX\_(STATEABBREVIATION)\_(CONTRACTID)\_(REPORTING PERIOD)\_(SUBMISSIONDATE).xlsx.



- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the month and year of the beginning of the reporting period in YYYYMM format (e.g., January 2021 would be 202101), and (SUBMISSIONDATE) with the year, month, and day of the submission in YYYYMMDD format (e.g., January 17, 2021 would be 20210117).
- The first worksheet in the template should be named “Rejected Claims.”
- The second worksheet in the template should be named “Key Acronyms.”
- The third worksheet in the template should be named “Addl Reject Codes\_Pharmacy Msgs.”

### File Layout

Field Name	Field Description	Allowable Values
MBI	Medicare Beneficiary Identifier (MBI) refers to the number assigned to an individual for the purpose of identifying him/her as a Medicare beneficiary. MBI will be shown in the beneficiary's insurance card and it is on the basis of this number that a beneficiary's Medicare claims are processed.	Field Type: Alpha-numeric
Member Enrollment Date	Identifies the date that each member enrolled. Enrollment eligibility begins on the 1 <sup>st</sup> of the month. If a member has a gap in coverage, provide the most recent enrollment date.	Field Type: Date in MM/DD/YYYY format
Member Disenrollment Date	Identifies the date that each member disenrolled. Eligibility continues through the last day of the month that the member disenrolls.	Field Type: Date in MM/DD/YYYY format If a member is still enrolled during the reporting period, please insert 12/31/9999 to indicate the member is currently enrolled.
Cardholder ID	Insurance ID assigned to the cardholder or identification number used by the MMP. May be the same as MBI.	Field Type: Alpha-numeric

Field Name	Field Description	Allowable Values
CCN	Claim Control Number (CCN). A claim control number is a unique number given to each claim.	Field Type: Alpha-numeric
CMS Contract ID	Designation assigned by CMS that identifies a specific sponsor.	Field Type: Alpha-numeric
Plan Name	Plan Name	Field Type: Text
NDC 11 (no hyphens)	National Drug Code Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. FDA publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC.	Field Type: Numeric Note: 11-digit NDC code with no hyphens
Date of Service	Identifies date the prescription was filled. This date may be outside the reporting period as long as the associated Date of Rejection is after the Date of Service.	Field Type: Date in MM/DD/YYYY Format
Date of Rejection	Identifies the date the claim was rejected. The Date of Rejection must occur during the reporting period.	Field Type: Date in MM/DD/YYYY Format
Claim Quantity	Quantity dispensed expressed in metric decimal units.	Field Type: Numeric Allowable Values: >0
Claim Days Supply	Estimated number of days the prescription will last.	Field Type: Numeric Allowable Values: >0; < 999
Compound Code	Code indicating whether or not the prescription is a compound.	Field Type: Numeric Allowable Values: 0 = not specified 1 = not a compound 2 = compound
Rejection Category (1=NF, 2=PA, 3=ST)	Rejection Category: Use category 1 if the rejection is for Non-Formulary drug. Use category 2 if the rejection is for Prior Authorization. Use category 3 if the rejection is for Step Therapy.	Field Type: Numeric Allowable Values: 1=Non-Formulary 2=Prior Authorization 3=Step Therapy

Field Name	Field Description	Allowable Values
Reject Code 1	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 1	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 2	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 2	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 3	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 3	Reject Message used in MMP's claim adjudication system.	Field Type: Text
***MMP must provide all reject codes and messaging, not limited to the number of fields in the "Rejected Claims" template. Please insert columns in the "Addl Reject Codes_Pharmacy Msgs" template as necessary.***	Provide any additional reject codes and messaging.	

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- An audit of a sample of claims will be performed. Claims not excluded from the analysis will be flagged as “potentially inappropriate.” A sample of up to 30 potentially inappropriate claims will be selected for further review, including: protected class drugs and non-protected class drugs. If at least 15 protected and 15 non-protected class drugs are submitted, 15 protected and 15 non-protected class drugs will be sampled. If fewer than 15 claims are submitted in either drug class, additional claims from the opposing drug class will be selected, until a sample of 30 is reached (e.g., 13 protected and 17 non-protected drugs). If the MMP submits fewer than 30 rejected claims, the sample will consist of all submitted rejected claims. MMPs will be required to review claims and address the following:
  - Was the claim an appropriate rejection? (Y/N).
  - Patient setting (e.g., nursing facility, acute care hospital, etc.).
  - Patient DOB.
  - Provide a brief explanation as to why the claim was appropriate or inappropriate, related to one of the three rejection categories.

- Was the claim paid? (Y/N).
  - If the claim was paid, provide the date the claims was paid for the drug in question.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission. Any claims that do not pass validation will be excluded from the analysis. These checks will include the following:
- The CMS Contract ID is formatted as 5 alpha-numeric characters.
  - The CMS Contract ID matches the submitting Contract ID.
  - The NDC consists of 11 numeric characters.
  - The NDC is a valid NDC.
  - The Date of Service is in the MM/DD/YYYY format.
  - The Date of Rejection is in the MM/DD/YYYY format.
  - The Date of Rejection is during the reporting period.
  - The Date of Rejection is on or after the Date of Service.
  - The Rejection Category is 1, 2, or 3.
  - The Claim Quantity is greater than zero.
  - The Claim Days Supply is greater than zero.
  - The Claim Days Supply is between 1 and 3 numeric characters (1-999).
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will calculate an overall score once MMPs have reviewed and provided comments.
  - For all class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims sampled (denominator) to calculate an overall rate of inappropriate denials.
  - For protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.
  - For non-protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for non-protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- This measure assesses only the following three denial types: non-formulary, prior authorization, and step therapy.
  - Non-formulary drugs are drugs that are not on an MMP's formulary.
  - Prior Authorization is defined as approval that a member must get from the MMP before filing a prescription in order for the MMP to cover the

prescription. The MMP may require prior authorization for certain drugs.

- Step Therapy is a coverage rule used by some MMPs that requires a member to try one or more similar, lower cost drugs to treat their condition before the MMP will cover the prescribed drug.

#### Reporting Period Guidance

- The reporting period for this measure will begin at the start of the passive enrollment period. Once reporting begins, members should be included regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Passive enrollment periods may vary by state. MMPs should refer to their state's three-way contract for specific requirements.
- Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for Core Measure 1.2 falls on a weekend or holiday, MMPs may submit data on the following business day.

#### POS Claims Guidance

- MMPs should include all denied claims including adjusted and reprocessed claims, even if repeated claims are attempted on the same day.
- Denials ensuing from requests for early refills should be excluded.

#### Additional Submissions

- CMS reserves the right to extend the reporting frequency after the first wave of passive enrollment, if necessary.
- Subsequent 14-day submissions may be necessary for MMPs that meet or exceed the threshold or have an insufficient sample size. MMPs will receive an MMP-specific report indicating whether an MMP passed, failed, or had an insufficient sample size following the full 28-day period.
  - Any MMP that failed or had an insufficient sample size must undergo another round and must submit data during the next wave of passive enrollment (unless otherwise directed by the CMT).
  - For MMPs in states with monthly passive enrollment, the MMP must report the last 14 days of the next month of passive enrollment (i.e., days 14 through 28).
  - For MMPs with passive enrollment that is not month to month, the MMP must submit the first 14 days of the next wave of passive enrollment.
- MMPs that pass the first 28-day period will not need a subsequent round of review.

#### F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://hsagonline.sharepoint.com/teams/FAI/>

**Section II. Assessment**2.1 Members with an assessment completed within 90 days of enrollment.<sup>i</sup>

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
2. Assessment	Monthly during the implementation period, beginning after 90 days of implementation	Contract	Current Calendar Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period  Ex: Demo implementation is January 1, 2021; 90 days after enrollment is March 31, 2021; the first report is due by April 30, 2021.
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
2. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

- A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Field type: Numeric
B.	Total number of members who were documented as unwilling to participate in the assessment within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of A.  Unwillingness to participate must be clearly documented.
C.	Total number of members the MMP was unable to reach, following three documented outreach attempts, to participate in the assessment within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field type: Numeric  Note: Is a subset of A.  Three outreach attempts must be clearly documented.
D.	Total number of members with an assessment completed within 90 days of enrollment.	Of the total reported in A, the number of members with an assessment completed within 90 days of enrollment.	Field type: Numeric  Note: Is a subset of A.  Completed assessments must be clearly documented.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that the sum of data elements B, C, and D is less than or equal to data element A.
  - MMPs should validate that members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
  - MMPs should validate that members included in data element A were enrolled as of the last day of the reporting period.
  - MMPs should validate that members included in data element B were included in data element A.
  - MMPs should validate that members included in data element C were included in data element A.
  - MMPs should validate that members included in data element D were included in data element A.
  - MMPs should validate that members reported in data element B were not reported in data elements C or D.
  - MMPs should validate that members reported in data element C were not reported in data elements B or D.
  - MMPs should validate that members reported in data element D were not reported in data elements B or C.
  - MMPs should validate that members reported in data element B were clearly documented as unwilling to participate in the assessment within 90 days of enrollment.
  - MMPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.
  - MMPs should validate that members reported in data element D had a completed assessment clearly documented within 90 days of enrollment.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who:
- Were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
    - $\text{Percentage} = (B / A) * 100$
  - The MMP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
    - $\text{Percentage} = (C / A) * 100$



- Had an assessment completed within 90 days of enrollment.
  - Percentage =  $(D / A) * 100$
- Were willing to participate and who could be reached who had an assessment completed within 90 days of enrollment.
  - Percentage =  $(D / (A - B - C)) * 100$

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member's effective enrollment date.
  - When reporting quarterly results for Ongoing reporting periods, MMPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in Ongoing reporting for the third quarter as long as they were still enrolled on the last day of the reporting period).

#### Data Element B

- For data element B, MMPs should report the number of members who were documented as unwilling to participate in the assessment if a member (or his or her authorized representative):
  - Affirmatively declines to participate in the assessment, affirmatively declines care management activities overall, or refuses any contact with the MMP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the MMP.
  - Expresses willingness to complete the assessment but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 days). Discussions with the member must be documented by the MMP.
  - Schedules an appointment to complete the assessment but cancels or is a no-show and then is subsequently non-responsive to additional

outreach attempts by the MMP. All attempts to contact the member must be documented by the MMP.

- Initially agrees to complete the assessment, but then declines to answer a sufficient number of questions in the assessment, as determined by the MMP. The declination must be documented by the MMP.
- If a member was not reached after three outreach attempts, but then subsequently is reached and refuses the assessment within 90 days of enrollment, the member should be classified in data element B.

### Data Element C

- For data element C, MMPs should report the number of members the MMP was unable to reach after three documented attempts to contact the member. MMPs should refer to their state's three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email), as CMS and the state may validate this number. If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.
  - Note that the applicable three-way contract may require more than three outreach attempts. MMPs must continue to follow such contract requirements; however, for purposes of reporting this measure, MMPs may count a member under data element C following three outreach attempts.
- There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

### Data Element D

- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.
- If a member's assessment is in progress, but is not completed within 90 days of enrollment, then the assessment should not be considered completed, and therefore, the member should not be counted in data element D.
- If a member initially refused the assessment or could not be reached after three outreach attempts, but then subsequently completes the assessment within 90 days of enrollment, the member should be classified in data element D.

## General Guidance

- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).
- MMPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to Core Measure 2.3.
- Additional guidance is included in the state-specific reporting appendices. MMPs should refer to their state's reporting appendix for measure reporting variations from the Core Reporting Requirements and for information on reporting assessments completed by the MMP prior to a member's effective enrollment date, reporting assessments for members with a break in coverage, and reporting assessments completed previously by the MMP's affiliated product. Note that the applicability of such guidance varies across states.
- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within the required timeframe. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, MMPs should not include such members in the counts for data elements B or C.
- For additional guidance on identifying each data element, including examples and scenarios for correctly reporting members who may meet the criteria for multiple data elements, please reference the Core Measure 2.1 FAQ document located on the CMS website: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

### F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

## 2.2 Members with an assessment completed.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
2. Assessment	Monthly	Contract	Current Calendar Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members with an assessment completed within the reporting period.	Total number of members with an assessment completed within the reporting period.	Field Type: Numeric
B.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period.	Field type: Numeric  Note: This data element should not be reported until 90 days after implementation.
C.	Total number of members enrolled for 90 days or longer who had an assessment completed.	Of the total reported in B, the number of members enrolled for 90 days or longer who had an assessment completed.	Field type: Numeric  Note: Is a subset of B.  Note: This data element should not be reported until 90 days after implementation.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data element C is less than or equal to data element B.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will use enrollment data to evaluate the percentage of members:
- Who had an assessment completed within the reporting period.
    - Percentage =  $(A / \text{Total Members Enrolled}) * 100$
  - Enrolled for 90 days or longer as of the last day of the reporting period who had an assessment completed.
    - Percentage =  $(C / B) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).

#### Data Element B

- For data element B, MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through at least 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member's effective enrollment date.

#### Data Element C

- The members reported in data element C could have had an assessment completed at any time prior to the end of the reporting period, not necessarily during the current reporting period.

#### General Guidance

- MMPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to Core Measure 2.3.

- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state’s three-way contract for specific requirements.
- Data element A will be reported after the first month following the beginning of the Implementation period, whereas data elements B and C will not be reported until after 90 days.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

2.3 Members with an annual reassessment.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
2. Assessment	Annually	Contract	Calendar Year, beginning CY2	By the end of the second month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members enrolled as of the last day of the current reporting period.	Total number of members enrolled as of the last day of the current reporting period.	Field Type: Numeric
B.	Total number of members who had an assessment completed during the previous reporting period.	Of the total reported in A, the number of members who had an assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
C.	Total number of members with a reassessment completed during the current reporting period.	Of the total reported in B, the number of members who had a reassessment completed during the current reporting period.	Field Type: Numeric  Note: Is a subset of B.
D.	Total number of members with a reassessment completed within 365 days of the most recent assessment completed.	Of the total reported in C, the number of members with a reassessment completed during the current reporting period that occurred within 365 days of the most recent assessment completed during the previous reporting period.	Field Type: Numeric  Note: Is a subset of C.
E.	Total number of members who did not have an assessment completed during the previous reporting period.	Of the total reported in A, the number of members enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period.	Field Type: Numeric  Note: Is a subset of A.
F.	Total number of members with an assessment completed during the current reporting period.	Of the total reported in E, the number of members who had an assessment completed during the current reporting period.	Field Type: Numeric  Note: Is a subset of E.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data elements B and E are less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- MMPs should validate that data element D is less than or equal to data element C.
- MMPs should validate that data element F is less than or equal to data element E.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who:

- Had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period.
  - Percentage =  $(C / B) * 100$
- Had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period that was within 365 days of the most recent assessment completed during the previous reporting period.
  - Percentage =  $(D / B) * 100$
- Were enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period but had an assessment completed during the current reporting period.
  - Percentage =  $(F / E) * 100$

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.

Data Element B

- For reporting data element B, include all members who were enrolled as of the last day of the current reporting period who received an assessment (initial or reassessment) during the previous reporting period.

Data Element C

- For reporting data element C, include all members reported in data element B who had a reassessment completed at any time during the current reporting period.



### Data Element D

- For reporting data element D, include all members reported in data element C who had a reassessment completed during the current reporting period that was completed within 365 days of the date of the member's most recent assessment (initial or reassessment) completed during the previous reporting period.
  - For example, if a member was assessed twice during CY 2020 (previous reporting period), first on May 15, 2020 and again on October 15, 2020, count 365 days continuously from October 15, 2020 to determine if a reassessment occurred within 365 days.
  - In this example, if the member completes a reassessment on September 15, 2021, they would be included in data element D for CY 2021 reporting. Conversely, if the member's reassessment was not completed until November 15, 2021, they would not be included in data element D for CY 2021 reporting. In either case, the member would be captured in data element C.
- For members who disenroll and reenroll in the MMP, MMPs should count 365 days continuously from the member's most recent assessment date within the previous reporting period, even if that assessment was conducted during the member's prior enrollment period.

### Data Element E

- For reporting data element E, include all members who were enrolled as of the last day of the current reporting period, who were enrolled for at least 90 continuous days during the previous reporting period who did not receive an assessment (initial or reassessment) during the previous reporting period.
  - For members who disenroll and reenroll in the MMP, MMPs should include members who had any continuous enrollment of 90 days or more in the previous year, even if that enrollment preceded a break in coverage by the MMP.
  - 90 days of enrollment will be equivalent to three full calendar months.

### Data Element F

- For reporting data element F, include all members reported in data element E who had an assessment completed at any time during the current reporting period.

### General Guidance

- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.

- For reporting all data elements, MMPs should report unduplicated counts of members meeting the criteria for each data element. Members with more than one assessment or reassessment completed during a reporting period should be reported only once in the relevant data elements.
- In certain circumstances, a member with a break in coverage who reenrolls in the MMP and has an assessment completed upon reenrollment during the current reporting period may be reported under both Core Measure 2.1 and Core Measure 2.3.
  - For example, consider a member that was previously assessed on June 15, 2020, subsequently disenrolled on October 1, 2020, reenrolled on January 1, 2021, assessed again on February 15, 2021, and remained enrolled as of December 31, 2021. The member would be counted in Quarter 1 2021 reporting for Core Measure 2.1 (data elements A and D) and in CY 2021 reporting for Core Measure 2.3 (data elements A, B, C, and D).
- The term “current reporting period” in data elements A, C, D, and F refers to the current calendar year. The term “previous reporting period” in data elements B, D, and E refers to the prior calendar year.
- This measure is reported starting with the MMP’s second year of operation (i.e., Calendar Year 2). All MMPs that have operated for at least two years must report the measure.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

**Section III. Care Coordination**

- 3.1 Members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care. (modified from NQF #0648) – **Retired**
- 3.2 Members with a care plan completed within 90 days of enrollment.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
3. Care Coordination	Monthly during the implementation period, beginning after 90 days of implementation	Contract	Current Calendar Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period  Ex: Demo implementation is January 1, 2021; 90 days after enrollment is March 31, 2021; the first report is due by April 30, 2021.
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
3. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

- A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Field type: Numeric
B.	Total number of members who were documented as unwilling to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of A.  Unwillingness to participate must be clearly documented.
C.	Total number of members the MMP was unable to reach, following three documented outreach attempts, to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment.	Field type: Numeric  Note: Is a subset of A.  Three outreach attempts must be clearly documented.
D.	Total number of members with a care plan completed within 90 days of enrollment.	Of the total reported in A, the number of members with a care plan completed within 90 days of enrollment.	Field type: Numeric  Note: Is a subset of A.  Completed care plans must be clearly documented.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that the sum of data elements B, C, and D is less than or equal to data element A.
  - MMPs should validate that members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
  - MMPs should validate that members included in data element A were enrolled as of the last day of the reporting period.
  - MMPs should validate that members included in data element B were included in data element A.
  - MMPs should validate that members included in data element C were included in data element A.
  - MMPs should validate that members included in data element D were included in data element A.
  - MMPs should validate that members reported in data element B were not reported in data elements C or D.
  - MMPs should validate that members reported in data element C were not reported in data elements B or D.
  - MMPs should validate that members reported in data element D were not reported in data elements B or C.
  - MMPs should validate that members reported in data element B were clearly documented as unwilling to complete the care plan within 90 days of enrollment.
  - MMPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.
  - MMPs should validate that members reported in data element D had a completed care plan clearly documented within 90 days of enrollment.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who:
- Were documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment.
    - Percentage =  $(B / A) * 100$
  - The MMP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment.
    - Percentage =  $(C / A) * 100$

- Had a care plan completed within 90 days of enrollment.
  - Percentage =  $(D / A) * 100$
- Were willing to participate and who could be reached who had a care plan completed within 90 days of enrollment.
  - Percentage =  $(D / (A - B - C)) * 100$

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member's effective enrollment date.
  - When reporting quarterly results from Ongoing reporting periods, MMPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in Ongoing reporting for the third quarter as long as they were still enrolled on the last day of the reporting period).

#### Data Element B

- For data element B, MMPs should report the number of members who were documented as unwilling to complete a care plan if a member (or his or her authorized representative):
  - Affirmatively declines to complete the care plan, affirmatively declines care management activities overall, or refuses any contact with the MMP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the MMP.
  - Expresses willingness to complete the care plan but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the care plan within 90 days). Discussions with the member must be documented by the MMP.
  - Schedules an appointment to complete the care plan but cancels or is a no-show and then is subsequently non-responsive to additional

outreach attempts by the MMP. All attempts to contact the member must be documented by the MMP.

- Initially agrees to complete the care plan, but then declines to participate in the development of the care plan. The declination must be documented by the MMP.
- If a member could not be reached after three outreach attempts, but then subsequently is reached and refuses to complete a care plan within 90 days of enrollment, the member should be classified in data element B.

### Data Element C

- For data element C, MMPs should report the number of members the MMP was unable to reach after three documented attempts to contact the member. The three documented outreach attempts to contact the member must be for the purpose of completing the care plan.
  - If an MMP was able to reach a member for the purpose of completing only an assessment, at least three new and distinct outreach attempts for the purpose of completing the care plan must be made and documented.
  - However, if an MMP was unable to reach a member for the purpose of completing both an assessment and a care plan, and has documented three unsuccessful outreach attempts, the MMP is not expected to make additional outreach attempts about the completion of a care plan. The MMP would report this member in data element C.
- MMPs should refer to their state's three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email), as CMS and the state may validate this number. If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.
  - Note that the applicable three-way contract may require more than three outreach attempts. MMPs must continue to follow such contract requirements; however, for purposes of reporting this measure, MMPs may count a member under data element C following three outreach attempts.
- There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

### Data Element D

- The requirements for care plan development may vary by state. The care plan should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.

- If a member's care plan is in progress, but is not completed within 90 days of enrollment, then the care plan should not be considered completed, and therefore, the member should not be counted in data element D.
- MMPs should only report completed care plans where the member or the member's authorized representative was involved in the development of the care plan.
- If a member initially refused to complete a care plan or could not be reached after three outreach attempts, but then subsequently completes a care plan within 90 days of enrollment, the member should be classified in data element D.

### General Guidance

- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).
  - MMPs should only report members with an initial care plan for this measure.
  - Additional guidance is included in the state-specific reporting appendices. MMPs should refer to their state's reporting appendix for measure reporting variations from the Core Reporting Requirements and for information on reporting care plans completed by the MMP prior to a member's effective enrollment date, reporting care plans for members with a break in coverage, and reporting care plans completed previously by the MMP's affiliated product. Note that the applicability of such guidance varies across states.
  - There may be certain circumstances that make it impossible or inappropriate to complete a care plan within the required timeframe. For example, a member may be medically unable to participate and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a care plan. However, MMPs should not include such members in the counts for data elements B or C.
  - For additional guidance on identifying each data element, including examples and scenarios for correctly reporting members who may meet the criteria for multiple data elements, please reference the Core Measure 3.2 FAQ document located on the CMS website: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).



## Section IV. Enrollee Protections

4.1 Part D Appeals. – **Retired**; see *Part D Reporting Requirements Section V – Coverage Determinations, Redeterminations, and Reopenings* for required reporting.

4.2 Grievances and Appeals.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
4. Enrollee Protections	Monthly	Contract	Current Calendar Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
4. Enrollee Protections	Annually	Contract	Calendar Quarters Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the final quarterly reporting period

Note: MMPs should report all **non-Part D (i.e., Part C, Medicaid, and supplemental benefit) grievances and appeals for data elements A-S**, in addition to reporting the already required Medicare Part D appeals and grievances as follows:

- Part D grievances are reported according to Part D Reporting Requirements (see Part D Section III Grievances);
- Part D appeals are reported according to Part D Reporting Requirements (see Part D Section V Coverage Determinations, Redeterminations, and Reopenings);

Medicare Part D Reporting Requirements can be found on the CMS website at: [https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting\\_ReportingOversight.html](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html).

- A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

### Grievances

Element Letter	Element Name	Definition	Allowable Values
A.	Total Grievances – Total number of grievances.	Total number of grievances for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric
B.	Grievance Timeliness – Total number of grievances for which the MMP provided timely notification of its decision.	Of the total reported in A, the number of grievances for which the MMP provided timely notification of its decision during the reporting period.	Field Type: Numeric. Note: Is a subset of A.
C.	Grievance Category – Total number of grievances related to access to care.	Of the total reported in A, the number of grievances related to access to care for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Grievance Category – Total number of grievances related to transportation.	Of the total reported in A, the number of grievances related to transportation for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric. Note: Is a subset of A.
E.	Grievance Category – Total number of grievances related to billing.	Of the total reported in A, the number of grievances related to billing for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of A.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
F.	Grievance Category – Total number of grievances related to home health/personal care.	Of the total reported in A, the number of grievances related to home health/personal care for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric.  Note: Is a subset of A.
G.	Grievance Category – Total number of other grievances not related to categories mentioned above.	Of the total reported in A, the number of other grievances not related to categories mentioned above for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric  Note: Is a subset of A.

### Appeals

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
H.	Total Appeals – Total number of appeals.	Total number of appeals for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric
I.	Appeal Timeliness – Total number of appeals for which the MMP provided timely notification of its decision.	Of the total reported in H, the number of appeals for which the MMP provided timely notification of its decision during the reporting period.	Field Type: Numeric  Note: Is a subset of H.
J.	Appeal Decision – Total number of appeals for which the MMP's decision was fully favorable.	Of the total reported in H, the number of appeals for which the MMP provided notification of a fully favorable decision within the reporting period.	Field Type: Numeric  Note: Is a subset of H.

Element Letter	Element Name	Definition	Allowable Values
K.	Appeal Decision – Total number of appeals for which the MMP’s decision was partially favorable.	Of the total reported in H, the number of appeals for which the MMP provided notification of a partially favorable decision within the reporting period.	Field Type: Numeric Note: Is a subset of H.
L.	Appeal Decision – Total number of appeals for which the MMP’s decision was adverse.	Of the total reported in H, the number of appeals for which the MMP provided notification of an adverse decision within the reporting period.	Field Type: Numeric Note: Is a subset of H.
M.	Appeal Category – Total number of appeals related to denial or limited authorization of specialty services.	Of the total reported in H, the number of appeals related to denial or limited authorization of specialty services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H.
N.	Appeal Category – Total number of appeals related to denial or limited authorization of HCBS services.	Of the total reported in H, the number of appeals related to denial or limited authorization of HCBS services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H.

Element Letter	Element Name	Definition	Allowable Values
O.	Appeal Category – Total number of appeals related to denial or limited authorization of institutional services.	Of the total reported in H, the number of appeals related to denial or limited authorization of institutional services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric  Note: Is a subset of H.
P.	Appeal Category – Total number of appeals related to denial or limited authorization of mental health services.	Of the total reported in H, the number of appeals related to denial or limited authorization of mental health services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric  Note: Is a subset of H.
Q.	Appeal Category – Total number of appeals related to denial or limited authorization of substance use treatment services.	Of the total reported in H, the number of appeals related to denial or limited authorization of substance use treatment services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric  Note: Is a subset of H.
R.	Appeal Category – Total number of post-service payment appeals.	Of the total reported in H, the number of post-service payment appeals for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric  Note: Is a subset of H.  Note: This data element should <u>not</u> include post-service payment appeals from contract providers.

Element Letter	Element Name	Definition	Allowable Values
S.	Appeal Category – Total number of other appeals not related to categories mentioned above.	Of the total reported in H, the number of other appeals not related to categories mentioned above for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric  Note: Is a subset of H.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that the sum of data elements C, D, E, F, and G is equal to data element A.
- MMPs should validate that the sum of data elements J, K, and L is equal to data element H.
- MMPs should validate that the sum of data elements M, N, O, P, Q, R, and S is equal to data element H.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

CMS and the state will use enrollment data to evaluate the following per 10,000 member months:

- Total number of grievances
  - Rate =  $(A / \text{Total Member Months}) * 10,000$
- Total number of grievances related to:
  - Access to care
    - Rate =  $(C / \text{Total Member Months}) * 10,000$
  - Transportation
    - Rate =  $(D / \text{Total Member Months}) * 10,000$
  - Billing
    - Rate =  $(E / \text{Total Member Months}) * 10,000$
  - Home health/personal care
    - Rate =  $(F / \text{Total Member Months}) * 10,000$
  - Other grievances
    - Rate =  $(G / \text{Total Member Months}) * 10,000$
- Total number of appeals
  - Rate =  $(H / \text{Total Member Months}) * 10,000$

- Total number of appeals related to:
  - Denial or limited authorization of specialty services
    - Rate =  $(M / \text{Total Member Months}) * 10,000$
  - Denial or limited authorization of HCBS services
    - Rate =  $(N / \text{Total Member Months}) * 10,000$
  - Denial or limited authorization of institutional services
    - Rate =  $(O / \text{Total Member Months}) * 10,000$
  - Denial or limited authorization of mental health services
    - Rate =  $(P / \text{Total Member Months}) * 10,000$
  - Denial or limited authorization of substance use treatment services
    - Rate =  $(Q / \text{Total Member Months}) * 10,000$
  - Post-service payment appeals
    - Rate =  $(R / \text{Total Member Months}) * 10,000$
  - Other appeals
    - Rate =  $(S / \text{Total Member Months}) * 10,000$

CMS and the state will evaluate the percentage of appeals for which the MMP's decision was:

- Fully favorable
  - Percentage =  $(J / H) * 100$
- Partially favorable
  - Percentage =  $(K / H) * 100$
- Adverse
  - Percentage =  $(L / H) * 100$

CMS and the state will evaluate the percentage of:

- Grievances for which the MMP provided timely notification of its decision
  - Percentage =  $(B / A) * 100$
- Appeals for which the MMP provided timely notification of its decision
  - Percentage =  $(I / H) * 100$

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Grievances

- If a member files a grievance and then files a subsequent grievance on the same issue prior to the MMP's decision or deadline for decision notification (whichever is earlier), the issue is counted as one grievance.
- If a member files a grievance and then files a subsequent grievance on the same issue after the MMP's decision or deadline for decision notification (whichever is earlier), the issue is counted as a separate grievance.
- MMPs should include oral grievances, even if the oral grievance was resolved during the call.
- MMPs should exclude grievances that were withdrawn or dismissed. MMPs should also exclude grievances only made through the CMS Complaints Tracking Module.

- A grievance involving multiple issues should be reported under each applicable category and also counted the corresponding number of times under data element A.
  - For example, if the MMP receives a grievance that involves two issues – access to care and billing – the grievance would be reported under both data elements C and E and reported twice under data element A.
- Access to care grievances reported in data element C should include grievances related to inability to get an appointment with a provider, excessive wait times for an appointment with a provider, inability to access a provider who demonstrates cultural competency, inability to access a provider who can communicate with the member in his/her primary language or via a translation service, and inability to access a provider that offers sufficient accommodations for the member's disability. Note that this category does not include grievances related to transportation used to access providers, as those grievances would be reported under data element D.
- Home health/personal care grievances reported in data element F should include all grievances related to home health/personal care benefits, such as (but not limited to) issues with the demeanor of the home health/personal care aide, tardiness/absenteeism from the home health/personal care aide, and quality of home health/personal care provided.

### Appeals

- Only appeals decided by the MMP should be included in the measure (i.e., do not include appeal decisions made by the Independent Review Entity, Quality Improvement Organization, and/or state fair hearing agency).
- Include appeals that were requested by the member, the member's authorized representative, or a provider making the request on behalf of the member. Do not include appeals from contract providers that are governed under the contractual arrangement between the MMP and the provider.
- MMPs should exclude appeals that were withdrawn or dismissed.
- For data elements M through Q, appeals related to the denial or limited authorization of a service should also include reductions, suspensions, or terminations of a previously authorized service.
- For data element M, specialty services are defined as any service or medical care provided or directed by a "specialist" (as opposed to a Primary Care Provider) that would not be a service offered by a Primary Care Provider or fitting into another category.
  - Specialty service providers should include occupational/physical/speech therapy, dental, vision, transportation, and durable medical equipment.
  - Primary Care Provider will be defined in the state-specific appendix.
- For data element R, MMPs should include all payment disputes (i.e., requests for payment and requests for adjustment to the paid amount), regardless if the appeal is made by the member, the member's authorized representative, or a non-contract provider who signed a Waiver of Liability. Duplicate



payment appeals should be counted only once. Do not include payment disputes from contract providers.

#### General Guidance

- As noted above, MMPs should report all non-Part D (i.e., Part C, Medicaid, and supplemental benefit) grievances and appeals under this measure.
- There are no minimum enrollment criteria for this measure. All grievances and appeals should be reported regardless of how long a member has been enrolled in the MMP or if he/she has disenrolled from the MMP prior to the end of the reporting period.
- The date the MMP notified the member of its decision should be used to assess which reporting period the grievance or appeal should be reported within.
  - For example, if a grievance was received on March 24 and the MMP provided notification of its decision on April 4, then the grievance would be included in the second quarter when reporting this measure.
- MMPs should refer to their state's three-way contract for definitions of timely grievance and appeal resolution for purposes of reporting data elements B and I.

#### F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

## Section V. Organizational Structure and Staffing

### 5.1 Care coordinator to member ratio.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
5. Organizational Structure and Staffing	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
5. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of full time equivalent (FTE) care coordinators working on the Demonstration.	Total number of FTE care coordinators working on the Demonstration as of the last day of the reporting period.	Field Type: Numeric
B.	Total FTE care coordinators assigned to care management and conducting assessments.	Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of FTE care coordinators that left the MMP.	Total number of FTE care coordinators that left the MMP during the reporting period.	Field type: Numeric

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data element B is less than or equal to data element A.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

Note: This measure is not adjusted for case mix, and care coordination will vary for each demonstration and each MMP’s care plan model structure. Therefore, this measure will be used solely to track care coordination investments and changes in each MMP’s care coordinator to member ratio longitudinally.

CMS and the state will:

- Use enrollment data to evaluate the number of members per FTE care coordinator.
    - Rate = (Total Members Enrolled / A)
  - Evaluate the percentage of FTE care coordinators who were assigned to care management and conducting assessments.
    - Percentage = (B / A) \* 100
  - Evaluate the percentage of FTE care coordinators that left the MMP during the reporting period.
    - Percentage = (C / (C + A)) \* 100
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- MMPs should refer to their state’s three-way contract for the definition of care coordinator. Different terms may be used in different states.
- FTE is defined as full time equivalent.

Data Element C

- Data element C includes care coordinators who are assigned to a different role within the MMP.

General Guidance

- To calculate the number of FTE care coordinators, add up all of the care coordinators' work hours during the reporting period and divide this value by the number of normal working hours for one full-time employee that occurred during the reporting period.
  - In instances where care coordinators support multiple lines of business, include only the time associated with the demonstration/MMP.
- For all data elements, FTE reported values should be rounded to the nearest positive integer.
- All part-time and full-time care coordinators will be counted, regardless of whether they are subcontracted or employed directly by the MMP.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

5.2 Annual staffing worksheets. – **Retired**

5.3 Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with contractual requirements.<sup>i</sup>

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
5. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

MMPs will be required to submit information on each consumer advisory board and/or governance board meeting during the annual reporting period. One template per meeting should be completed and submitted. A template for providing information is located on the CMS website: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

- A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Date.	Date each meeting occurred during the annual reporting period.	Field Type: Numeric  Note: Date in YYYYMMDD Format.  Note: MMPs should input data into the template provided by CMS.
B.	Total number of board members invited.	Count of all consumer advisory board/governance board members invited to the meeting.	Field Type: Numeric  Note: MMPs should input data into the template provided by CMS.
C.	Total number of board members in attendance.	Count of all consumer advisory board/governance board members in attendance either in-person or remotely.	Field Type: Numeric  Note: MMPs should input data into the template provided by CMS.  Note: Is a subset of B.
D.	Total number of board members invited who are actual beneficiaries or family caregivers.	Count of board members invited who are actual beneficiaries or family caregivers. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: Numeric  Note: MMPs should input data into the template provided by CMS.  Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of board members who are actual beneficiaries or family caregivers in attendance.	Count of board members who are actual beneficiaries or family caregivers in attendance either in-person or remotely. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: Numeric  Note: MMPs should input data into the template provided by CMS.  Note: Is a subset of both C and D.
F.	Agenda.	Agenda for each meeting during the annual period.	Field Type: N/A  Note: MMPs should input data into the template provided by CMS.
G.	Minutes.	Minutes for each meeting held during the annual reporting period.	Field Type: N/A  Note: MMPs should input data into the template provided by CMS.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- Meeting dates are within the performance period.
  - MMPs should validate that the number of members reported in data element C is a subset of the number of members reported in data element B.
  - MMPs should validate that the number of members reported in data element D is a subset of the number of members reported in data element B.
  - MMPs should validate that the number of members reported in data element E is a subset of the number of members reported in each of the data elements C and D.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the:

- Number of board meetings per quarter.
- Number of board meetings per quarter with beneficiaries or family caregivers in attendance.
- Percentage of invited board members who are beneficiaries or family caregivers.
  - $(\text{Sum of D across meetings}) / (\text{Sum of B across meetings}) * 100$
- Percentage of board members in attendance who are beneficiaries or family caregivers.
  - $(\text{Sum of E across meetings}) / (\text{Sum of C across meetings}) * 100$

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should submit one Microsoft Word template per meeting.
- For reporting data elements B, C, D, and E, MMPs should only include established consumer advisory board/governance board members.
- MMPs should only include a total count of the members who satisfy each data element; MMPs are no longer required to provide the full names of the members/board members.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://hsagonline.sharepoint.com/teams/FAI/>
- Required File Format is Microsoft Word File.
- The file name extension should be “.docx”.
- File name = (STATEABBREVIATION)\_(CONTRACTID)\_(REPORTING PERIOD)\_(MEETINGDATE).docx.
- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year of the reporting period in YYYY format (e.g., 2021), (MEETINGDATE) with the year, month, and date of the meeting in YYYYMMDD format (e.g., March 31, 2021 would be 20210331).

## Section VI. Performance and Quality Improvement

- 6.1 Screening for Clinical Depression and Follow-up Plan. (modified from NQF #0418)<sup>ii</sup> – **Retired**

## Section VII. Provider Network

- 7.1 Medicare Provider Network.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
7. Provider Network	Annually	Contract	Current network as of the date of submission.	By the third Tuesday of September

- A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	MMP Health Service Delivery Provider Table	Refer to MMP Medicare Network Submission Guidance for data definitions.	Field Type: Data Entry
B.	MMP Health Service Delivery Facility Table	Refer to MMP Medicare Network Submission Guidance for data definitions.	Field Type: Data Entry

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will assess Health Service Delivery (HSD) tables against Medicare MMP standards that are available on the CMS website.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm HSD tables will properly upload into HPMS using the plan upload functionality.
  - MMPs should validate that MMP Medicare Networks meet MMP standards using the plan upload functionality prior to the MMP Medicare Network Annual submission.



D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS will assess the submitted HSD tables against the MMP Medicare Network Standards.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should refer to the MMP Medicare Network Submission Guidance that will be issued separately for the relevant reporting year and posted on the CMS website: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPApplicationandAnnualRequirements.html>.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

## Section VIII. Systems

8.1 Long Term Services and Supports (LTSS) clean claims paid within 30 days, 60 days, and 90 days.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
8. Systems	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of LTSS clean claims paid within the reporting period.	Total number of LTSS clean claims paid within the reporting period.	Field Type: Numeric
B.	Total number of clean claims paid within 30 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 30 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of clean claims paid within 60 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 60 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of clean claims paid within 90 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 90 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of LTSS clean claims that were paid within:
- 30 calendar days of receipt.
    - Percentage =  $(B / A) * 100$
  - 60 calendar days of receipt.
    - Percentage =  $(C / A) * 100$
  - 90 calendar days of receipt.
    - Percentage =  $(D / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- Long Term Services and Supports (LTSS) will be defined in the state-specific appendix.
- A clean claim is one that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

#### General Guidance

- The 30-, 60-, and 90-day cutoffs should be calculated using individual calendar days, unlike Core Measures 2.1, 2.2, 2.3, and 3.2 where “90 days of enrollment” is considered equivalent to three full calendar months.
  - MMPs should include LTSS clean claims if they were paid during the reporting period. LTSS clean claims submitted during the reporting period, but not paid during the reporting period, should not be included.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

## Section IX. Utilization

### 9.1 Emergency department (ED) behavioral health services utilization.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
9. Utilization	Annually	Contract	Calendar Quarters Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the final quarterly reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of ED visits with a principal diagnosis related to behavioral health.	Total number of ED visits with a principal diagnosis related to behavioral health during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.

- N/A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will use enrollment data to evaluate the total number of ED visits with a principal diagnosis related to behavioral health per 10,000 member months during the reporting period.
  - $\text{Rate} = (A / \text{Total Member Months}) * 10,000$

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- MMPs should include all ED visits with a principal diagnosis related to behavioral health for members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should use the ED value set to identify ED visits. MMPs should use facility claims to identify ED visits.
- MMPs should use the Mental Health Diagnosis value set to identify a behavioral health diagnosis.
- If there are two different ED visits with the same date of service within the reporting period (and there are two separate, adjudicated claims), then both ED visits should be reported in data element A. Adjudicated claims refers to claims that are in final status, including paid claims and denied claims. Pending claims should not be included.

Data Element A Exclusion

- MMPs should exclude ED visits followed by admission to an acute or nonacute inpatient care setting (same or different facility as ED visit) on the date of the ED visit. To identify admissions to an acute or nonacute inpatient care setting:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
  - Identify the admission date for the stay

An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay and should be excluded from data element A.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

9.2 Nursing Facility (NF) Diversion.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
9. Utilization	Annually	Contract	Calendar Year, beginning CY2	By the end of the second month following the last day of the reporting period

- A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members who were continuously enrolled in the MMP for at least 5 out of the last 6 months during the previous reporting period <b>and</b> continuously enrolled in the MMP for at least 11 out of 12 months during the current reporting period.	Total number of members who were continuously enrolled in the MMP for at least 5 out of the last 6 months during the previous reporting period <b>and</b> continuously enrolled in the MMP for at least 11 out of 12 months during the current reporting period.	Field Type: Numeric
B.	The total number of members who were classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Of the total reported in A, the number of members who were classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who did not reside in a NF for more than 100 continuous days during the current reporting period.	Of the total reported in B, the number of members who did not reside in a NF for more than 100 continuous days during the current reporting period.	Field Type: Numeric Note: Is a subset of B.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data element B is less than or equal to data element A.
  - MMPs should validate that data element C is less than or equal to data element B.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- For members classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period, CMS and the state will evaluate the percentage of members who did not reside in a NF for more than 100 continuous days during the current reporting period.
    - Percentage =  $(C / B) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- For the purposes of this measure, the “previous reporting period” is defined as the previous calendar year. The “current reporting period” is defined as the current calendar year.
  - For example, for data submitted on February 28, 2022, the previous reporting period is January 1, 2020 – December 31, 2020, and the current reporting period is January 1, 2021 – December 31, 2021.
- The member must be enrolled as of the last day of both the previous and current reporting periods to be included in this measure.
- For reporting members in data element A, members must meet both continuous enrollment criteria in order to be included in this data element. Therefore, the member must be continuously enrolled as a Medicare-Medicaid member in the MMP for at least 5 out of the last 6 months during the previous reporting period **and** continuously enrolled as a Medicare-Medicaid member in the MMP for at least 11 out of 12 months during the current reporting period. Members meeting these criteria for only one of the reporting periods should not be included in data element A.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each reporting period (i.e., July through December [previous reporting period] and January through December [current reporting

period]). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

#### Data Element A Exclusions

- MMPs should exclude members who are transitioned to hospice services in either the current or previous reporting periods when reporting this measure. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Encounter and Hospice Intervention value sets), or supplemental data.
- MMPs should exclude members who expired in either the current or previous reporting period when reporting this measure using the Discharges due to Death value set.

#### Data Element B

- Nursing home certifiable members are defined as members living in the community but requiring an institutional level of care. Additionally, members who have a stay in a NF may be considered nursing home certifiable depending on the length of stay. MMPs should refer to their state's specific definition for additional information.
- To identify members for inclusion in data element B, MMPs should first identify all members who were nursing home certifiable for more than 100 continuous days at any point during the previous reporting period (January through December). Then, MMPs should exclude any of these members who resided in a NF for at least 101 continuous days during the previous reporting period.
  - For example, a member who entered a NF on September 4 and remained there on December 31 of the previous reporting period has more than 100 continuous days in a NF in the previous reporting period (119 days within the previous reporting period) and would not be included in data element B. A member who entered a NF on October 4 of the previous reporting period and remained there through February 1 of the current reporting period would not have more than 100 continuous days in a NF during the previous reporting period (residing there only 89 days during the previous reporting period) and would be included in data element B as long as they were nursing home certifiable for more than 100 continuous days during the previous reporting period.
  - MMPs should use all available data to document and confirm a member's status as nursing home certifiable. In the event of missing data for members who had a single, 1-month-long gap in coverage during the previous reporting period and who were documented as nursing home certifiable before the 1-month gap and after the 1-month



gap, MMPs may assume that the member was nursing home certifiable during the 1-month gap.

### Data Element C

- For reporting data element C, MMPs should exclude all members who reached their 101st continuous day of a NF stay during the current reporting period. This may include members who entered the NF within the **previous** reporting period as well as members who entered the NF during the **current** reporting period.
  - For example, a member who entered a NF on October 4 of the previous reporting period and remained there on February 1 of the current reporting period reached his or her 101st day on January 13 and, therefore, would be excluded from data element C. Alternatively, a member who entered a NF on August 1 of the current reporting period and remained there on December 31 of the current reporting period reached his or her 101st day on November 9 and would also be excluded from data element C.

### General Guidance

- For data elements B and C, when determining the number of continuous days a member resided in the NF, if a member is transferred or discharged from the NF and then is readmitted to any NF within 30 days, the transfer/discharge and subsequent readmission do not disrupt the count of continuous days.
  - For example, if a member is transferred from the NF to the hospital on day 57 and is subsequently readmitted to the same or a different NF 29 days later, this will be counted as the same episode. The member's first day after returning to a NF (i.e., the day the member is readmitted to the NF) will count as day 58 for that episode, not as day 1.
  - If a member is transferred from the NF and then is readmitted to any NF after 30 days, the date of readmission is the start of a new episode in the NF and will count as day 1 toward the member's continuous days in the facility.
- NF services are those services provided by nursing homes certified by Medicaid, Medicare, or other state agencies. NF includes skilled nursing facilities (not Adult Family Care Homes [AFCH], Assisted Living Facilities [ALF], Intermediate Care Facilities [ICF], or Supportive Living Facilities [SLF]).
- This measure is reported starting with the MMP's second year of operation (i.e., Calendar Year 2). All MMPs that have operated for at least two years must report the measure.

#### F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

## 9.3 Minimizing Institutional Length of Stay.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
9. Utilization	Annually	Contract	Calendar Year, beginning CY2	By the end of the fourth month following the last day of the reporting period

A. Data Element Definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of admissions to institutional facilities.	Total number of admissions to institutional facilities between July 1 of the year prior to the reporting period and June 30 of the current reporting period for members who were continuously enrolled from the date of the institutional facility admission (IFA) through 160 days following the IFA date, with no gaps in enrollment.	Field Type: Numeric
B.	Total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission.	Of the total reported in A, the number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of expected discharges to the community.	Total number of expected discharges to the community for all admissions in data element A.	Field Type: Numeric

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data element B is less than or equal to data element A.
  - MMPs should validate that data element C is less than or equal to data element A.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. An observed performance rate, expected performance rate, and the ratio of observed to expected rates are reported.
- For the total number of admissions to institutional facilities, CMS and the state will evaluate the percentage of observed discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission. (Observed Performance Rate)
    - $\text{Percentage} = (B / A) * 100$
  - For the total number of admissions to institutional facilities, CMS and the state will evaluate the percentage of expected discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission. (Expected Performance Rate)
    - $\text{Percentage} = (C / A) * 100$
  - CMS and the state will evaluate the ratio of observed to expected discharge rates.
    - $\text{Observed Performance Rate} / \text{Expected Performance Rate}$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- An institutional facility (i.e., institution) is a Medicaid- or Medicare-certified nursing facility providing skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as

“custodial care”) or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

- An institutional facility admission (IFA) is an admission to the institutional setting directly from the community between July 1 of the year prior to the reporting period and June 30 of the current reporting period. Includes admissions to the institutional setting from the hospital setting only if the member lived in a community residence prior to the hospital admission.
- A discharge to the community is a discharge to a community residence from the institutional facility for all IFA between July 1 of the year prior to the reporting period and October 31 of the current reporting period. Includes discharges to the hospital setting only if the member was discharged from the hospital to a community residence between July 1 of the year prior to the reporting period and October 31 of the current reporting period.
- A community residence refers to any residence that is not an institutional facility. This may include assisted living, adult foster care, home, or another residential setting that is not defined as an institution.
- The classification period is the 180 days prior to and including the IFA date.

#### Data Element A

- Report on all paid claims only.
- For the purposes of this measure the “year prior to the reporting period” is defined as the previous calendar year. The “current reporting period” is defined as the current calendar year.
  - For example, for data submitted on April 30, 2022, the previous calendar year is 2020 and the current calendar year is 2021.
- MMPs should include all IFAs for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period.
- The denominator for this measure is based on admissions, not members.
- To identify all new IFAs:
  - Step 1: Identify all new admissions to institutional facilities (i.e., do not include admissions for continuing stays) between July 1 of the year prior to the reporting period and June 30 of the current reporting period (Institutional Facility value set).
  - Step 2: Remove admissions that are direct transfers from another institution. If the original admission date to the institutional facility is prior to July 1 of the year prior to the reporting period, exclude both the original admission and the transfer admission from the measure. Otherwise, keep the original admission date as the date of new IFA. A direct transfer is when the discharge date from the first institutional facility setting precedes the admission date to a second institutional facility setting by one calendar day or less. For example:
    - An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 1, is a direct transfer.

- An institutional facility discharge on June 1, followed by an admission to an institutional facility setting on June 2, is a direct transfer.
- An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 3, is not a direct transfer; these are two distinct new institutional facility stays.
- Step 3: Remove admissions to the institutional facility from the hospital when the hospital admission originated from an institution. Keep the original IFA date (that preceded the admission to the hospital) as the date of the new IFA.
- Step 4: Remove admissions that result in death in the institution or death within one day of discharge from the institution.
- Step 5: If the member is discharged to the hospital and remains in the hospital at the end of the current reporting period or dies in the hospital, exclude the admission from the count of IFA.
- Step 6: Calculate continuous enrollment. Remove admissions for members who do not meet the continuous enrollment criteria.

#### Data Element B

- Report on all paid claims only.
- To identify the count of discharges from an institutional facility to a community residence:
  - Step 1: Look for the location of the first discharge for each IFA in between July 1 of the year prior to the reporting period and October 31 of the current reporting period and:
    - If the member is discharged to the community, calculate length of stay (LOS) as the date of institution discharge minus the IFA date.
    - If there is no discharge, calculate LOS as the date of the last day of the current reporting period minus the IFA date.
    - If the member is discharged from the institution to a hospital, look for the hospital discharge and location of discharge from the hospital. If the member is discharged from the hospital to a community residence, calculate LOS as the date of hospital discharge minus the IFA date.
      - For example, consider a member who is admitted to a skilled nursing facility (SNF) from a hospital. After 50 days at the SNF, the member develops an infection and is admitted to a hospital for 14 days. The member is discharged to home from the hospital on day 15. The LOS is 64 days, or the date of hospital discharge minus the IFA date.
    - If the member is discharged from a hospital to the institution, repeat Step 1 until there is a discharge to the community or the end of the current reporting period.

- For example, consider a member who is discharged from a hospital to a SNF for recovery. After 50 days at the SNF, the member develops an infection and is admitted to a hospital for 14 days. The member is discharged from the hospital back to the SNF and is then discharged to home on day 41 of their second stay at the SNF. The LOS is 104 days, starting from the date of the IFA through the discharge home date.
- If the member is discharged to a different institution (i.e., a transfer), repeat Step 1 until there is a discharge to the community or the end of the current reporting period.
- When counting the duration of each stay within the reporting period, include the day of entry (admission) but not the day of discharge unless the admission and discharge occurred on the same day, in which case the number of days in the stay is equal to one.
- Step 2: Using information from Step 1, identify all IFA with length of stay of less than or equal to 100 days. This should include only discharges to the community (either directly from the institution or from the institution to the hospital to a community residence).
- Step 3: Remove discharge if the member was hospitalized, died or was re-admitted to the institution within 60 days of the day of discharge.

### Data Element C

- Data element C should be rounded and reported to two decimal places using standard round to nearest rules. For example, a value of 4.7346 rounds down to 4.73, while a value of 4.7352 rounds up to 4.74.

### *Risk Adjustment Determination*

- Report on all paid claims only.
- For each IFA, use the following steps to identify risk adjustment categories based on age and gender, dual eligibility, diagnoses from the IFA, and number of hospital stays and months of enrollment in the classification period.
  - Age and Gender
    - Determine the member's age and gender on the date of IFA and assign to the following categories:
      - Female age 18-44
      - Female age 45-64
      - Female age 65-74
      - Female age 75-84
      - Female age 85+
      - Male age 18-44
      - Male age 45-64
      - Male age 65-74
      - Male age 75-84
      - Male age 85+

- Dual eligibility
  - Determine the member's dual eligibility status on the date of IFA. All members should be identified as dually eligible.
- Diagnoses
  - Assign all applicable Chronic Conditions Data Warehouse (CCW) code(s) to the IFA based on the IFA's diagnoses using the CCW Categories value set.
  - For direct transfers, use all diagnoses that occurred during the episode (i.e., original admission diagnoses and direct transfer's diagnoses).
  - Exclude diagnoses that cannot be mapped to the Risk Adjustment Weights value set.
- Number of hospital stays
  - Determine if the member had any acute hospitalizations in the six months prior to the reporting period. Classify the total count of acute hospitalizations as 0, 1, or 2 or more.
- Days of enrollment in MMP
  - Determine the number of days the member has been enrolled in the MMP prior to the IFA date. Classify the total days of enrollment as less than 180 days or greater than or equal to 180 days.

#### *Risk Adjustment Weighting*

- For each IFA, use the following steps to identify risk adjustment weights based on age and gender, dual eligibility, diagnoses from the IFA, and number of hospital stays and months of enrollment in the classification period. Risk adjustment weights are provided in the Risk Adjustment Weights value set.
  - Step 1: Identify the base risk weight. The base risk weight will be the same for all members.
  - Step 2: Link the age and gender weights for each IFA.
    - The Male age 18-44 category is the reference category and does not have a weight assigned.
  - Step 3: Link the dual eligibility weight for each IFA. The dual eligibility weight will be assigned to all members.
  - Step 4: For each IFA with an admission CCW category, link the CCW category weight.
  - Step 5: For each IFA with one or more hospitalizations prior to IFA, link the number of hospitalizations weight.
    - There is no weight assigned to zero hospitalizations prior to the IFA because it is the reference category.
  - Step 6: For each IFA with six months or more of enrollment prior to the IFA, link the six months enrollment weight.
    - There is no weight assigned to each IFA with less than six months of enrollment (in the MMP) prior to the IFA because it is the reference category.

- Step 7: Sum all weights associated with the IFA (i.e., base, age and gender, dual eligibility, qualified CCW categories, number of hospitalizations, and six months of enrollment weight) to calculate the expected estimated probability of successful discharge to the community for each IFA.
  - Expected Discharge Probability =  $\frac{\exp(\text{sum of weights for IFA})}{1 + \exp(\text{sum of weights for IFA})}$   
Note: “exp” refers to the exponential or antilog function
- Step 8: Calculate the count of successful discharges to the community. The count of expected discharges is the sum of the estimated discharge probability calculated in Step 7 for each IFA.
  - Count of Expected Discharges =  $\sum(\text{Estimated Discharge Probability})$
- As an example, Table 3 on the following page provides a sample calculation of expected discharge probability for a hypothetical member with the following characteristics: male; 88 years old; dual eligibility; had two pre-period hospital stays; and had a stroke.

#### General Guidance

- This measure is reported starting with the MMP’s second year of operation (i.e., Calendar Year 2). All MMPs that have operated for at least two years must report the measure.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).



**Table 3. Expected Discharge Probability Example**

Base Risk Weight	Age	Gender	Age and Gender Weight	Dual Eligibility Weight	Number of Hospital Stays	Number of Hospital Stays Weight	ICD-10 Diagnosis Codes	CCW	CCW Weight	6+ Months of Enrollment	Sum of Weights	Expected Discharge Probability
-0.9966	88	Male	0.4395	0.1157	2	-0.4930	G45.9	Stroke	-0.5140	0	-1.4484	0.1902

In this example, the expected probability of having a successful discharge during the reporting period for this member is:

$$\text{Expected Discharge Probability} = \frac{\exp(-0.9966 + 0.4395 + 0.1157 - 0.4930 - 0.5140)}{1 + \exp(-0.9966 + 0.4395 + 0.1157 - 0.4930 - 0.5140)} = 0.1902$$



## Monthly Medicare Care Management Log 2.3 Instructions & Data Dictionary

Instructions: Submit a monthly report of Care Management completed in the reporting month. The Care Management activities that are being captured on this log are assessments, Individualized Care Plan (ICP) and referrals. Send records that are new or have an update from a previous submission (e.g. updated date of care goal discussion). Refer to the data dictionary for specifics on what each field should contain. Do not alter the templates in any way (e.g. adding or deleting columns or header rows). Always submit the most current template in Excel (.xlsx) format.

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First Name of Member
B	Member Last Name	CHAR Always Required	50	Last Name of Member
C	IEHP Member ID #	14 digit numeric characters	14	Cardholder identifier used to identify the beneficiary. This is assigned by IEHP and is 14 digits long
D	Date of Birth	MM/DD/YYYY	10	Member's Date of Birth
E	Case Status	Drop Down		Status of the case: Open or Closed
F	Case Level	Drop Down		Level of risk: High, Rising, Low. Do NOT enter any other values (e.g. Complex, Medium, a numeric value)
G	Date Case Opened	MM/DD/YYYY	10	Date the case was opened to CM
H	Name of Care Coordinator/Manager Assigned	CHAR Always Required	50	List the name of the assigned Care Coordinator or Care Manager
I	Date ICP Created	MM/DD/YYYY	10	Date the Individual Care Plan was created
J	Date ICP Last Updated	MM/DD/YYYY	10	Date the Individual Care Plan was last updated, as defined in policy, 12A3 - Care Management Requirements - Individual Care Plan.
K	Care Plan Type	Drop Down		Participation: Care plan was developed/updated with the participation of the Member or their authorized representative. There should be a matching contact with the Member to match the date of care plan development/update. UTC: Care plan was developed/updated but without Member participation (e.g. unable to contact care plan)
L	Date ICP sent to PCP	MM/DD/YYYY	10	Date the Individual Care Plan was sent to the PCP
M	Date Care Goals Discussed with Member	MM/DD/YYYY	10	Date the Care Goals were discussed with the Member. Only populate this field if there was successful contact with the member or an authorized representative.
N	Date of Member Reassessment	MM/DD/YYYY	10	Date of reassessment completed by the IPA. Only populate this field if there was successful contact with the member or an authorized representative.
O	Last Date of Member Contact	MM/DD/YYYY	10	Date of last Member contact. Only populate this field if there was successful contact with the member or an authorized representative.
P	Referred to CBAS	Drop Down		Yes: Member was referred to CBAS No: Member has a potential need but wasn't referred to CBAS NA: Not Applicable, Member didn't have a need and wasn't referred to CBAS
Q	Referred to county for IHSS	Drop Down		Yes: Member was referred to IHSS No: Member has a potential need but wasn't referred to IHSS NA: Not Applicable, Member didn't have a need and wasn't referred to IHSS
R	Referred to MSSP	Drop Down		Yes: Member was referred to MSSP No: Member has a potential need but wasn't referred to MSSP NA: Not Applicable, Member didn't have a need and wasn't referred to MSSP
S	Completion of Annual Cognitive Assessment for Member 65 years and older	Drop Down		Yes No Declined Member Not Eligible: Members Under 65, Prior diagnosis of Mild Cognitive Impairment & Prior diagnosis of dementia





DualChoice

## Monthly Medicare Interdisciplinary Care Team Log 1.0 Instructions and Data Dictionary

Instructions: Submit a monthly report of all Interdisciplinary Care Team (ICT) activities completed in the reporting month. Send records that are new or have an update from a previous submission. Refer to the data dictionary for specifics on what each file should contain. Do not alter the templates in any way (e.g. adding or deleting columns or header rows). Always submit the most current template in Excel (.xlsx) format.

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First Name of Member
B	Member Last Name	CHAR Always Required	50	Last Name of Member
C	IEHP Member ID #	14 digit numeric characters	14	Cardholder identifier used to identify the beneficiary. This is assigned by IEHP and is 14 digits long
D	Date ICT Was Assigned	MM/DD/YYYY	10	Date of Interdisciplinary Care Team Assigned
E	Date of ICT Meeting	MM/DD/YYYY	10	Date of Interdisciplinary Care Team meeting with ICT participants
F	PCP Attendance	Not Invited Invited Attended	Drop Down	PCP not invited PCP invited but didn't attend PCP invited and attended
G	IHSS SW Attendance	Not Invited Not Applicable Invited Attended	Drop Down	IHSS SW not invited Member does not have IHSS services IHSS SW invited but didn't attend IHSS invited and attended
H	MSSP SW Attendance	Not Invited Not Applicable Invited Attended	Drop Down	MSSP SW not invited Member does not have MSSP services MSSP SW invited but didn't attend MSSP invited and attended
I	Specialist Attendance	Not Invited Not Applicable Invited Attended	Drop Down	Specialist not invited Member does not have a Specialist Specialist invited but didn't attend Specialist invited and attended
J	Specialist Type	CHAR Free Text Optional	250	Specialist type that was invited and/or attended (e.g. Psychiatrist, Nephrologist, etc.)
K	Other Attendance	CHAR Free Text Optional	250	Any other persons who attended the ICT Meeting but does not fit into previous categories (e.g. Adult Protective Services Social Worker, Spiritual Leader, etc.)





## Monthly Medicare Care Plan Outreach Log 1.1 Instructions & Data Dictionary

**Instructions:** This report must list all outreach attempts made to the Member or their Authorized Representative during the reporting month, for the purpose of developing or updating the Member's Individual Care Plan (ICP). If the IPA made multiple outreaches to the Member in one month, then there should be multiple rows for that Member in one reporting month. Each outreach attempt only needs to be submitted once. Refer to the data dictionary for specifics on what each field should contain. Do not alter the templates in any way (e.g. adding or deleting columns or header rows). Always submit the most current template in Excel (.xlsx) format.

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First Name of Member
B	Member Last Name	CHAR Always Required	50	Last Name of Member
C	IEHP Member ID #	14 digit numeric characters	14	Cardholder identifier used to identify the beneficiary. This is assigned by IEHP and is 14 digits long
D	DOB	MM/DD/YYYY	10	Member's Date of Birth
E	Date of Outreach Attempt	MM/DD/YYYY	10	Date outreach attempt was made
F	Time of Outreach Attempt	HH:MM	5	Time outreach attempt was made in military time (e.g., 23:59)
G	Outreach Method	Drop Down		List method used for outreach: email, fax, in person, mail, phone or text
H	Outreach Disposition	Drop Down		State outreach disposition: refused, successful, or unsuccessful
I	Outreach Care Team Member	CHAR Always Required	50	List the title of the Care Team Member who made the outreach
J	Clinical Care Team Member?	Drop Down		Answer Yes or No: Is the Care Team Member, who made the outreach attempt, Clinical such as a Licensed Clinical Social Worker (LCSW), Licensed Vocational Nurse (LVN) or Registered Nurse (RN), etc.?





FIELD NAME	IEHP NOTES	ADDITIONAL DOCUMENTS NEEDED
NETWORK	Name of Delegated Network	
INITIAL or RECREC	Identify whether packet is Initial or Recredentialing	
INITIAL DATE	Provider's Credentialing Approval Date	
RECREC DATE	Provider's Recredentialing Approval Date	
TYPE	Identify whether the practitioner is a Specialist, PCP or Both	
LAST NAME	Last Name as Listed on License	
FIRST NAME	First Name as Listed on License	
M.I.	First Letter of Middle Name as Listed on License	
SUFFIX	Suffix (i.e. Jr., Sr., III...) as listed on License	
DEGREE	Degree M.D. (Medical Doctor) D.O. (Doctor of Osteopathic Medicine) D.P.M. (Podiatry) L.M.F.T. (Licensed Marriage Family Therapist) L.C.S.W. (Licensed Clinical Social Worker) Ph.D., Psy.D. (Doctor of Psychology) D.C. (Doctors of Chiropractic) L.Ac. (Acupuncture) D.D.S. (Doctor of Dental Surgery) D.M.D. (Doctor of Medicine in Dentistry) O.T. (Occupational Therapy) O.D. (Optometry Doctor) P.T. (Physical Therapist) P.A. (Physician Assistant) C.N.M. (Certified Nurse Midwife) N.P. (Nurse Practitioner) S.P. (Speech Pathology) Au. (Audiology) H.A. (Hearing Aids Dispenser)	
NPI	Please provide the Providers Individual NPI	
S.S.N.	Social Security Number	
D.O.B.	Date of Birth	
GENDER	Please identify whether the provide is Male or Female	
ETHNICITY	Provider's cultural background (Optional)	
PROVIDER LANGUAGE 1	Foreign Language Spoken (Fluently by Physician)	
PROVIDER LANGUAGE 2	Foreign Language Spoken (Fluently by Physician)	
PROVIDER LANGUAGE 3	Foreign Language Spoken (Fluently by Physician)	
SPECIALTY 1	Provider's primary specialty  IEHP does not accept the following provider are not delegated to the IPA, therefore do not submit: L.M.F.T. (Licensed Marriage Family Therapist) L.C.S.W. (Licensed Clinical Social Worker) Ph.D., Psy.D. (Doctor of Psychology) L.Ac. (Acupuncture) O.D. (Optometry Doctor)	
SPECIALTY 2	Provider's Secondary specialty  IEHP does not accept the following provider are not delegated to the IPA, therefore do not submit: L.M.F.T. (Licensed Marriage Family Therapist) L.C.S.W. (Licensed Clinical Social Worker) Ph.D., Psy.D. (Doctor of Psychology) L.Ac. (Acupuncture) O.D. (Optometry Doctor)	
PROVIDER'S AGE RANGE	Please provide any age limitations for the provider	
SUPERVISING PHYSICIAN	Applicable to Mid Level Practitioners only (Physician Assistants & Nurse Practitioners) Please provide the name of the Supervising Physician	Delegation of Services Agreement, Supervising Physician Form, Standardized Procedures, as applicable
SUPERVISING PHYSICIAN SPECIALTY	Applicable to Mid Level Practitioners only (Physician Assistants & Nurse Practitioners) Please provide Supervising Physician's Specialty	
PRIMARY PRACTICE NAME		
PRIMARY ADDRESS		
PRIMARY CITY		
PRIMARY STATE	Primary office location that will be marketed under IEHP	
PRIMARY ZIP		
PRIMARY PHONE	W-9's and Contracts (1st and signature page, any addendums to ensure that the provider is affiliated with that contract) are required for all offices marketed with IEHP.	
PRIMARY FAX		
PRIMARY TAX IDENTIFICATION NUMBER (TIN)		W-9
PRIMARY NAME AFFILIATED WITH TIN		Contract
PRIMARY OFFICE HOURS MONDAY		
PRIMARY OFFICE HOURS TUESDAY		
PRIMARY OFFICE HOURS WEDNESDAY		
PRIMARY OFFICE HOURS THURSDAY	Office Hours for the primary location (i.e. 9 am - 5pm or 9am - 12pm 2pm - 5pm or Closed)	





FIELD NAME	IEHP NOTES	ADDITIONAL DOCUMENTS NEEDED	
PRIMARY OFFICE HOURS FRIDAY	(i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)		
PRIMARY OFFICE HOURS SATURDAY			
PRIMARY OFFICE HOURS SUNDAY			
SECONDARY PRACTICE NAME			
SECONDARY ADDRESS	Secondary office location that will be marketed under IEHP		
SECONDARY CITY			
SECONDARY STATE			
SECONDARY ZIP			
SECONDARY PHONE			
SECONDARY FAX			
SECONDARY TAX IDENTIFICATION NUMBER (TIN)		W-9	
SECONDARY NAME AFFILIATED WITH TIN		Contract	
SECONDARY OFFICE HOURS MONDAY		Office Hours for the Secondary location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)	
SECONDARY OFFICE HOURS TUESDAY			
SECONDARY OFFICE HOURS WEDNESDAY			
SECONDARY OFFICE HOURS THURSDAY			
SECONDARY OFFICE HOURS FRIDAY			
SECONDARY OFFICE HOURS SATURDAY			
SECONDARY OFFICE HOURS SUNDAY			
TERTIARY PRACTICE NAME			
TERTIARY ADDRESS	Tertiary office location that will be marketed under IEHP		
TERTIARY CITY			
TERTIARY STATE			
TERTIARY ZIP			
TERTIARY PHONE			
TERTIARY FAX			
TERTIARY TAX IDENTIFICATION NUMBER (TIN)		W-9	
TERTIARY NAME AFFILIATED WITH TIN		Contract	
TERTIARY OFFICE HOURS MONDAY		Office Hours for the Tertiary location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)	
TERTIARY OFFICE HOURS TUESDAY			
TERTIARY OFFICE HOURS WEDNESDAY			
TERTIARY OFFICE HOURS THURSDAY			
TERTIARY OFFICE HOURS FRIDAY			
TERTIARY OFFICE HOURS SATURDAY			
TERTIARY OFFICE HOURS SUNDAY			
FOURTH PRACTICE NAME			
FOURTH ADDRESS	FOURTH office location that will be marketed under IEHP		
FOURTH CITY			
FOURTH STATE			
FOURTH ZIP			
FOURTH PHONE		W-9's and Contracts (1st and signature page, any addendums to ensure that the provider is affiliated with that contract) are required for all offices marketed with IEHP.	
FOURTH FAX			
FOURTH TAX IDENTIFICATION NUMBER (TIN)		W-9	
FOURTH NAME AFFILIATED WITH TIN		Contract	
FOURTH OFFICE HOURS MONDAY		Office Hours for the FOURTH location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)	
FOURTH OFFICE HOURS TUESDAY			
FOURTH OFFICE HOURS WEDNESDAY			
FOURTH OFFICE HOURS THURSDAY			
FOURTH OFFICE HOURS FRIDAY			
FOURTH OFFICE HOURS SATURDAY			
FOURTH OFFICE HOURS SUNDAY			
FIFTH PRACTICE NAME			
FIFTH ADDRESS	FIFTH office location that will be marketed under IEHP		
FIFTH CITY			
FIFTH STATE			
FIFTH ZIP			
FIFTH PHONE			
FIFTH FAX			
FIFTH TAX IDENTIFICATION NUMBER (TIN)		W-9	
FIFTH NAME AFFILIATED WITH TIN		Contract	
FIFTH OFFICE HOURS MONDAY		Office Hours for the FIFTH location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)	
FIFTH OFFICE HOURS TUESDAY			
FIFTH OFFICE HOURS WEDNESDAY			
FIFTH OFFICE HOURS THURSDAY			
FIFTH OFFICE HOURS FRIDAY			
FIFTH OFFICE HOURS SATURDAY			
FIFTH OFFICE HOURS SUNDAY			
SIXTH PRACTICE NAME			
SIXTH ADDRESS	SIXTH office location that will be marketed under IEHP		
SIXTH CITY			
SIXTH STATE			
SIXTH ZIP			
SIXTH PHONE			
SIXTH FAX			
SIXTH TAX IDENTIFICATION NUMBER (TIN)		W-9	



FIELD NAME	IEHP NOTES	ADDITIONAL DOCUMENTS NEEDED
SIXTH NAME AFFILIATED WITH TIN		Contract
SIXTH OFFICE HOURS MONDAY	Office Hours for the SIXTH location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)	
SIXTH OFFICE HOURS TUESDAY		
SIXTH OFFICE HOURS WEDNESDAY		
SIXTH OFFICE HOURS THURSDAY		
SIXTH OFFICE HOURS FRIDAY		
SIXTH OFFICE HOURS SATURDAY		
SIXTH OFFICE HOURS SUNDAY		
MEDICAL LICENSE#	Medical License # as listed on License	
MEDICAL LICENSE EXPIRATION DATE	Date Medical License expires (must be current at all times)	
DEA CERTIFICATE #	DEA Certificate Number as listed on certificate	
DEA EXPIRATION DATE	Date DEA Certificate expires (must be current at all times)	
MALPRACTICE INSURANCE CARRIER NAME	Malpractice Insurance Carrier Information as listed on Certificate (must be current at all times and applicable to all locations where IEHP patients will be treated)	
MALPRACTICE INSURANCE POLICY#		
MALPRACTICE INSURANCE PER CLAIM AMOUNT		
MALPRACTICE INSURANCE PER AGGREGATE AMOUNT		
MALPRACTICE INSURANCE EXPIRATION DATE		
HOSPITAL NAME PRIMARY	Name of IEHP affiliated Hospital, where the provider has admitting privileges *If the provider is using a Hospitalist, list the name of the IEHP Affiliated Hospital the admitter will be using to admit patients	Hospital Admitter Agreement
HOSPITAL PRIVILEGE TYPE PRIMARY	List the privilege type the provider has at the IEHP affiliated Hospital (provider must have admitting privileges i.e. Provisional, Active, Courtesy) *If the provider is using a Hospitalist, List Hospital Admitter and provide the name of the Hospital Admitter (as it's listed on his/her license)	
HOSPITAL SPECIALTY PRIMARY	List the Specialty privileges the provider has at the IEHP affiliated Hospital (Provider must have privileges for the specialty he/she is listed as under IEHP) *If the provider is using a Hospitalist, List the Hospitalists' specialty	
HOSPITALIST AGE RANGE PRIMARY	* If the provider is using a Hospitalist, list the age range for the Hospitalist who will be admitting patients	
HOSPITAL NAME SECONDARY	Name of IEHP affiliated Hospital, where the provider has admitting privileges *If the provider is using a Hospitalist, list the name of the IEHP Affiliated Hospital the admitter will be using to admit patients	Hospital Admitter Agreement
HOSPITAL PRIVILEGE TYPE SECONDARY	List the privilege type the provider has at the IEHP affiliated Hospital (provider must have admitting privileges i.e. Provisional, Active, Courtesy) *If the provider is using a Hospitalist, List Hospital Admitter and provide the name of the Hospital Admitter (as it's listed on his/her license)	
HOSPITAL SPECIALTY SECONDARY	List the Specialty privileges the provider has at the IEHP affiliated Hospital (Provider must have privileges for the specialty he/she is listed as under IEHP) *If the provider is using a Hospitalist, List the Hospitalists' specialty	
HOSPITALIST AGE RANGE SECONDARY	* If the provider is using a Hospitalist, list the age range for the Hospitalist who will be admitting patients	
HOSPITAL NAME TERTIARY	Name of IEHP affiliated Hospital, where the provider has admitting privileges *If the provider is using a Hospitalist, list the name of the IEHP Affiliated Hospital the admitter will be using to admit patients	Hospital Admitter Agreement
HOSPITAL PRIVILEGE TYPE TERTIARY	List the privilege type the provider has at the IEHP affiliated Hospital (provider must have admitting privileges i.e. Provisional, Active, Courtesy) *If the provider is using a Hospitalist, List Hospital Admitter and provide the name of the Hospital Admitter (as it's listed on his/her license)	
HOSPITAL SPECIALTY TERTIARY	List the Specialty privileges the provider has at the IEHP affiliated Hospital (Provider must have privileges for the specialty he/she is listed as under IEHP) *If the provider is using a Hospitalist, List the Hospitalists' specialty	
HOSPITALIST AGE RANGE TERTIARY	* If the provider is using a Hospitalist, list the age range for the Hospitalist who will be admitting patients	
NAME OF BOARD 1	Name of the Board who issued the certification (i.e. American Board of Internal Medicine)	
BOARD SPECIALTY 1	Specialty in which the provider holds the certification (i.e. Gastroenterology, Critical Care Medicine, Internal Medicine)	
BOARD STATUS 1	Status of the Board Certification (i.e. Active, Expired)	
BOARD CERTIFICATION EFFECTIVE 1	Board Certification Effective Date	
BOARD CERTIFIATION EXPIRATION 1	Board Certification Expiration Date (Lifetime Certification, please list lifetime or leave blank)	
BOARD VERIFICATION DATE (if applicable) 1	Board Verification Date (if applicable)	
NAME OF BOARD 2	Name of the Board who issued the certification (i.e. American Board of Internal Medicine)	
BOARD SPECIALTY 2	Specialty in which the provider holds the certification (i.e. Gastroenterology, Critical Care Medicine, Internal Medicine)	
BOARD STATUS 2	Status of the Board Certification (i.e. Active, Expired)	
BOARD CERTIFICATION EFFECTIVE 2	Board Certification Effective Date	
BOARD CERTIFIATION EXPIRATION 2	Board Certification Expiration Date (Lifetime Certification, please list lifetime or leave blank)	
BOARD VERIFICATION DATE (if applicable) 2	Board Verification Date (if applicable)	
NAME OF BOARD 3	Name of the Board who issued the certification (i.e. American Board of Internal Medicine)	



FIELD NAME	IEHP NOTES	ADDITIONAL DOCUMENTS NEEDED
BOARD SPECIALTY 3	Specialty in which the provider holds the certification (i.e. Gastroenterology, Critical Care Medicine, Internal Medicine)	
BOARD STATUS 3	Status of the Board Certification (i.e. Active, Expired)	
BOARD CERTIFICATION EFFECTIVE 3	Board Certification Effective Date	
BOARD CERTIFICATION EXPIRATION 3	Board Certification Expiration Date (Lifetime Certification, please list lifetime or leave blank)	
BOARD VERIFICATION DATE (if applicable) 3	Board Verification Date (if applicable)	
MEDICAL SCHOOL	Name of Medical School	
GRADUATION DATE	Date practitioner completed medical school	
INTERNSHIP INSTITUTION	Name of Internship Institution	
INTERNSHIP SPECIALTY	Type of Internship	
INTERNSHIP START DATE	Start Date of Internship	
INTERNSHIP END DATE	End Date of Internship	
RESIDENCY INSTITUTION 1	Name of residency Institution	
RESIDENCY SPECIALTY 1	Type of Training	
RESIDENCY START DATE 1	Start Date of residency	
RESIDENCY END DATE 1	End Date of residency	
RESIDENCY INSTITUTION 2	Name of residency Institution	
RESIDENCY SPECIALTY 2	Type of Training	
RESIDENCY START DATE 2	Start Date of residency	
RESIDENCY END DATE 2	End Date of residency	
FELLOWSHIP INSTITUTION 1	Name of Fellowship Institution	
FELLOWSHIP SPECIALTY 1	Type of Training	
FELLOWSHIP START DATE 1	Start Date of Fellowship	
FELLOWSHIP END DATE 1	End Date of Fellowship	
FELLOWSHIP INSTITUTION 2	Name of Fellowship Institution	
FELLOWSHIP SPECIALTY 2	Type of Training	
FELLOWSHIP START DATE 2	Start Date of Fellowship	
FELLOWSHIP END DATE 2	End Date of Fellowship	



**Inland Empire Health Plan  
Pre-Contractual Audit Preparation Instructions**

**Medicare**

Listed below are the items required for your Pre-contractual Audit  
All Desktop documents are due by the date specified in the Notice of Pre-Contractual Audit Letter.

DESKTOP	ON-SITE	DELEGATION OVERSIGHT
✓		- Biographical Information
✓		- Sub-Contracted Service by Facility/Agency
✓		Prepare for the audit by having the following information available:
✓		<b>All sections</b> of the DOA tool documented with <b>road mapping</b> instructions for each element
✓		Organizational chart(s)
✓		Current job descriptions as relevant to audit
✓		Delegation agreements with any sub-delegated provider
✓		Ownership and Control Documentation

The following is a list of items needed to prepare for the Offsite and Onsite audit.

DESKTOP	ON-SITE	Quality Management
✓		Program, Plan and Description <b>(Desk Review)*</b>
✓		Committee meeting minutes from last 12 months to include agenda, sign-in sheet (attendance) and signed confidentiality statement: <b>(Desk Review or On-site Review)* :</b>
✓		- Recommendation of policy decisions
✓		- Review and evaluation of QI activities
		- Practitioner participation in the QI program through planning, design, implementation or review
		- Identification and follow up of needed actions
✓		Annual Work Plan <b>(Desk Review)*</b>
✓		Annual QM Program Evaluation <b>(Desk Review)*</b>
✓		Semi-Annual Reports for Health Plan <b>(Desk Review)*</b>



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Pre-Contractual Audit Preparation Instructions**

**Medicare**

DESKTOP	ON-SITE	Quality Management
✓		Standards of Medical Care Access Policy and Procedure <b>(Desk Review)*</b>
✓		Notification of Termination policy and evidence that members were notified of practitioner termination
✓		Continued Access to Practitioners policy and evidence that the delegate followed policy requirements
✓		Sample supportive documentation or materials such as studies, audits, and surveys completed during the reporting period

DESKTOP	ON-SITE	UTILIZATION MANAGEMENT
✓		Program, Plan and Description <b>(Desk Review)*</b>
✓		Sample Annual Work Plan
✓		Sample Annual Program Evaluation
✓		Policies and procedures <b>(Desk Review)*</b>
✓		Committee minutes from last 12 months: <b>(Desk Review)*</b>
✓		- Board of Directors
✓		- Utilization Management Committee
✓		- Subcommittee Meeting Minutes
		Annual Inter-Rater Reliability Audit
✓		Two examples that demonstrate the use of Board Certified consultants to assist with determinations (
✓		Criteria for Length of Stay and Medical Necessity used during the past 2 years )*
✓		Fifteen (15) redacted referral files to include Denials, Modifications, Cancellations and Approvals;
✓		Utilization Management statistics from the last twelve (12) months



**Inland Empire Health Plan  
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DESKTOP	ON-SITE	UTILIZATION MANAGEMENT
✓		Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions
✓		Evidence, other than via a denial letter, that the providers have been notified that they may contact a physician reviewer to discuss denial decisions
✓		Sample Provider communications from last 12 months
✓		Semi-Annual Reports for last 12 months
✓		Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO)) and Employees (Registered Nurse (RN), Licensed Vocational Nurse (LVN)) who make UM Decisions
✓		Copies of most recent mailroom policies

**Utilization Management**

DESKTOP	ON-SITE	CARE MANAGEMENT
✓		Program Plan and Description
✓		Care Management Policies and Procedures
✓		Five (5) Redacted CM files with all required attachments
✓		Five (5) sample cases of Carve Out/Waiver Programs
✓		Five (5) sample cases with documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services in accordance with California-specific measure CA1.7 on Care Coordination

**Care Management**

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**Inland Empire Health Plan  
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**Medicare**

<b>DESKTOP</b>	<b>ON-SITE</b>	<b>CREDENTIALING (Look back period of)</b>
		NCQA Certification, if applicable
		Policies and procedures
✓		Sample Credentialing meeting minutes including date and voting attendees from the look back period, which may include, but not limited to, references from: <b>(DesktopReview) (Virtual Review)</b>
✓		- Quality Management Committee minutes
✓		- Credentialing Committee minutes
✓		- Peer Review Committee minutes
✓		40 Credentialing Files selected by Delegate
✓		40 Recredentialing files selected by Delegate
✓		Evidence of Ongoing Monitoring of Sanctions
✓		Practitioner files of those terminated for quality issues
✓		Practitioner files that have appealed a decision
✓		<b>Sample Delegation Agreements with any sub-delegated provider</b>
✓		HIV/AIDS Annual Survey



**Inland Empire Health Plan  
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DESKTOP	ON-SITE	CREDENTIALING (Look back period of)
		Policy and File review will include, but not limited to, review for the following items: (Visual Review)(Desktop Review) <ul style="list-style-type: none"> <li>- Performance Monitoring;</li> <li>- Medicare Opt-Out Review;</li> <li>- Medicare Exclusions/Sanctions;</li> <li>- Medi-Cal Suspended &amp; Ineligibility;</li> <li>- Reporting to Authorities;</li> <li>- Fair Hearing Panel Composition;</li> <li>- Assessment of Organizational Providers;</li> <li>- Delegation Agreements for all Sub-Delegation Arrangements;</li> <li>- Human Immunodeficiency Virus (HIV/AIDS) Identification Process;</li> <li>- Drug Enforcement Administration (DEA) Verifications within one hundred and eighty (180) calendar days;</li> <li>- Work History verification within one hundred and eighty (180) calendar days; and</li> <li>- Hospital Admitting Privileges.</li> </ul>
		Delegate must submit a spreadsheet of all organizational providers. IEHP will select credentialing and recredentialing files and the delegate may provide their spreadsheet tracking mechanism or file for the file audit
		Credentialing delegation data, if applicable
		Health Delivery Organization Tracking Mechanism for A





**Inland Empire Health Plan  
Pre-Contractual Audit Preparation Instructions**

**Medicare**

DESKTOP	ON-SITE	CLAIMS
✓		Policies and Procedures
✓		Contracts Boilerplate(s) for:
✓		- PCP's, Specialists, Ancillary Providers, Hospitals
✓		Blinded Claims Sample:
✓		- 15 Paid (See Claims Sample Detail Below)
✓		- 5 Denied (See Claims Sample Detail Below)
✓		- 5 Provider Payment Disputes (See Claims Sample Detail Below)
✓		Sample Reports and Logs:
✓		- Paid Claims (See Claims Sample Detail Below)
✓		- Denied Claims (See Claims Sample Detail Below)
✓		- Provider Payment Disputes (See Claims Sample Details below)
✓		- Pended Claims (See Claims Sample Details below) Open
✓		- Claims/Inventory (See Claims Sample Details below)
✓		- Overpayments (See Claims Sample Details below)
✓		- Check Mailing Attestation Log (See Claims Sample Details below)
✓		- Redirected Claims (See Claims Sample Details below)
✓		Claims Processing Systems Review
✓		Operational Review



**Inland Empire Health Plan  
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**Medicare**

<b>Claims</b>
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**Inland Empire Health Plan  
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DESKTOP	ON-SITE	<b>COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 1 year)</b>
✓		Compliance policies and procedures
✓		Fraud, Waste and Abuse Policies and procedures
✓		Sanction/Exclusion Screening Process policies and procedures
✓		Standards/Code of Conduct
✓		Copies of Compliance and FWA Training provided during the audit period
✓		Compliance Committee Meeting minutes from the last 12 months to include agenda and sign-in sheet (attendance)
✓		Annual Compliance Work Plan
✓		Annual Audit and Monitoring Plan If one does not exist, please complete Tab A-A&M Activities Universe of Compliance and FWA Audit Tool.
✓		Annual Risk Assessment Report
✓		Employee Universe: Submit in excel a list of all current employees, including job title, department and start date who have performed job duties related to IEHP's lines of business. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The definition of employees includes full and part time employees as well as temporary employees, interns, or volunteers. Members of the Governing Body/Board of Directors should also be included. Refer to <i>Employee Universe</i> Template
✓		Downstream Entity/Subcontractors Universe: Submit a list of all downstream entities/subcontractors contracted with the IPA and/or MSO anytime during the audit period, including Individual/Entity Name, detailed description of services provided contract start and end dates, Refer to tab B. <i>Universe_Subcontractors</i> of the Compliance and FWA Audit tool for required template.



**Inland Empire Health Plan  
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✓	<p>A sample* of (10) ten employees (5 hired within the audit period and 5 hired prior to the audit period): will be selected from the Employee Universe by the IEHP Auditor for which evidence of the following will be requested.</p> <ol style="list-style-type: none"> <li>1. New Hires:             <ol style="list-style-type: none"> <li>a. Pre-hire exclusion check of the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and Medi-Cal Suspended &amp; Ineligible Provider List (S&amp;I)</li> <li>b. Completion of Compliance, FWA, within ninety (90) days of hire or start.</li> <li>c. Standards/Code of Conduct distribution</li> </ol> </li> <li>2. Established Employees:             <ol style="list-style-type: none"> <li>a. Monthly exclusion checks performed of OIG LEIE, GSA SAM, and Medi-Cal S&amp;I for a sample of (3) three consecutive months.</li> <li>b. Completion of Annual Compliance and FWA training</li> </ol> </li> </ol>
	<p>A sample of five (5) audits and/or monitoring activities will be selected from the IPA’s Audit and Monitoring Plan or A&amp;M Activities Universe. Evidence of the following will be required: <b>(Desk Review)*</b></p> <ol style="list-style-type: none"> <li>a. Results/Findings Reports</li> <li>b. Activity outcomes were reported to an oversight body, senior leadership, and/or the board of directors and corrective actions were developed and implemented, as applicable.</li> </ol> <p>•</p>



**Inland Empire Health Plan  
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		<p>A sample of three (3) Downstream Entities/Subcontractors will be selected in tab 4. File Review_FDR Oversight. Evidence of the following will be required: <b>(Desk Review)*</b></p> <ul style="list-style-type: none"> <li>a. Auditing or monitoring oversight activities;</li> <li>b. Activity outcomes were reported to an oversight body, senior leadership, and/or the board of directors; and corrective actions, if applicable.</li> </ul>
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<p><b>COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 1 year)</b></p>
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DESKTOP	ON-SITE	HIPAA PRIVACY PROGRAM
✓		HIPAA Privacy Program policies and procedures
✓		Copies of HIPAA Privacy Training provided during the audit period
✓		Privacy Incident Universe: Submit a list of reported suspected privacy incidents impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period. Refer to tab A. <i>Universe_Privacy Incidents</i> of the HIPAA Privacy tool for required template.



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✓		<p>A sample* of 10 employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the <i>Employee Universe</i> by the IEHP Auditor for which evidence of the following will be requested: New Hires:</p> <ul style="list-style-type: none"> <li>a. Completion of HIPAA Privacy &amp; Security Training upon hire/start</li> <li>b. Completion of Confidentiality Statement prior to access to PHI</li> </ul> <p>1. Established Employees:</p> <ul style="list-style-type: none"> <li>a. Completion of HIPAA Privacy &amp; Security Training</li> <li>b. Annual completion of Confidentiality Statement</li> </ul>
✓		<p>A sample of five (5) privacy incidents will be selected from the <i>Privacy Incidents Universe</i>. Evidence of the following will be required:</p> <ul style="list-style-type: none"> <li>a. Date incident was reported to the Privacy/Compliance Officer;</li> <li>b. Completion of a Risk Assessment for issue/investigation;</li> <li>c. Notification was sent to IEHP with HIPAA BAA Requirements of discovery of a suspected breach; and</li> <li>d. Corrective actions taken, if applicable.</li> </ul>

**HIPAA PRIVACY PROGRAM**

- c. completion of Confidentiality Statement

DESKTOP	ON-SITE	IT SECURITY
✓		The name of the medical management system(s) used for the utilization management, care management, and claims functions.

**IT SECURITY**



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**Note: \*- Denotes items to be sent to IEHP for desk review prior to the audit.**

**Claims Sample Details**

Applicant Entity Name:	
Audit Date:	

PROVIDE THE FOLLOWING DOCUMENTS FOR CLAIMS REVIEW:	
1	<b>Paid/Denied (5 paid non-contracted provider clean claims; 5 paid non-contracted provider unclean claims; 5 paid contracted provider claims; 3 denied claims with member liability; 2 denied claims with provider liability; include a mix of inpatient &amp; outpatient hospital, emergency claims, professional, radiology, labs, anesthesia claims paid/denied in past 90 days)</b>
	a. Actual Claim Form and supporting documentation submitted with claim
	b. Provider explanation of benefits or remittance advice for claims
	c. Copy of check with documentation regarding date the check was cashed
	d. Denial letters
	e. Acknowledgement of Receipt or Proof of Date Entered in System
	f. Any correspondence and/or pertinent information related to the claim, including evidence of medical review, eligibility screens, authorizations, information request letters, overpayment/adjustment requests, claim appeal documentation, original claim information for provider payment disputes (including claim and EOB/RA), documentation of overpayment requests, applied overpayments (refunds or retractions), etc.
	g. Copy of fee schedule or contract rate applied to each claim. This can be in the form of a page from a contract or a screen print identifying the type of schedule applied (i.e., Medical, Medicare, etc.). For non-contracted providers, a copy of the policy identifying basis for payment.
	h. Copies of contracts or letters of agreement for any providers of service wherein provider has agreed to upcoding or downcoding of services rendered; claims submission or payment timeframes that supersede regulatory requirements; or retraction of overpayments, if applicable.
2	<b>Provider Payment Disputes (5 provider payment disputes; include a mix of favorable &amp; unfavorable disputes for contracted &amp; non-contracted providers within past 90 days)</b>
	a. Provider payment dispute and supporting documentation
	b. Original Claim (face sheet with date of receipt visible) and EOB/RA
	c. EOB/RA of the Dispute
	d. Written Notice of the dispute
	e. Other supporting documentation or correspondence pertinent to the outcome of the dispute and related adjustment, as applicable.



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**Report /Log Required Fields**

Type of Report	Required fields
Paid Claims	<ul style="list-style-type: none"> <li>• Member name</li> <li>• Member ID#</li> <li>• Date of Service</li> <li>• Provider of Service</li> <li>• Provider Contract Status</li> <li>• Amount Billed</li> <li>• Date claim received</li> <li>• Claim Number</li> <li>• Amount paid</li> <li>• Date claim paid</li> <li>• Age of claim</li> </ul>
Denied Claims	<ul style="list-style-type: none"> <li>• Member Name</li> <li>• Member ID #</li> <li>• Date of service</li> <li>• Provider of service</li> <li>• Provider Contract Status</li> <li>• Amount billed</li> <li>• Date claim received</li> <li>• Claim Number</li> <li>• Date claim denied</li> <li>• Reason for denial</li> <li>• Age of claim</li> </ul>
Pended Claims	<ul style="list-style-type: none"> <li>• Member name</li> <li>• Member ID#</li> <li>• Date of service</li> <li>• Provider of service</li> <li>• Amount billed</li> <li>• Date claim received</li> <li>• Claim Number</li> <li>• Date claim pended</li> <li>• Pend Reason (must separately identify requests for ER Notes, Medical Records and all other information)</li> <li>• Age of claim</li> <li>• Processor Initials</li> </ul>
Open Claims/Inventory	<ul style="list-style-type: none"> <li>• Member name</li> <li>• Member ID#</li> <li>• Date of Service</li> <li>• Provider of Service</li> <li>• Amount Billed</li> <li>• Date claim received</li> <li>• Status of claim</li> </ul>





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Pre-Contractual Audit Preparation Instructions**

**Medicare**

Overpayments	<ul style="list-style-type: none"> <li>• Member Name</li> <li>• Member ID#</li> <li>• Original Claim #</li> <li>• Date original claim Paid</li> <li>• Provider of service</li> <li>• Provider Contract Status</li> <li>• Date of request for overpayment</li> <li>• Date overpayment processed in System</li> <li>• Recovery Type (i.e., withhold, refund, none)</li> <li>• Total Dollars Recovered</li> </ul>
Provider Payment Disputes	<ul style="list-style-type: none"> <li>• Date of Service</li> <li>• Original Claim #</li> <li>• Date Provider Payment Dispute Received</li> <li>• Provider Payment Dispute Claim #</li> <li>• Date Provider Payment Dispute Acknowledged</li> <li>• Provider of Service Submitting Payment Dispute Request</li> <li>• Determination Decision (i.e., upheld, overturned, goodwill)</li> <li>• Date Provider Payment Dispute Resolved</li> <li>• Date Dispute Payment Made</li> </ul>
Redirected Claims	<ul style="list-style-type: none"> <li>• Date Received</li> <li>• Billing Provider of Service</li> <li>• Date of Service</li> <li>• Patient Identifier (name, ID#, etc.)</li> <li>• Date Redirected</li> <li>• Where Redirected</li> <li>• Claim # (if applicable)</li> </ul>
Check Mailing Attestation Log	<ul style="list-style-type: none"> <li>• Check #</li> <li>• Check Date</li> <li>• Check Amount</li> <li>• Payee</li> <li>• Signature</li> <li>• Title of Signee</li> <li>• Date Mailed</li> </ul>

## **Program Description DualChoice Denial Letter Sanction Calendar Year 2021**

### **Section I: Overview**

The 2021 DualChoice Sanction Program is a continuation and enhancement to the original 2015-2016 program. In an ongoing effort to collaborate with the IPAs to ensure that denial letters meet CMS standards, IEHP is continuing the Denial Letter Sanction Program with some minor improvements.

### **Section II: Oversight and Monitoring**

All IPAs will be required to submit IEHP specified (based on Medicare specifications) universes for Service Authorization Requests. IEHP will continue to conduct monthly review of denial letters. This will allow for timely feedback and more face to face interaction which will enhance communication of regulations and requirements.

### **Section III: Denial Letter Sanctions**

Denial Letters must meet, with 100% accuracy, the below components:

1. Use of correct letter template including attachments.
2. Member denial language that is understandable (sixth grade reading level).
3. Denial letter is processed timely, with the inclusion of accurate dates of receipt.
4. Denial reason is in accordance to appropriate criteria cited and coincides with denial type.

### **2020 Sanction limits:**

A \$1,000 sanction will be issued for each denial letter with a deficiency. A maximum of thirty (30) denial letters per IPA will be reviewed each month. If an IPA has less than thirty (30) denials, all denials will be reviewed.

### **New Sanction Limits for 2021:**

There is a maximum of \$3,000 sanction total versus \$1,000 per case for Timeliness and Template deficiencies (related to system issues) to minimize the impact on IPA's. The IPA will be allowed 90 days to implement changes to correct system issues. Failure to implement changes within 90 days will result in moving to \$1,000 per deficient denial letter for subsequent months until the system issue is rectified. Criteria and Language deficiencies will continue with the current sanction of \$1,000 per case (no limit on sanctions). A maximum of thirty (30) denial letters per IPA will be reviewed each month on a random basis selection process. If an IPA has less than thirty (30) denials, all denials will be reviewed.

### **Section IV: Appeal Process**

If the IPA wishes to appeal the results of the Denial Letter Sanctions, a written appeal must be submitted within 30 days of receiving the results. The written appeal should be submitted to the Director of Delegation Oversight, Juan Ortega (see Provider Manual policy *16.B.4 Appeal and Grievance Resolution Process for Providers; IPA, Hospital and Practitioner*). IPAs (Delegates) must cite reasons for their appeal, including disputed items or deficiencies.

IPAs that consistently fail to meet IEHP standards, as confirmed through monthly monitoring and/or focused audits or other oversight activities, are subject to actions up to and including Corrective Action Plans (CAPs), increased sanctions, rescission of delegated functions, and non-renewal of the IEHP contract or termination of the IPA participation in the IEHP network.

## Delegation Oversight Audit Tool Quality Management 2022 NCQA Standards

<b>IPA:</b>	
<b>Date:</b>	
<b>QI Total Score:</b>	<b>0%</b>

NCQA QI 1: Program Structure and Operations						
The organization clearly defines its quality improvement (QI) program structure and processes, assigns responsibility to appropriate individuals and operationalizes its QI program.						
Element A: QI Program Structure		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization's QI program description specifies:						
1	The QI program structure.	X				
2	Involvement of a designated physician in the QI program.	X				
3	Oversight of QI functions of the organization by the QI Committee.	X				
<b>Total Requirements Element A: QI Program Structure</b>		3			<b>Score</b>	
Requirement Met		0	0	0	0%	
% of Requirement Met		0%	0%	0%		
Element B: Annual Work Plan		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses:						
1	Yearly planned QI activities and objectives.	X				
2	Time frame from each activity's completion.	X				
3	Staff members responsible for each activity.	X				
4	Monitoring of previously identified issues.	X				
5	Evaluation of the QI program.	X				
<b>Total Requirements Element B: Annual Work Plan</b>		5			<b>Score</b>	
Requirement Met		0	0	0	0%	
% of Requirement Met		0%	0%	0%		
Element C: Annual Evaluation		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization conducts an annual written evaluation of the QI program that includes the following information:						
1	A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.	X				
2	Trending of measures of performance in the quality and safety of clinical care and quality of service.	X				
3	Evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices.	X				
<b>Total Requirements Element C: Annual Evaluation</b>		3			<b>Score</b>	
Requirement Met		0	0	0	0%	
% of Requirement Met		0%	0%	0%		
Element D: QI Committee Responsibilities		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization's QI Committee:						
1	Recommends policy decisions.	X				
2	Analyzes and evaluates the results of QI activities.	X				
3	Ensures practitioner participation in the QI program through planning, design, implementation or review.	X				
4	Identifies needed actions.	X				
5	Ensures follow-up, as appropriate.	X				
<b>Total Requirements Element D: QI Committee Responsibilities</b>		5			<b>Score</b>	
Requirement Met		0	0	0	0%	
% of Requirement Met		0%	0%	0%		
NCQA NET 4: Continued Access to Care						
The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.						
Element A: Notification of Termination		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
1	The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.	X				
<b>Total Requirements Element A: Notification of Termination</b>		1			<b>Score</b>	
Requirement Met		0	0	0	0%	
% of Requirement Met		0%	0%	0%		
Element B: Continued Access to Practitioners		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows:						
1	Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.	X				
2	Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.	X				
<b>Total Requirements Element B: Continued Access to Practitioners</b>		2			<b>Score</b>	
Requirement Met		0	0	0	0%	
% of Requirement Met		0%	0%	0%		



# Delegation Oversight Audit Tool Utilization Management 2022

## Delegation Oversight Annual Audit

<b>IPA:</b>	
<b>Date:</b>	
<b>UM Total Score:</b>	<b>0%</b>

### NCQA UM 1: Utilization Program Structure

The organization's UM program has clearly defined structures and processes, and assigns responsibility to appropriate individuals.

Element A: Written Program Description		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
The organization's UM program description includes the following:	0	0.5	1			
1	A written description of the program structure.	X				
2	Involvement of a designated senior-level physician in UM program implementation.	X				
3	The program scope and process used to determine benefit coverage and medical necessity.	X				
4	Information sources used to determine benefit coverage and medical necessity.	X				
<b>Total Requirements Element A - Written Program Description</b>		<b>4</b>			<b>Score</b>	
Requirement Met		4	0	0	0%	
% of Requirement Met			0.0%	0.0%		
Element B: Annual Evaluation		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
The organization annually evaluates and updates the UM program, as necessary.	0	0.5	1			
		X				
<b>Total Requirements Element B - Annual Evaluation</b>		<b>1</b>			<b>Score</b>	
Requirement Met		1	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		

### NCQA UM 2: Clinical Criteria for UM Decisions

The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria.

Element A: UM Criteria		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
The organization applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.	0	0.5	1			
1	Has written UM decision-making criteria that are objective and based on medical evidence.	X				
2	Has written policies for applying the criteria based on individual needs.	X				
3	Has written policies for applying the criteria based on an assessment of the local delivery system.	X				
4	Involves appropriate practitioners in developing, adopting and reviewing criteria.	X				
5	Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate.	X				
<b>Total Requirements Element A - UM Criteria</b>		<b>5</b>			<b>Score</b>	
Requirement Met		5	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		
Element B: Availability of Criteria		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
The organization:	0	0.5	1			
1	States in writing how practitioners can obtain UM criteria.	X				
2	Makes the criteria available to its practitioners upon request.	X				
<b>Total Requirements Element B - Availability of Criteria</b>		<b>2</b>			<b>Score</b>	
Requirement Met		2	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		
Element C: Consistency in Applying Criteria		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
At least annually, the organization:	0	0.5	1			
1	Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making.	X				
2	Acts on opportunities to improve consistency, if applicable.	X				
<b>Total Requirements Element C - Consistency in Applying Criteria</b>		<b>2</b>			<b>Score</b>	
Requirement Met		2	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		



## Delegation Oversight Audit Tool Utilization Management 2022

NCQA UM 3: Communication Services						
The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.						
Element A: Access to Staff		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization provides the following communication services for members and practitioners:						
1	Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.	X				
2	Staff can receive inbound communication regarding UM issues after normal business hours.	X				
3	Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.	X				
4	TDD/TTY services for members who need them.	X				
5	Language assistance for members to discuss UM issues.	X				
<b>Total Requirements Element A - Access to Staff</b>		5			<b>Score</b>	
<b>Requirement Met</b>		5	0	0	0.0%	
<b>% of Requirement Met</b>			0.0%	0.0%		
NCQA UM 4: Appropriate Professionals						
Qualified licensed health professionals assess the clinical information used to support UM decisions.						
Element A: Licensed Health Professionals		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization has written procedures:						
1	Requiring appropriately licensed professionals to supervise all medical necessity decisions.	X				
2	Specifying the type of personnel responsible for each level of UM decision making.	X				
<b>Total Requirements Element A - Licensed Health Professionals</b>		2			<b>Score</b>	
<b>Requirement Met</b>		2	0	0	0.0%	
<b>% of Requirement Met</b>			0.0%	0.0%		
Qualified licensed health professionals assess the clinical information used to support UM decisions.						
Element B: Use of Practitioners for UM Decisions		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:						
1	Education, training or professional experience in medical or clinical practice.	X				
2	A current clinical license to practice or an administrative license to review UM cases.	X				
<b>Total Requirements Element A - Use of Practitioners for UM Decisions</b>		2			<b>Score</b>	
<b>Requirement Met</b>		2	0	0	0.0%	
<b>% of Requirement Met</b>			0.0%	0.0%		
Qualified licensed health professionals assess the clinical information used to support UM decisions.						
Element C: Practitioner Review of Nonbehavioral Healthcare Denials		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity.		X				
<b>Total Requirements Element C - Practitioner Review of Nonbehavioral Healthcare Denials</b>		1			<b>Score</b>	
<b>Requirement Met</b>		1	0	0	0.0%	
<b>% of Requirement Met</b>			0.0%	0.0%		
Element F: Use of Board-Certified Consultants		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization:						
1	Has written procedures for using board-certified consultants to assist in making medical necessity determinations.	X				
2	Provides evidence that it uses board-certified consultants for medical necessity determinations.	X				
<b>Total Requirements Element F - Use of Board-Certified Consultants</b>		2			<b>Score</b>	
<b>Requirement Met</b>		2	0	0	0.0%	
<b>% of Requirement Met</b>			0.0%	0.0%		



# Delegation Oversight Audit Tool Utilization Management 2022

NCQA UM 5: Timeliness of UM Decisions						
The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation.						
Element A: Notification of Nonbehavioral Decisions		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care.		0	0.5	1		
1	For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.	X				
2	For urgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.	X				
3	For nonurgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 14 calendar days of the request.	X				
4	For postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.	X				
<b>Total Requirements Element A - Notification of Nonbehavioral Decisions</b>		4			<b>Score</b>	
Requirement Met		4	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		
Element D: UM Timeliness Report		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
The organization monitors and submits a report for timeliness of:		0	0.5	1		
1	Nonbehavioral UM decision making.	X				
2	Notification of nonbehavioral UM decisions.	X				
<b>Total Requirements Element D - UM Timeliness Report</b>		2			<b>Score</b>	
Requirement Met		2	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		
NCQA UM 6: Clinical Information						
When determining coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner.						
Element A: Relevant Information for Nonbehavioral Healthcare Decisions		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.		0	0.5	1		
		X				
<b>Total Requirements Element A - Relevant Information for Nonbehavioral Healthcare Decisions</b>		1			<b>Score</b>	
Requirement Met		1	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		

## Delegation Oversight Audit Tool Utilization Management 2022

NCQA UM 7: Denial Notices						
Element A: Discussing a Denial With a Reviewer		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer.		X				
<b>Total Requirements Element A - Discussing a Denial With a Reviewer</b>		1			<b>Score</b>	
Requirement Met		1	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		
Element B: Written Notification of Nonbehavioral Healthcare Denials		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information:						
1	The specific reasons for the denial, in easily understandable language.	X				
2	A reference to the benefit provision, guidelines, protocol or other similar criterion on which the denial decision is based.	X				
3	A statement that members can obtain a copy of the actual benefit provision, guidelines, protocol or other similar criterion on which the denial decision was based, upon request.	X				
<b>Total Requirements Element B - Written Notification of Nonbehavioral Healthcare Denials</b>		3			<b>Score</b>	
Requirement Met		3	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		
Element C: Nonbehavioral Healthcare Notice of Appeal Rights/Process		Point Value			Include: Document Name, Page and Sections	Comment /Guidance
		0	0.5	1		
The organization's written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information:						
1	A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.	X				
2	An explanation of the appeal process, including members' rights to representation and appeal time frames.	X				
3	A description of the expedited appeal process for urgent preservice or urgent concurrent denials.	X				
4	Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.	X				
<b>Total Requirements Element C - Nonbehavioral Healthcare Notice of Appeal Rights/Process</b>		4			<b>Score</b>	
Requirement Met		4	0	0	0.0%	
% of Requirement Met			0.0%	0.0%		
NCQA UM 12: UM System Controls						
The organization has UM system controls to protect data from being altered outside of prescribed protocols.						





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**CMC 1A: Individualized Care Plan (ICP) Operations**

The organization has clearly defined policies and procedures to demonstrate that the Member receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process to include:

	Description	Meets	Comments
1	Ability to provide education materials specific to the Members condition and care options		
2	If Member chooses, how family and/or social supports may be involved in the care planning process		
3	Ability for Member to self-direct care options		
4	Ability for Member to sign ICP		
5	Ability for Member to refuse involvement in the development of the ICP		
6	Information on how to access LTSS services if applicable		
7	Information on how to access IEHP benefits such as transportation, nurse advice line, health education and behavioral health services		

**CMC 2A-1: Individualized Care Plan (ICP) Timeframes**

The organization has clearly defined policies and procedures to demonstrate that all CalMedi Connect Members have a comprehensive, person-centered ICP will developed for each Member that includes the following processes

	Description	Meets	Comments
1	Complete the initial ICP with Member within 90 calendar days from initial enrollment		
2	Includes timeframes for reassessment and must be done at least annually, when there is a change in PCP or if a significant change in condition occurs		
3	If Member refuses involvement in the development of the ICP, IPA must seek to revisit the refusal at least at the time of reassessment or if the PCP changes		



Delegation Oversight - Cal MediConnect  
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Care Management

CMC 2A-2: Individualized Care Plan (ICP) Assessment Activities			
The organization has clearly defined policies and procedures to demonstrate that all CalMedi Connect Members are assessed to aid in the development of a comprehensive, person-centered ICP that includes the following processes			
	Description	Meets	Comments
1	Review of all Medicare and Medi-Cal utilization data available		
2	Reviews needs identified through the Health Risk Assessment, In-Home Supportive Services (IHSS) assessment results, Multipurpose Senior Services Program (MSSP) and Community-Based Audit Services (CBAS) records, behavioral health utilization, other data, self and provider referrals, and input from Members of the Interdisciplinary Care Team		
3	Identification of LTSS needs and process of referring Members		
4	Identification of behavioral health needs and process of referring Members		
5	Identification of community resource needs and process of referring Members		
6	Identification of caregivers/authorized representatives with Members direction about level of involvement in the ICP process		
7	Identification of current needs and any supports or services that may be needed in the immediate future		
8	Identification of medical needs and process of referring Members		
9	Identification of needs necessary for Member to optimize their health status		
11	Assessment of behavioral health status		
12	Assessment of functional status		



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13	Assessment of cognitive status		
14	Assessment of cultural and linguistic needs, preferences or limitations		
15	Assessment of life planning activities		
16	Assessment of Member's living conditions		
CMC 2A-3: Individualized Care Plan (ICP) Process			
The organization has clearly defined policies and procedures to demonstrate that all CalMedi Connect Members have a comprehensive, person-centered ICP will developed for each Member that includes the following processes			
	Description	Meets	Comments
1	A comprehensive, person-centered ICP is developed for each Member		
2	ICP includes Members goals and preferences		
3	ICP includes measurable objectives and timetables to meet medical, behavioral and long-term supports and services needs		
4	ICP provided to Members no less than annually		
5	ICP includes name and contact information for Members current assigned care manager		
6	ICP includes name and contact information for the Member's PCP and any Specialist		
7	A complete and current list of Members medications		
8	If Member is receiving iHSS, the ICP will include name and contact information for the county social worker with the responsibility for authorizing and overseeing IHSS hours and the name of the IHSS worker		
9	If Member is receiving behavioral health services, the ICP will also include the name and contact information for the primary county or county contracted behavioral health provider		



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<i>10</i>	<del>Assessed</del> assessed at least annually or if a significant change in condition occurs	Care Management
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**CMC 3-A: Interdisciplinary Care Team (ICT) Composition**

The organization has clearly defined policies and procedures to demonstrate that all CalMedi Connect Members have an ICT process includes the following

	Description	Meets	Comments
1	Process for offering participation to the Member an/or representative		
2	Process for Member to have the ability to opt out of ICT participation		
3	Member may request the exclusion of any ICT Member.		
4	ICT is composed of the following Members: - Member and his/or authorized representative - Family member and/or caregiver as approved by Member - If receiving IHSS, the County IHSS social worker - Care Coordinator - Primary Care Provider		



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<p><i>DualChoice</i></p>	<p>ICT is inclusive of individuals or providers who are actively involved in the Members care:</p> <ul style="list-style-type: none"> <li>- Hospital discharge planner</li> <li>- Nurse</li> <li>- Social Worker</li> <li>- Nursing Facility representative</li> <li>- Specialized providers such as physician specialists, pharmacists, physical therapist and occupational therapist</li> <li>- If receiving IHSS, the IHSS provider if approved by Member</li> <li>- If participating in CBAS, the CBAS provider</li> <li>- If enrolled in the MSSP waiver program, MSSP care manager</li> <li>- Behavioral health service provider</li> <li>5 - Other professionals as appropriate</li> </ul>	<p>Care Management</p>	
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CMC 3-A1: Interdisciplinary Care Team (ICT) Functions			
The organization has clearly defined policies and procedures to demonstrate that all CalMedi Connect Members have an ICT process includes			
	Description	Meets	Comments
1	ICT to facilitate in care management, including HRA, care planning, authorization of services and transition care needs		
2	ICT must work closely with Member to stabilize medical conditions, increase compliance with care plans, maintain functional status and meet care plan goals		
3	Development and implement a care plan in participation with the Member and/or caregiver		
4	Conduct ICT meetings periodically and at the Member's request		



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<i>DualChoice</i>		Care Management	
5	Manage communication and information flow regarding referrals, transitions, and care delivered outside of the primary care site		
6	Maintain a call line and other mechanisms for the Member's inquiries or input Maintain a process for referring the Member to other agencies such as LTSS or behavioral health agencies as appropriate		
7	Maintain a mechanism for Member's complaints and grievances		
8	Use secure email, fax, web portals or written correspondence when communication with Members		
9	When communicating with the Member, the ICT must take his or her needs (e.g. communication, cognitive or other barriers) into account		

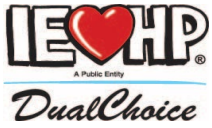
CMC 4-A1: Care Coordinator Assignment			
The organization has clearly defined policies and procedures to demonstrate that all CalMedi Connect Members have a process in place with			
	Description	Meets	Comments
1	Process for assigning a care coordinator to each Member needing or requesting one		
2	Coordinator should have the appropriate experience and qualifications to work with the Member based on Members need and risk level		
CMC 5-A1: Care Management Trainings			
The organization has clearly defined policies and procedures to demonstrate that all IPA staff Members involved in a CMC Member's care			
	Description	Meets	Comments



Delegation Oversight - Cal MediConnect  
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Qualification	Description	Meets	Comments
	Employees who interact with and provide services to CMC Members will complete the <i>IEHP Care Management Guidelines</i>		
1	Training		
2	Training must occur within 30 days of initial hire		
3	Training must include roles and responsibilities of care coordinator		
4	Training must include critical incident/abuse training and how to report		
5	Training must also occur annually		
6	IPA will be able to produce evidence of training such as training completion logs and/or attestations		

CMC 5-A2: Care Management Trainings - LTSS and Social Services			
The organization has clearly defined policies and procedures to demonstrate that all IPA staff Members involved in CMC Member's care			
	Description	Meets	Comments
1	Identification of LTSS needs and process of referring Members		
2	Identification of behavioral health needs and process of referring Members		
3	Identification of community resource needs and process of referring Members		
4	List of community supports/resources available		



Delegation Oversight - Cal MediConnect  
 Policies and Procedures Audit Tool  
 Care Management

Results	
Category Name	% Score
CMC 1A: Individualized Care Plan (ICP) Operations	N/A
CMC 2A-1: Individualized Care Plan (ICP) Timeframes	N/A
CMC 2A-2: Individualized Care Plan (ICP) Assessment Activities	N/A
CMC 2A-3: Individualized Care Plan (ICP) Process	N/A
CMC 3-A: Interdisciplinary Care Team (ICT) Composition	N/A
CMC 3-A1: Interdisciplinary Care Team (ICT) Functions	N/A
CMC 4-A1: Care Coordinator Assignment	N/A





Delegation Oversight - Cal MediConnect  
Policies and Procedures Audit Tool

<del>Health Care</del> Management Trainings	Care Manag	N/A
CMC 5-A2: Care Management Trainings - LTSS and Social Services		N/A

Overall Score

N/A

Comments:



INLAND EMPIRE HEALTH PLAN

**INLAND EMPIRE HEALTH PLAN  
REQUEST FOR UM CRITERIA LOG**

Submitted by: \_\_\_\_\_

Log for Year: \_\_\_\_\_

Date Requested	Date Sent	Sent via: F = fax EM = email GM =ground mail	Name of the Requesting Practitioner or Member	Member Name and IEHP ID #	Line of Business (MC, CMC)	Criteria Requested (i.e. InterQual-MRI Brain)	Reason for Request	Medical Necessity	Benefit	Carve-Out	Out-of- Network

**Legend:** F = Fax  
EM = email  
GM = Ground

MC = Medi-Cal

CMC = IEHP DualChoice

IEHP DualChoice (HMO D-SNP)

<Date>

<Name>

<Address>

<Address>

RE: Request for Utilization Management (UM) Criteria

Dear <Name>:

Attached is the clinical guideline or criteria used for determining health care services specific for the procedure or condition requested.

The materials provided to you are guidelines used by the Delegate to authorize, modify, or deny services for Members with a similar illness or condition. Specific care and treatment may vary depending on individual needs and the benefits covered under your health plan.

Sincerely,

<Utilization Management Department>



**INLAND EMPIRE HEALTH PLAN  
SECOND OPINION TRACKING LOG**

IPA Name: \_\_\_\_\_

Date Submitted: \_\_\_\_\_

Report for Month of: \_\_\_\_\_

Submitted by: \_\_\_\_\_

Member Name and IEHP ID #	Name of the Requesting Practitioner or Member	Diagnosis	Reason for Second Opinion <i>(use codes below)</i>	Request Date	Decision Date	Decision Code (circle one)	Second Opinion to be provided by (name):	Date of Appoint.	Date Consult Report Received	*See Legend Below For Member Type
						Approved Modified Denied				
						Approved Modified Denied				
						Approved Modified Denied				
						Approved Modified Denied				

**Second Opinion Reason Codes:**

- Reason 1: The Member questions the reasonableness or necessity of recommended surgical procedures.
- Reason 2: The Member questions a diagnosis or plan or care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition.
- Reason 3: If clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/Specialist is unable to diagnose the condition and the Member requests an additional diagnosis.
- Reason 4: If the treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment.
- Reason 5: The Member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care

**Legend:** MC = IEHP Medi-Cal  
 CMC = IEHP DualChoice (HMO D-SNP)

**Inland Empire Health Plan  
Delegated IPA Delegation Oversight Audit Tool  
Sub-Contracted Facility/Agency Services and Delegated Functions**

This form is to be completed for all ancillary services where the IPA/MSO has established a contract directly with a facility or agency.

- Directions:
1. Mark yes or no (Y or N) for each **Service** listed where your IPA/MSO has established a contract.
  2. In the **CONTRACTED FACILITY/AGENCY** list the name of each contracting facility or agency.
  3. In the **ACCREDITED BY** column, indicate if the facility or agency is accredited and by whom. In the **DELEGATED FUNCTION** column mark X in each row where your IPA/MSO has delegated any functions.

ANCILLARY SERVICE REVIEW								
Service	Y	N	Capitated Services	Contracted Facility/Agency	Accredited by	Date Accreditation Expiration	Delegated Function	Date License Expiration
1. Alcohol/Substance Abuse								
2. Home Health Agency								
3. DME, Orthotics, Prosthesis								
4. Mental Health								
5. Short-term Rehabilitation; P.T./O.T.								
6. Short-term Rehabilitation; Speech								
7. Hospice								
8. Infusion Center								
9. Renal Dialysis								
10. Family Planning								
11. Chiropractor								
12. Skilled Nursing Facilities								
13. Tertiary Care Facility								
14. X-ray								
15. Ultrasound MRI/CT								
16. Laboratory								
17. Surgi-Centers								
18. Urgent Care Centers								
19. Transportation (ambulance, ambulans)								

**Note:** The Delegated Credentialing function is evaluated separately