
18. PROVIDER NETWORK

A. Primary Care Provider

1. IPA and Hospital Affiliations

APPLIES TO:

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

POLICY:

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

~~A.~~

- ~~A.~~ Within IEHP's service area, IEHP contracts with available Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Facilities (IHF) to ensure Member access to the services provided by these Providers.¹

~~B.~~

PROCEDURES:

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

¹ Department of Health Care Services (DHCS) All Plan Letter (APL) 21-006 supersedes APL 20-003, "Network Certification Requirements"

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1. IPA and Hospital Affiliations

Hospitals to comply with the two (2) Provider IPA/Hospital Affiliations rule, with the exception of PCPs with rural clinics which are allowed three (3) IEHP DualChoice Provider IPA/Hospital Affiliations as long as they fit the criteria as outlined in Policy 6E, “Rural Health Clinics.”

- E. A PCP may not transfer their assigned Membership with one (1) Provider IPA/Hospital Affiliation to another Provider IPA/Hospital Affiliation unless a written notification has been submitted to IEHP specifying that they will no longer continue with one of their Provider affiliations and that Provider Affiliation will be terminated. IEHP does not allow Providers to transfer Members back and forth between their existing Provider IPA/Hospital Affiliations due to the undue burden it places on Members being transferred from one IPA or hospital relationship to another. If a PCP has decided not to continue a relationship with an IPA or hospital, that Provider Affiliation must be terminated for Members to be transferred to the PCP’s other or new Provider Affiliation.
- F. IEHP will allow PCPs to have two (2) IPA affiliations at one (1) site linked to one (1) hospital as long as that IPA meets the criteria specified in Policies 18F, “Specialty Network Requirements” and 18H, “Hospital Affiliations.”
- G. IEHP verifies IPA and Hospital affiliation privileges and geographic distribution as stated in Policy 5B, “Hospital Privileges.”
- H. PCPs employed by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Facilities (IHF) are subject to the same stipulations cited above although assignment of Members is made to the clinic and not to the individual PCPs at the clinic. If an employed PCP leaves one of these types of clinics, the Members remain assigned to the clinic under the care of the PCP(s) currently credentialed at the clinic.²

² DHCS APL 21-006

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A. Primary Care Provider

1. IPA and Hospital Affiliations

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2021 <u>2023</u>

18. PROVIDER NETWORK

B. Provider Directory

APPLIES TO:

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

POLICY:

- A. IEHP publishes a printed IEHP Provider Directory on a monthly basis.^{1,2}
- B. Each Provider Directory contains information on IPAs and Hospitals, Primary Care Providers (PCPs), OB/GYNs, Specialists, Behavioral Health (BH) Providers, Behavioral Health Treatment (BHT) Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, Advanced Practice Practitioners (e.g. Nurse Practitioners (NPs), Physician Assistants (PAs), and Midwives), and other Providers who have been credentialed and are contracted with IEHP directly or through a subcontracted agreement with network IPAs.³
- C. Each PCP is listed individually in the Provider Directory to help facilitate the selection process by the Member.
- D. Based on IEHP PCP/ IPA affiliations, a PCP can be listed twice in the Provider Directories, except for those Physicians who also service IEHP rural areas.
- E. A PCP with two (2) IPA/Hospital affiliations, credentialed and board certified in two (2) IEHP approved specialties, can be listed a maximum of four (4) times in the Provider Directory.
- F. A listing of all contracted IPAs, Hospitals, PCP, Specialists, OB/GYNs, Behavioral Health Providers, BHT Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, and other Providers are included in the Provider Directory.
- G. IEHP also maintains a Web-based Provider Directory (known as “Find a Doctor search”) including other Provider Directory links for IEHP contracted Provider Networks, referred to as the Doctor Search, to provide Members and prospective members with the most updated IEHP Provider Network including IPAs, Hospitals, PCPs, Specialists, OB/GYNs, Behavioral Health Providers, BHT Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, and other Providers.^{4,5}

¹ California Health and Safety Code §1367.27

² Senate Bill 137

³ Ibid.

⁴ Ibid.

⁵ CA Health & Saf. Code §1367.27

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B. Provider Directory

- H. If a contracted Provider informs IEHP Provider Services or Contracts directly of a Provider Directory change or inaccuracy, IEHP will make that change to the IEHP internal systems or inform the delegated Provider of the inaccuracy in their Directory. When the internal systems are updated the network updates are reflected on the web-based directory by the following day.
- I. IEHP investigates each time it receives a report of a potential Provider Directory inaccuracy. Provider Services or Contracts reaches out to the Provider within five (5) business days of the inaccuracy report for confirmation of the following:⁶
1. Contracting Provider is no longer accepting new patients for any line of business.
 2. Removal of Provider or Provider group who has retired, ceased to practice, or no longer under contract with IEHP for any reason.
 3. Change in Provider's practice location or update of demographic information.
 4. Any information that affects the content or accuracy of the Provider Directory.
- J. Upon confirmation of the correct Provider information, a request if needed is sent to update IEHP's internal systems. When the internal systems are updated, the network updates are reflected on the web-based directory by the following day.
- K. As part of IEHP's monitoring process, on an annual basis, IEHP requires delegated contracted entities such as Kaiser Permanente, and American Specialty Health (ASH)) to provide a report of identified/reported inaccuracies and the timeframe of the correction as stated in Policy 25A2, "Delegation Oversight - Audit".

PROCEDURES:

- A. IEHP publishes the Provider Directory on a monthly basis to provide existing and potential Members with current information and changes in IEHP's network.
- B. Members, potential members or other requestors can receive the IEHP Provider Directory through the following:
1. IEHP mails a copy of the Provider Directory directly to new Members upon enrollment with IEHP.
 2. Members, potential members, or other requestors may call IEHP Member Services Department directly at (877) 273-4347 to receive a copy within five (5) days.^{7,8}

⁶ CA Health & Saf. Code §1367.27

⁷ Ibid.

⁸ SB 137

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3. Members can also access the Find a Doctor Search online at www.iehp.org. All network updates are reflected on web-based Provider Directory the same day.
- C. The printed IEHP Provider Directory contains information regarding IEHP's network Practitioners, including the following elements which are subject to change based on Program requirements, including but not limited to:^{9,10}
1. Headers to indicate City or Region Names (in alphabetical order);
 2. Specialty (e.g Family Medicine) including board certification if any;
 3. Provider Name (last, first – listed alphabetically);
 4. Gender;
 5. Eye Exams or Frame and Lens only (Vision Provider only);
 6. Provider's office email address, where the mail is intended for Member communication, regularly monitored and maintained in a manner consistent with State and Federal health privacy laws. The Provider will also attest to the security of the email address;
 7. Street Address, City and Zip Code;
 8. California license number and type of license;
 9. Age Restriction;
 10. Appointment Needed;
 11. Federally Qualified Health Center (FQHC);
 12. Board Certified;
 13. Telephone Number (including area code);
 14. Fax Number (including area code);
 15. Website;
 16. Affiliated Hospital;
 17. Hospital Admitting Privileges
 18. Affiliated IPA/Clinic;
 19. IEHP Assigned Doctor Number;
 20. National Provider Identifier (NPI) Number;

⁹ CA Health & Saf. Code §1367.27

¹⁰ SB 137

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B. Provider Directory

21. Languages (other than English) spoken by clinical staff including Physician;
 22. Business Hours and Days of operations;
 23. Bus Route Information;
 22. Panel Status (indication on whether a Provider is accepting new Patients, existing Patients only, not accepting new Patients currently- or if they are only available to see Patients by referral or only through a hospital or facility);¹¹
 23. Accessibility Level; and
 24. Extended Office Hours (Providers who are open before 8am, open after 5pm, or open weekends are 'bolded').
- D. The online IEHP Provider Directory also known as Find a Doctor, contains information regarding IEHP's network Practitioners, the following elements which are subject to change based on Program requirements, including but not limited to:
1. Provider Name
 2. Gender
 3. Office Phone Number
 4. Office Fax Number
 5. Office e-mail Address
 6. Office Hours
 7. Website
 8. After Hours
 9. Walk In
 10. Languages
 11. Address
 12. Bus Information
 13. Language Interpreter Available
 14. Clinical Staff Language
 15. Non-Clinical Staff Language

¹¹ CA Health & Saf. Code §1367.27

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B. Provider Directory

16. Specialty
17. Provider Number
18. National Provider Identification
19. Medical Board License
20. Directory ID
21. Plan (Line of Business)
22. Panel Status
23. Hospital
24. Age Restriction
25. Independent Practice Association (IPA)

- E. The Provider Directory also includes instructions for Members on how to use the Directory for selecting a Provider.
- F. IEHP requires all contracted Providers who are not accepting new Members to direct an enrollee or potential enrollee seeking to become a new Member to IEHP for additional assistance in finding a Provider and to the California Department of Health Care Services (DHCS) to report any potential Directory inaccuracy.^{12,13}
- G. IEHP maintains 100% verification of the elements listed above by faxing verification requests and calling each Practitioner that doesn't respond to the written request. If IEHP can not verify a Provider's information at a minimum once every three hundred sixty-five (365) days, IEHP will notify the Provider of pending Directory removal ten (10) business days prior to removal. Non-responsive Providers will be removed from the Directory at the next required update, except for general acute care Hospitals.
- H. IEHP may omit a Provider, Provider Group, or category of Providers similarly situated, from its directory if one of the following conditions are met:¹⁴
 1. Upon submission of a signed statement from an individual Provider to IEHP that the Provider is currently enrolled in the Safe at Home Program;
 2. Upon submission of a signed statement from an individual Provider to IEHP that the Provider fears for his or her safety or the safety of his or her family due to his or her

¹² CA Health & Saf. Code §1367.27

¹³ SB 137

¹⁴ Ibid.

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B. Provider Directory

affiliation with a health care service facility or due to his or her provision of health care services;

3. Upon submission of a signed statement from a person authorized by a Provider group to IEHP stating that a facility or any of its Providers, employees, volunteers, or Members is or was the target of threats or acts of violence within one (1) year of the date of the statement; or
 4. Upon the Department's prior approval pursuant to a finding of good cause or extraordinary circumstances.
- I. In instances where IEHP does not meet time and distance standards for specific Provider types in IEHP's service region, IEHP will allow Members to see a Provider who is not currently in IEHP's contracted network. IEHP has identified some zip codes and Provider types that do not meet the required time and distance standards. Department of Health Care Services (DHCS) requires approval for alternative access standards for these zip codes and Provider types. IEHP's web-based Find a Doctor Search contains information on the list of [eligible approved zip codes and Provider types by county](#).
 - J. Due to population mix in Riverside and San Bernardino Counties, IEHP evaluates the Spanish speaking capability of Practitioner's and their staff who have indicated they have capabilities to speak Spanish, at the time of entry into the network and annually through language competency audits, before this designation is listed in the Provider Directory as outlined in Policies 9H1, "Cultural and Linguistic Services - Foreign Language Capabilities" and 9H2, "Cultural and Linguistic Services –Language Competency Audits" for more information. Threshold Languages for Riverside and San Bernardino Counties, defined by the California Department of Health Care Services (DHCS) are English, Spanish, Chinese (including Mandarin and Cantonese), and Vietnamese.
 - K. IEHP posts a report every six (6) months on the secure Provider website of the most current listing of contracted and credentialed PCPs, Specialists, OB/GYNs, Physician Extenders and Ancillary Providers including their Hospital affiliation. All IPAs must examine these lists carefully in order to ensure the validity and integrity of the information provided.
 - L. Any errors in the information listed should be reported to IEHP Provider Services within five (5) days of receipt in order to update the Directory.
 - M. Provider shall inform IEHP within five (5) business days when either of the following occur:¹⁵
 1. Provider is not accepting new patients; or

¹⁵ SB 137.

18. PROVIDER NETWORK

B. Provider Directory

2. If Provider had previously not accepted new patients, Provider is currently accepting new patients.¹⁶
- N. IEHP investigates each time it receives a report of a potential Directory inaccuracy. IEHP will investigate by contacting the affected Provider within five (5) business days, and document the receipt, investigation and outcome of each reported potential Directory inaccuracy. IEHP will verify the accuracy of the information and update the information in the Provider Directory within thirty (30) calendar days if the update is needed based on findings of the investigation.¹⁷
- O. Changes made to the Provider Directory information as a result of any investigation will take place at the next required update, or the next scheduled update thereafter as applicable to the online Directory.

¹⁶ CA Health & Saf. Code §1367.27 (j)(1)

¹⁷ CA Health & Saf. Code §1367.27

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B. Provider Directory

NLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	September 1, 1996
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2022 <u>2023</u>

18. PROVIDER NETWORK

C. -PCP, Specialist, Vision and Behavioral Health Provider Network Changes

APPLIES TO:

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

POLICY:

- A. Primary Care Providers (PCPs) must provide sixty (60) days advance written notice to IEHP and their IPA regarding any changes in their operations including but not limited to address, IPA and/or Hospital affiliation.
- B. Specialist, Vision and Behavioral Health Providers must provide sixty (60) days advance written notice to IEHP of any changes in their clinic operation including but not limited to address.
- C. IPAs are required to submit coverage plans sixty (60) days in advance of the effective date whenever they are notified that a subcontracted PCP is relocating or terminating their IPA affiliation as outlined in ~~Section Policy~~ 18D1, “IPA Reported Provider Changes - PCP Termination.”
- D. IEHP allows changes in Hospital and IPA affiliations; however, PCPs should review their current contractual clauses regarding contract termination with their IPA before terminating the agreement.
- E. IEHP sends to Members thirty (30) days advance written notice about any changes to their PCP, Specialist and Behavioral Health Providers’ clinic operations including but not limited to address and terminations of agreements. If sufficient advance notice of sixty (60) days is not provided to IEHP regarding a change to the aforementioned Providers’ clinic operations, IEHP sends Members notice as soon as possible upon receiving notification of the change from the Provider.¹

PROCEDURES:

PCP Change in Affiliations

- A. PCPs must send written notification informing IEHP and their IPAs of a change in IPA and/or hospital affiliation sixty (60) days prior to the effective date of the change.
- B. IPAs have sixty (60) days from the effective date of a PCP’s IPA affiliation change to submit the initial credentialing packet to IEHP. Failure to do so will result in freezing ~~of the~~ PCP to

¹ DHCS All Plan Letter (APL) 21-003 Supersedes Policy Letter (PL) 16-001, “Medi-Cal Network Provider and Subcontractor Terminations”

18. PROVIDER NETWORK

C. -PCP, Specialist, Vision and Behavioral Health Provider Network Changes

new ~~membership~~ Membership assignment for sixty (60) days from the effective date of the IPA affiliation change or possible termination.

- C. For IPA changes, IEHP verifies that the new IPA has an approved specialty network in accordance with Policy 18F, “Specialty Network Requirements.” If the Hospital changes, IEHP verifies the new IPA has an approved Hospital link and the PCP has privileges or admitting arrangements in place at the new Hospital. A signature page of the agreement between the PCP and IPA is required to be submitted to IEHP by the new IPA. Once all information is verified and the new affiliation is accepted and processed then the PCP is assigned a new Provider IPA/Hospital Affiliation.
- D. Members are transferred from the old Provider IPA/Hospital Affiliation to the new Provider IPA/Hospital Affiliation on the first day of the month when the change is deemed effective by IEHP. Members are notified by IEHP thirty (30) days in advance of the effective date of the change.²
1. An IPA change becomes effective on the first of the month following sixty (60) days from the date notification is received by IEHP, unless otherwise approved by Provider Relations Management with a different date.
 2. A Hospital change becomes effective on the first of the month following sixty (60) days from the date notification is received by IEHP, unless otherwise approved by Provider Relations Management with a different date.
- E. Once all information is verified, IEHP sends a letter to the PCP with a copy to the old IPA and new IPA, if applicable, informing the PCP of ~~his/her~~ their new Provider IPA/Hospital Affiliation, effective date of the change, and status of ~~his/her~~ their ~~membership~~ Membership (See Attachments, “Change in IPA Affiliation Letter” and “Change in Hospital Affiliation Letter in Section 18).
- F. The above procedures for Member assignment may be modified due to circumstances that, in the judgment of the IEHP Chief Operating Officer (COO) or Chief Medical Officer (CMO) are in the best interest of the Member.

PCP Changes in Office Location

- A. IPAs and PCPs must provide written notification to IEHP that a PCP is relocating to another office within IEHP’s geographic service area sixty (60) days prior to the relocation.
- B. When a PCP site relocates, an initial Facility Site Review (FSR) is completed within sixty (60) days of notification or discovery of the completed move. IEHP allows the PCP to continue to see their assigned Members however, the PCP site is not assigned new Members

² DHCS APL 21-003

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C. -PCP, Specialist, Vision and Behavioral Health Provider Network Changes

until they receive passing FSR and MRR scores as outlined in Policy 6A, “Facility Site Review and Medical Record Review Survey Requirements and Monitoring.”³

- C. If a sixty (60) day advance notice is not received, the PCP is frozen to Member auto assignment; (not Member choice enrollment) for a period of sixty (60) days from the date IEHP received notification from the IPA.
- D. ~~When geographically appropriate,~~ Members remain with the PCP as long as time or distance access standards per Policy 9A, “Access Standards” are met. ~~unless the PCP moves to a different geographic area, defined as ten (10) miles, from the PCP’s former location.~~ IEHP makes every effort to notify Members thirty (30) days in advance of the effective date of the relocation.
- E. If a PCP moves to a ~~different~~ geographic area that goes beyond time or distance access standards per Policy 9A, “Access Standards,” IEHP reassigns Members to a new PCP that has the capacity and can accommodate the affected Members. IEHP cannot guarantee that a Member remains part of the IPA’s network.
- F. If the PCP practiced in a hospital-based clinic, county clinic, teaching clinic, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), ~~Indian Health Facilities (IHF)~~ Tribal Federally Qualified Health Center (Tribal FQHC), or other site IEHP determined functions as a clinic in which PCPs are employed, the Member will remain assigned to the clinic where the PCP practiced and the Member can continue their care at the clinic.
- G. The above procedure for Member assignment may be modified due to circumstances that in the judgment of the IEHP Chief Operating Officer (COO) or Chief Medical Officer (CMO) are not in the best interest of the Member.
- H. IPAs and PCPs also must submit written notification to IEHP Provider Services when there is a change in other office operations. For example, but not limited to, a change in phone or fax number, office hours, specialty, and/or capacity status.

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

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

³ DHCS APL 20-006 Supersedes PL 14-004, “Site Reviews: Facility Site Review and Medical Record Review”

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C. -PCP, Specialist, Vision and Behavioral Health Provider Network Changes

Specialist, Vision and Behavioral Health (BH) Provider Termination

- A. Specialist, Vision Providers and BH Providers no longer interested in participation in the IEHP network must submit a minimum of sixty (60) day written notice of intent to terminate. IEHP makes every effort based on the timing of notification by the Provider to provide impacted Members with a minimum of thirty (30) days' notice in advance of the effective date of the termination.⁴
- B. When a BH Provider is unable to continue to provide treatment for an IEHP Member, either due to going on medical leave, maternity leave, vacation, military duty, etc., the BH Provider or the Providers' office is responsible for coordinating the transition of impacted IEHP Members to other appropriate IEHP BH Providers to avoid patient abandonment. IEHP BH Providers are expected to follow all licensing board requirements and maintain ethical standards of practice while care is being transitioned.
- C. When a BH Provider is being terminated, the BH Provider or the BH Provider's office needs to cooperate with IEHP Behavioral Health and Care Management department in developing a transition plan for impacted IEHP Members that ensures Members are not abandoned and that BH Providers are compliant with their licensing board requirements and maintain ethical standards of practice. In order to coordinate the transition of IEHP Members, BH Providers may be required to provide a list of active IEHP Members who will need to be transitioned to another BH Provider, treatment records, and/or medication lists with the IEHP BH [& CM](#) Department.

⁴ DHCS APL 21-003

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C. -PCP, Specialist, Vision and Behavioral Health Provider Network Changes

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 202 3 ²

18. PROVIDER NETWORK

D. IPA Reported Provider Changes

1. PCP Termination

APPLIES TO:

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

POLICY:

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

~~D. A. IEHP monitors IPA compliance with policy on an annual basis.~~

PROCEDURES:

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

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D. IPA Reported Provider Changes

1. PCP Termination

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

Monitoring and Oversight

A. IEHP monitors IPA compliance with policy on an annual basis.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007

18. PROVIDER NETWORK

D. IPA Reported Provider Changes

1. PCP Termination

Chief Title: Chief Operating Officer	Revision Date:	January 1, 2021 2023
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18. PROVIDER NETWORK

D. IPA Reported Provider Changes

2. Specialty and Ancillary Provider Termination

APPLIES TO:

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

POLICY:

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

PROCEDURES:

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

18. PROVIDER NETWORK

D. IPA Reported Provider Changes

2. Specialty and Ancillary Provider Termination

2. Are currently under on-going care; or
 3. Have an open referral.
- C. After receiving written notification from the IPA, the ~~Sspecialty Provider~~ or Ancillary Provider is terminated in IEHP's system with the effective date of the termination.
- D. IEHP reserves the right to make final decisions regarding continuity of care for all Members.
- E. Members have the right to review IEHP final decisions, as well as obtain copies of this policy. Members desiring review of a decision, or wanting a copy of this policy, should contact IEHP at (877) 273-4347.
- F. IEHP monitors IPA compliance with notification requirements on a quarterly and annual basis, as part of its oversight of the IPA's specialty and ancillary network, as outlined in Policy 18F, "Specialty Network Requirements," and Policy 25B10, "Credentialing Standards – Credentialing Quality Oversight of Delegates."

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

18. PROVIDER NETWORK

D. IPA Reported Provider Changes

2. Specialty and Ancillary Provider Termination

		January 1, 2020 <u>2023</u>
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18. PROVIDER NETWORK

E. Management Services Organization Changes

APPLIES TO:

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

POLICY:

- A. IEHP evaluates all Management Services Organizations (MSOs) that are contracted with IPAs to ensure that they can meet IEHP operational requirements and standards.
- B. Any IPA wishing to contract with a new MSO must provide adequate notice to IEHP so that a pre-contractual audit can be performed to ensure that the MSO can meet IEHP operational requirements and standards.
- C. Prior to being included in IEHP's Provider network, the IPA or MSO must meet IEHP's contractual, financial, administrative, and quality standards.
- D. IEHP performs an on-site audit of the IPA or MSO to review information provided in the pre-contractual response.
- E. If an IPA wishes to change MSOs, the IPA must provide IEHP a ninety (90) day advance written notice of the change.
- F. The new MSO will be subject to a pre-contractual audit prior to approval.
- G. The IPA must submit a transition plan of services thirty (30) days prior to change from the existing MSO to the new MSO.
- H. If the MSO does not meet IEHP standards, the IPA is not allowed to transition to the new MSO. For new IPAs, failure to have an MSO or in-house staff and procedure that meet minimum standards will result in all contracting efforts being halted.
- I. In the event that a MSO contracted with a IPA experiences significant operational or financial failures that result in the termination of the IPA, IEHP reserves the right to eliminate the MSO or its principals for future management services for any of our currently contracted or new IPAs.
- J. If the MSO is providing management services for more than one (1) currently contracted IPA in the IEHP network and is undergoing significant operational or financial failures a review will be performed to ensure that the MSO is meeting IEHP operational requirements and standards for each contracted IPA.
- K. If the MSO is providing management services for more than one (1) currently contracted IPA in the IEHP network and is in good standing, a new pre-contractual audit may be waived, only the transition plan will be required.

PROCEDURES:

18. PROVIDER NETWORK

E. Management Services Organization Changes

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2021 2023

18. PROVIDER NETWORK

F. Specialty Network Requirements

APPLIES TO:

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

POLICY:

A. IEHP maintains adequate numbers and types of Specialists to provide access to preventive and managed health care services to its Members.¹

B. IEHP has identified its high-volume Specialists based on demographics and number of encounters. To ensure that Members have adequate access to such high-volume Specialists, IEHP and the its IPAs (when applicable) must maintain the following minimum ratios of high-volume specialty Providers to Members:

<u>1. OB/GYNs</u>	<u>1: 25,000</u>
<u>2. Physical Therapist</u>	<u>1:10,000</u>
<u>3. Orthopedic Surgery</u>	<u>1: 7,143</u>
<u>4. Ophthalmology</u>	<u>1: 5,556</u>
<u>5. Cardiology/Interventional Cardiology</u>	<u>1: 7,143</u>
<u>6. Pain Management</u>	<u>1:15,000</u>

C. IEHP has identified its high impact Specialists based on Utilization data such as Claims and encounters on an annual basis. To ensure that the Members have adequate access to such highly impacted Specialists, IEHP maintains the following minimum ratios of high-impact specialty Providers to Members.

<u>1. Hematology</u>	<u>1:7,143</u>
<u>2. Oncology</u>	<u>1:7,143</u>

D. IEHP has identified its high-volume Behavioral Health (BH) Providers based on demographics and number of encounters. To ensure that the Members have adequate access to such high-volume Behavioral Health BH Providers, IEHP maintains the following minimum ratios of high-volume Behavioral Health BH Providers to Members:

<u>1. Mental Health Practitioners</u>	<u>1: 7,000</u>
<u>2. Marriage and Family Therapist</u>	<u>1: 7,000</u>
<u>3. Licensed Clinical Social Worker</u>	<u>1: 7,000</u>

¹ Title 22 California Code of Regulations (CCR) § 53853(a)

18. PROVIDER NETWORK

F. Specialty Network Requirements

4. Psychiatrists 1: 2,500

5. Psychologists 1: 7,000

~~A. State Regulators mandate the types of Specialists required in IEHP's network (See Attachment, "Specialty Panel Worksheet" in Section 18 for required specialties).²~~

~~B. All Members must receive access to all covered services without restriction based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.³~~

~~C.A. IEHP requires IPAs to provide covered services to all Members assigned to them at an appropriate facility without imposing restrictions as listed in Policy B.~~

~~D.A. IEHP requires IPAs to submit a complete listing of their specialty network including Specialists, contracted Hospitalists, Admitters, Extenders and Ancillary Providers to identify the IPA's current Provider network.~~

~~E.A. IEHP monitors the specialty network including Specialists, Hospitalists, Admitters, Extenders and Ancillaries for each affiliated Hospital on a semi-annual basis.~~

~~F. Prior to establishing a "link" to a network Hospital and prior to receiving enrollment in each geographic area:~~

~~1. All IPAs must submit a complete IPA Hospital Link Responsibility Grid in the format required by IEHP (See Attachment, "IPA Hospital Link Responsibility Grid—IEHP DualChoice" in Section 18) Hospitalist or Admitters and Ancillary Providers, contracted and credentialed, that have privileges at IEHP contracted Hospitals. Upon receipt of a complete specialty network, IEHP will schedule the review of the data according to the current needs of the plan as they relate to access and network adequacy.~~

~~2.1. A complete specialty network of Physicians is defined as consisting of a minimum of two (2) unique Providers for every specialty listed in this policy and two (2) unique Providers contracted with the IPA in every specialty in each local geographic service area as it relates to the Hospital affiliation. A Specialist Provider who has offices in several geographic regions counts as one (1) unique Specialist regardless of the number of Hospitals at which the Specialist has privileges.~~

~~3.1. For inpatient utilization oversight, the use of on-site Hospitalists is required.~~

² CMS Health Service Delivery (HSD) Instructions for MMPs Annual Medicare Network Submission (CY2019).

³ Title 42 Code of Federal Regulations (CFR) § 442.110.

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F. Specialty Network Requirements

~~4.E.~~ IEHP requires IPAs to have all IEHP Specialists under contract must be located within thirty (30) miles or sixty (60) minutes of a Member's residence, via public or private transportation.

~~G.A.~~ IEHP has identified its high volume Specialists based on demographics and number of encounters. To ensure that Members have adequate access to such high volume Specialists, IEHP and the IPA (when applicable) must maintain the following minimum ratios of high volume specialty Providers to Members:

1. OB/GYNs	1: 25,000
2.1. Physical Therapist	1:10,000
3.1. Orthopedic Surgery	1: 7,143
4.1. Ophthalmology	1: 5,556
5.1. Cardiology/Interventional Cardiology	1: 7,143
6.1. Pain Management	1:15,000

~~I.~~ IEHP has identified its high impact Specialists based on Utilization data such as Claims and encounters on an annual basis. To ensure that the Members have adequate access to such highly impacted Specialists, IEHP maintains the following minimum ratios of high impact specialty Providers to Members:

1. Hematology	1:7,143
2.1. Oncology	1:7,143

~~H.A.~~ IEHP has identified its high volume Behavioral Health Providers based on demographics and number of encounters. To ensure that the Members have adequate access to such high volume Behavioral Health Providers, IEHP maintains the following minimum ratios of high volume Behavioral Health Providers to Members:

1. Mental Health Practitioners	1: 7,000
2.1. Marriage and Family Therapist	1: 7,000
3.1. Licensed Clinical Social Worker	1: 7,000
4.1. Psychiatrists	1: 2,500
5.1. Psychologists	1: 7,000

DEFINITIONS:

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

18. PROVIDER NETWORK

F. Specialty Network Requirements

~~A.~~

B. ~~A~~ ~~h~~ High-volume Specialist ~~is defined as a~~ ~~A~~ Physician located in an expected high-volume geographic area or in high-volume specialties or both and most likely provides services to the largest segment of the membership.

C. ~~A~~ ~~h~~ High-impact Specialist ~~is defined as a~~ ~~A~~ Physician that treats conditions that have mortality and morbidity rates and where treatment requires significant resources.

D. ~~A~~ ~~e~~ Complete ~~s~~ Specialty ~~n~~ Network of Physicians ~~is defined as~~ ~~For the purpose of this policy, a complete specialty network of physicians is defined as~~ consisting of a minimum of two (2) unique Providers for every specialty listed ~~in this policy~~ and two (2) unique Providers contracted with the IPA in every specialty in each local geographic service area as it relates to the Hospital affiliation. A Specialist Provider who has offices in several geographic regions counts as one (1) unique Specialist regardless of the number of Hospitals at which the Specialist has privileges.

PROCEDURES:

IPA Responsibilities

A. ~~IEHP requires IPAs to provide covered services to all Members assigned to them at an appropriate facility without imposing restrictions 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, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment as listed in Policy B.~~⁴ See Policy 9H.3, “Culture and Linguistics – Non-Discrimination” for more information.

B. ~~IEHP requires IPAs to submit a complete listing of their specialty network, including Specialists, contracted Hospitalists, Admitters, Extenders and Ancillary Providers to identify the IPA’s current Provider network.~~

~~A.C.~~ In order for an IPA to establish a link (affiliation) ~~at to~~ an IEHP contracted Hospital, the IPA must submit ~~via in~~ the format ~~approved required~~ by IEHP ~~their network of contracted and credentialed Physicians for the~~ following DHCS Core ~~Specialty Specialties~~ (see Attachment, “IPA Hospital Link Responsibility Grid – IEHP DualChoice in Section 18”). ~~network of Physicians, contracted and credentialed, and IEHP requires at~~ a minimum of two (2) unique Physicians and two (2) unique Physician contracts for each specialty ~~in place~~ that have admitting privileges at the designated Hospital (unless other inpatient coverage as delineated in Policy 5B “Hospital Privileges”):

1. Dermatology;

⁴ Title 42 Code of Federal Regulations (CFR) § 422.110(a)

18. PROVIDER NETWORK

F. Specialty Network Requirements

2. Endocrinology;
3. Gastroenterology;
4. General Surgery;
5. Infectious Disease/HIV Specialist;
6. Nephrology;
7. Neurology;
8. Orthopedics Surgery;
9. Otolaryngology (ENT);
10. Psychiatry;
11. Physical Medicine and Rehabilitation; and
12. Pulmonary ~~Medicine~~ Medicineology.

B. Prior to receiving enrollment at this established link, the IPA must ensure ~~that the following specialty network of Physicians, consisting of that~~ a minimum of two (2) unique Providers and two (2) unique Provider contracts per specialty are contracted and credentialed within the local geographic service area of the linked Hospital (See Attachment, “Hospital Geographic Service Areas” in Section 18 ~~for geography coverage~~):

1. Allergy and Immunology;
2. Cardiac/Thoracic Surgery;
3. Neurosurgery (if the Hospital provides this service);
4. Speech Therapy
5. Plastic Surgery;
6. Podiatry;
7. Rheumatology;
8. Urology; and
9. Ancillary Provider.

~~a)~~a. Audiology

~~b)~~b. Diagnostic Radiology

~~c)~~c. DME

~~d)~~d. Home Health

~~e)~~e. Home Infusion Agency

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F. Specialty Network Requirements

~~f.)~~ Imaging/Diagnostic/X-Ray

~~g.)~~ Laboratory

~~h.)~~ Radiology

C. If the network Hospitals within the affiliated Hospital's local geography do not offer these services, the IPA is not required to have the corresponding specialty in place as outlined above, but must make regionally appropriate arrangements with other Hospitals in the IEHP network. IEHP will verify availability of Specialists before approving regionally appropriate arrangements.

D. For inpatient utilization oversight, the use of on-site Hospitalists is required.

~~D-E.~~ After receiving the IPA's complete specialty network ~~presented by the IPA~~, the Director of Provider Relations will determine the scheduling of the network review and approval in accordance with access and network adequacy requirements. Once confirmed, the Provider Relations Manager or Provider Services Representative will advise the IPA when the specialty network will be reviewed and provide an estimate of an effective date of the new affiliation, dependent upon the completeness of the specialty network presented.

~~E-F.~~ In the event that a Member is at ~~the a~~ linked or non-linked Hospital and requires a consult from a specialty physician that the IPA does not have under contract at that Hospital, the IPA must arrange and pay the Specialist for the consulting services rendered at the rate required by the Specialist.

G. In the event a Member must be transferred to another Hospital due to a lack of a contracted Specialist that is available at the Hospital, the IPA will be financially responsible for the transfer transportation costs.

H. ~~In certain instances w~~When services required are unavailable within the IEHP network, the IPA must arrange for the provision of specialty services from Providers outside the contracted network to ensure uninterrupted care to Members and timely access as outlined in Policy 9A, "Access Standards." IPA must initiate and execute a Letter of Agreement (LOA) for services rendered outside the network. IPA must ensure that the cost to the Member should be no greater than it would be if the services were provided in-network.

I. ~~On a semi-annual basis, IEHP posts on its secure Provider website the IPA's specialty network roster. IPAs are required to review and update all information located on the secure Provider website provided~~ within thirty (30) days of the information being made available ~~online.~~

Specialist Responsibilities

~~F-A.~~ Specialists are required to offer the same hours of operation for appointments or walk in for all patients, regardless of line of business.

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F. Specialty Network Requirements

~~G.C. In the event a Member must be transferred to another Hospital due to a lack of a contracted Specialist that is available at the Hospital, the IPA will be financially responsible for the transfer transportation costs.~~

~~H.C. In certain instances when services required are unavailable within the IEHP network, the IPA must arrange for the provision of specialty services from Providers outside the contracted network to ensure uninterrupted care to Members and timely access as outlined in Policy 9A, "Access Standards." IPA must initiate and execute a Letter of Agreement (LOA) for services rendered outside the network. IPA must ensure that the cost to the Member should be no greater than it would be if the services were provided in-network.~~

~~I.C. On a semi-annual basis, IEHP posts the IPA's specialty network roster on its secure provider website including adult/Pediatric Hospitalists, adult/Pediatric Admitters, Extenders, and Ancillary Providers submitted previously by the IPA to IEHP that identifies the IPA's current Provider network that includes:~~

~~1. Practitioner name;~~

~~2.1. Address;~~

~~3.1. Phone number;~~

~~4.1. License number;~~

~~5.1. Specialty type;~~

~~6.1. Hospital affiliations;~~

~~7.1. IPA credentialing committee dates;~~

~~8.1. For Obstetricians only, the Hospitals they deliver; and~~

~~9.1. IPAs are required to verify and update the above information. Specific reporting requirements are delineated in Policy 5C, "IEHP Quality Oversight of Participating Practitioners."~~

~~J.C. IPAs are required to update all information located on the secure Provider website within thirty (30) days of the information being made available online.~~

~~K.C. Failure of the IPA to complete the required updates in a timely manner including written termination notifications of Specialist as stated in Policy 18D2, "IPA Reported Provider Changes - Specialty Provider Termination," may result in freezing the IPA for a period up to sixty (60) days.~~

~~L.C. IEHP reviews the information provided by the IPA and tracks the specialty network including adult/Pediatric Hospitalists, adult/Pediatric Admitters, Extenders and Ancillary Providers of~~

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F. Specialty Network Requirements

~~each IPA geographically to identify any “holes,” missing required Specialist(s) or lacking Hospital or geographic coverage.~~

~~M.C. The Provider Network Team analyzes the IPA’s specialty network. Upon concluding review of the specialty network, IEHP will issue a communication to the IPA with its findings. The communication will outline the network deficiencies that were identified. The IPA will be given thirty (30) days to respond and will be given ninety (90) days to cure those deficiencies.~~

~~N.C. Depending on the impact to either the Member or Hospital, IEHP may immediately freeze the affected IPA/Hospital link or the IPA from receiving any new enrollment until such deficiencies are corrected.~~

~~O.C. If the IPA is unable to correct the deficiencies within the allotted timeframe, IEHP may transfer the existing enrollment from the affected IPA to other IPAs that have adequate specialty networks and terminate linkage.~~

~~P.C. No enrollment is given to any new PCP until the IPA’s specialty network at the affiliated Hospital has been approved by IEHP.~~

Monitoring and Oversight

A. State Regulators mandate the types of Specialists required in IEHP’s network (See Attachment, “Specialty Panel Worksheet” in Section 18 for required specialties).⁵

~~IEHP monitors the specialty network including Specialists, Hospitalists, Admitters, Extenders and Ancillaries for each affiliated Hospital on a semi-annual basis.~~

B. On a semi-annual basis, IEHP posts on its secure Provider website the IPA’s specialty network roster on its secure provider website including adult/Pediatric Hospitalists, adult/Pediatric Admitters, Extenders, and Ancillary Providers submitted previously by the IPA, including but not limited to to IEHP that identifies the IPA’s current Provider network that includes:

1. Practitioner name;
2. Address;
3. Phone number;
4. License number;
5. Specialty type;
6. Hospital affiliations;
7. IPA credentialing committee dates; and
8. For Obstetricians only, the Hospitals wherethey deliver; and.

⁵ CMS Health Service Delivery (HSD) Instructions for MMPs Annual Medicare Network Submission (CY2019).

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F. Specialty Network Requirements

IPAs are required to verify and update the above information. Specific reporting requirements are delineated in Policy 5C, “IEHP Quality Oversight of Participating Practitioners.”

C. Failure of the IPA to complete the required updates in a timely manner including written termination notifications of Specialist as stated in Policy 18D2, “IPA Reported Provider Changes – Specialty and Ancillary Provider Termination,” may result in freezing the IPA for a period up to sixty (60) days.

~~IEHP reviews the information provided by the IPA and tracks the specialty network including adult/Pediatric Hospitalists, adult/Pediatric Admitters, Extenders and Ancillary Providers of each IPA geographically to identify any “holes,” missing required Specialist(s) or lacking Hospital or geographic coverage.~~

D. The Provider Network Team analyzes the IPA’s specialty network. Upon concluding review of the specialty network, IEHP will issue a communication to the IPA with its findings. The communication will outline the network deficiencies that were identified.

~~1. The IPA will be given thirty (30) days to respond, -and will be given ninety (90) days to cure those deficiencies.~~

1.

2. Depending on the impact to either the Member or Hospital, IEHP may immediately freeze the affected IPA/Hospital link or the IPA from receiving any new enrollment until such deficiencies are corrected.

3. If the IPA is unable to correct the deficiencies within the allotted timeframe, IEHP may transfer the existing enrollment from the affected IPA to other IPAs that have adequate specialty networks and terminate linkage.

4. No enrollment is given to any new PCP until the IPA’s specialty network at the affiliated Hospital has been approved by IEHP.

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F. Specialty Network Requirements

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2022 2023

18. PROVIDER NETWORK

G. Provider Resources

APPLIES TO:

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

POLICY:

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

18. PROVIDER NETWORK

G. Provider Resources

their mailing address or email address.

- G. It is crucial to the success of IEHP and its Delegates to develop relationships and communication between its Practitioners, ancillary Providers, and contracted partners.

PROCEDURES:

A. Joint Operations Meetings (JOMs):

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

B. Care Management Teams:

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

18. PROVIDER NETWORK

G. Provider Resources

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

C. IEHP Provider Relations Team:

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

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G. Provider Resources

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

D. [IEHP Contracts Service Team](#)

18. PROVIDER NETWORK

G. Provider Resources

~~1. Provider Contracting Services Representatives (PCSRs):~~

- ~~a. IEHP PCSRs are trained in accordance with regulations set forth by the State Programs Regulations.~~
- ~~b. IEHP PCSRs provide detailed information about IEHP benefits, IEHP programs, and managed care concepts to IEHP Ancillary Providers and Hospitals, and serve as the focal point for staff to obtain information about IEHP programs, DHCS, CMS and other regulatory issues, as applicable.~~
- ~~c. For the purposes of visits, the PCSRs are assigned geographic areas to visit IEHP Ancillary Providers and Hospitals.~~
- ~~d. On an initial, periodic and Provider requested basis, PCSRs provide training to IEHP Ancillary Providers and their staff covering an array of topics, including but not limited to:
 - ~~1) Prior Authorization Requests~~
 - ~~2) Member Eligibility~~
 - ~~3) Website Tools~~
 - ~~• Electronic Referrals~~
 - ~~• Care Plans~~
 - ~~• Member Health Records~~
 - ~~• Online formulary search~~
 - ~~• IEHP Guidelines for Care Management~~
 - ~~• Compliance Training and Fraud, Waste and Abuse (FWA)~~
 - ~~• Provider Orders for Life-Sustaining Treatment (POLST) Registry~~
 - ~~4) Claims~~
 - ~~• Claim Status~~
 - ~~• Clean Claim requirements~~
 - ~~• Provider Dispute Resolution (PDR) Process~~
 - ~~• Correct Billing Entities and Division of Financial Responsibility~~
 - ~~• Prohibition of balance billing Members~~
 - ~~5) Program updates and communications~~
 - ~~• Review of blast faxes sent in previous quarter~~~~

18. PROVIDER NETWORK

G. Provider Resources

~~6) Providers and their staff are encouraged to ask questions with their IEHP PCSRs, especially to help the staff understand complex State regulations concerning Medi-Cal Program beneficiaries.~~

E. Nurse Educators (NE) and/or Quality Program Nurses (QPN)

1. Nurse Educators develop Provider Trainings for areas determined to be of concern such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, Quality Improvement initiatives and Medical Record documentation.
2. Provider on-site trainings to the Provider Network in areas determined to be of concern. Coordinate trainings with other departments such as Provider Services, Contracting and Medical Management.
3. Perform Facility Site Audit and Medical Record Audits trainings for Primary Care Providers (PCPs).

F. Medicare Sales Team

1. IEHP Medicare Sales Team is trained in accordance with regulations set forth by the Centers for Medicare and Medicaid Services (CMS).
2. The IEHP Medicare Sales Team provides detailed information about the IEHP DualChoice including the benefits available to IEHP DualChoice Members.

G. IEHP University:

1. On an annual basis or when applicable, IEHP conducts a one (1) day training seminar (“IEHP University”) for IPAs and Hospital key staff.
2. IEHP offers various IEHP plan administration “courses” for the IPA and Hospital key staff to choose from.
3. Each IPA and Hospital is required to send a minimum of three (3) key staff members to each IEHP University.

H. Provider Newsletter (The Heartbeat)

1. The Heartbeat is a newsletter that is distributed by mail to all IEHP Providers on a bi-annual basis.
2. The purpose of the Heartbeat is to communicate information to Providers of any policy, benefit, service, program, State and Federal regulatory changes and/or updates.
3. Inform Providers of featured health education programs available to Members, so that Providers can refer Members to applicable IEHP health education program or encourage attendance at those programs.
4. Inform Providers of results of quality studies or other quality of care related information.
5. Provide and reiterate important information to Providers.

I. Provider Staff Newsletter (ScrubTalk)

18. PROVIDER NETWORK

G. Provider Resources

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

J. Special Provider Notices

1. Regulatory changes made by DHCS, California Department of Managed Health Care (DMHC), or CMS are communicated to our Providers.
2. The Provider Services Department determines the need for such special notices.

K. IEHP Website – www.iehp.org

1. IEHP's website is a valuable business tool created to provide our Providers with twenty-four (24) hours, seven (7) days a week access to IEHP resources.
2. IEHP's website has an enhanced security system that provides additional levels of security to Providers. These features ensure Health Insurance Portability and Accountability Act (HIPAA) privacy, security compliance and limit employee access to claims, clinical, P4P and other reimbursement information.
3. Providers are encouraged to use the IEHP website in an effort to go 100% paperless.
4. IEHP strives to provide our Provider Network with all the tools necessary to deliver the highest quality of care. These include:
 - a. Non-Secure Site
 - 1) Find a Provider
 - 2) Provider Login
 - 3) Pay for Performance (P4P)
 - Pay For Performance (P4P) Program – DualChoice Annual Visit
 - Medicare P4P IEHP Direct
 - Global Quality P4P Program
 - Hospital P4P Program
 - OB/GYN P4P Program
 - 4) Proposition 56
 - Electronic Payments

18. PROVIDER NETWORK

G. Provider Resources

- Adverse Childhood Experiences Screening (ACES) Services
- Developmental Screening Services
- Family Planning Services
- 5) Ground Emergency Medical Transport (GEMT) Payment
 - HYDE
 - Proposition 56 and GEMT Payment Schedule
 - Proposition 56 Payment Dispute Process
- 6) Proposition 56 – Value Based Payments (VBP)
- 7) Plan Updates
 - Correspondence
 - Coronavirus (COVID-19) Advisory
 - IEHP Holiday Schedule
 - Medicare Beneficiary Identifier (MBI)
 - Newsletters
 - The Heartbeat
 - ScrubTalk
 - Public Health Advisory
 - Riverside County Public Health System
 - San Bernardino County Public Health System
 - Centers for Disease Control and Prevention (CDC)
 - California Department of Public Health (CDPH)
 - Regulatory Updates
 - Medicare Outpatient Observation Notice (MOON)
 - Updates
 - [IEHP DualChoice](#) [Cal Medi Connect](#) Quality Withhold Measures
 - Flu Updates
 - Preventive Services
- 8) Provider [Policy & Procedure](#) Manuals
 - General Information

18. PROVIDER NETWORK

G. Provider Resources

- Acknowledgement of Receipt (AOR)
- [2022-2023](#) Manuals
 - Provider [Policy and Procedure](#) Manual – Medi-Cal
 - Provider [Policy and Procedure](#) Manual – [IEHP](#) DualChoice [Cal MediConnect](#)
 - Benefit Manual Information
 - Electronic Data Interchange
 - Regulatory Trainings
 - [2022-2023](#) Acknowledgement of Receipt
- 9) Provider Resources
 - Claims
 - Medi-Cal Learning Portal
 - Medi-Cal Rates and Codes
 - Medicare Physician Fee Schedule
 - IEHP Fee Schedule
 - Other Health Coverage (OHC)
 - Coordination of Benefits with Other Health Coverage (OHC)
 - Frequently Asked Questions (FAQs) - OHC
 - Compliance
 - IEHP Code of Business Conduct and Ethics
 - Compliance, Fraud, Waste and Abuse (FWA), and Privacy Program Training
 - Exclusion Screening
 - Fraud, Waste, and Abuse (FWA) Guidelines for Care Management Training
 - Privacy Incident/Breach
 - Reporting Information
 - Frequently Asked Questions (FAQs)
 - Guidelines for Care Management Training
 - Contact the OIG
 - Educational Opportunities

18. PROVIDER NETWORK

G. Provider Resources

- [IEHP DualChoice Medicare-~~CM~~IPA Training](#)
- Specialty Mental Health Care Coordination
- Staying Health Assessment (SHA) Training
- National Lesbian, Gay, Bisexual, Transgender (LGBT) Health Education Webinars
- Online Cultural Competency Training
- Forms
 - Behavioral Health
 - Claims
 - Compliance
 - Delegation Oversight Audit (DOA)
 - Grievance
 - Growth Chart
 - Health and Wellness
 - Historical Data Form
 - Medi-Cal Letter Templates
 - Medicare-Medicaid Plan Letter Templates
 - Medicare
 - Non-Contracted Providers
 - Perinatal
 - Pharmacy
 - Provider Preventable Conditions (PPC)
 - Staying Health Assessment (SHA)
 - UM/CM
 - Vision
 - Other
- Health & Wellness
 - Brochures and Handouts
 - Diabetes Prevention Program (DPP) – Live the Life You Love
 - Educational Resources

18. PROVIDER NETWORK

G. Provider Resources

- POLST Registry
- Pharmacy Services
- Quality & Clinical Resources and Tools
 - Preventive Care Guidelines
 - Clinical Practice Guidelines Library
- Additional Tools & Resources
 - After Hours Care
 - After Hours Phone Numbers for Coverage Determination and Expedited Appeals (IEHP ~~Medicare~~ DualChoice ~~Cal~~ MediConnect Members)
 - IEHP Access Standards
 - IEHP Direct Adult Hospitalists
 - LabCorp Locations
 - Urgent Care Clinics
- Utilization Management Criteria
 - Behavioral Health
 - Diagnostic Testing
 - DME and Medical Supplies
 - ENT
 - Gynecology and Obstetrics
 - Neurology
 - Oncology
 - Orthopedic
 - Pain Management
 - Pediatric
 - Surgical Procedures
 - Other

10) Pharmacy Services

- Academic Detailing
- [IEHP DualChoiceCal MediConnect](#)

18. PROVIDER NETWORK

G. Provider Resources

- Clinical Information
 - Clinical Practice Guidelines
 - High Risk Medications
 - Medication Therapy Management
 - Pharmacy Pain Management
 - Prescription Drug Prior Authorization Drug Treatment Criteria
 - Safety Resources
- DHCS Medi-Cal Rx
- Drug MAC
- Formulary
- Pharmacy Forms and Manuals
 - Prior Authorization/Coverage Determination
 - Drug Request
 - Medicare
 - Mail Order
 - Other Pharmacy Provider Forms
 - WIC Program Forms (California Department of Public Health)
 - Pharmacy Manuals
- Pharmacy Network Lists
 - IEHP Pharmacy Network
 - Specialty Pharmacy Network List
 - Vaccine Pharmacy Network List
- Pharmacy P4P Program
 - Program Overview
 - Program Eligibility Criteria
 - Program Timeline
 - Program Components
 - Pharmacy Recognition
 - Pharmacy P4P Communications
- Pharmacy Quality Ratings

18. PROVIDER NETWORK

G. Provider Resources

- Provider Communications

11) Special Programs

- Alcohol Misuse Screening and Counseling (AMSC – formerly SBIRT)
- Baby-N-Me
- Behavioral Health Integration Incentive Program (BHIIP)
- California Children Services (CCS)
- Health Homes Program
- IEHP Gender Health
- Independent Living and Diversity Resources
 - ADA and Beyond
 - Enforcement
 - Facts and Information
 - Legal Obligations
 - Technical Assistance
 - Community Based Adult Services (CBAS)
 - SPD Awareness Training
- MyPath Palliative Care
- Services for Teen Patients
- Tobacco Cessation Services
- Total Fracture Care Program

12) Join Our Network

- Ancillary
- Behavioral Health
 - Behavioral Health Forms
 - Frequently Asked Questions (FAQs)
- Hospitals
- IPA
- PCP and Specialists
- Provider Network Expansion Fun

18. PROVIDER NETWORK

G. Provider Resources

- Screening and Enrollment
 - Vision
- b. Secure Site Login
- 1) Home (Landing Page)
 - AMSC (formerly known as SBIRT) Services
 - Coronavirus (COVID-19) Advisory
 - Department of Public Health
 - Department of Social Services Requirements
 - Division of Financial Responsibility (DOFR) (for IPAs only)
 - Events and Training
 - Forms
 - Global Quality P4P Program (For PCPs Only)
 - IEHP Direct Hospitalist for Adults (for IPAs only)
 - Provider Network Expansion Fund
 - Special Programs
 - Updates
 - 2) Eligibility (including Other Health Coverage information)
 - Other Health Coverage FAQs
 - 3) Rosters
 - Admitter List (for IPAs only)
 - Ancillary Roster (for IPAs only)
 - Assigned Roster
 - CM Plan Referrals (for IPAs only)
 - CCS
 - COVID-19 Positive
 - COVID-19 Vaccine
 - Direct Ancillary Roster (For Direct Contracted Providers only)
 - Direct Specialty Roster (For Direct Contracted Providers only)
 - DocOnline

18. PROVIDER NETWORK

G. Provider Resources

- Early Start Roster
- HCC (for IPAs only)
- Health Management
 - Asthma Roster
 - Care Plans and HRAs
 - Diabetes Roster
- Initial Health Assessment
- Inpatient Discharges
- Long Term Services and Support (LTSS) Roster
- NEMT PCS Roster
- Nurse Advice Line
- Preventive Care (for Direct Contracted Providers only)
 - ADHD Medication (Follow-up Care)
 - Adult BMI Assessment
 - Annual Monitoring for Patients on Persistent Medications
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
 - Breast Cancer Screen
 - Cervical Cancer Screen
 - Childhood Immunizations
 - Chlamydia Screening
 - Controlling High Blood Pressure
 - Diabetes Care
 - DualChoice Annual Visit
 - Immunizations for Adolescents
 - Medication Management for People with Asthma
 - Prenatal and Postpartum Care
 - Screening for Clinical Depression
 - Weight Assessment and Counseling Nutrition and Physical Activity
 - Well Care (0-15 Months)

18. PROVIDER NETWORK

G. Provider Resources

- Well Care (3-6 Years)
 - Well Care (Adolescent)
 - Yellow Card
- 4) Global Quality P4P (for IPAs only)
- ADHD Medication (Follow-up Care)
 - Adult BMI Assessment
 - Annual Monitoring for Patients on Persistent Medications
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
 - Breast Cancer Screen
 - Cervical Cancer Screen
 - Childhood Immunizations
 - Chlamydia Screening
 - Controlling High Blood Pressure
 - Diabetes Care
 - Immunizations for Adolescents
 - Medication Management for People with Asthma
 - Prenatal and Postpartum Care
 - Screening for Clinical Depression
 - Weight Assessment and Counseling Nutrition and Physical Activity
 - Well Care (0-15 Months)
 - Well Care (3-6 Years)
 - Well Care (Adolescent)
 - Yellow Card
- 5) Encounter
- 6) Vision Providers Only
- Claims Entry
 - Vision Exception Request
 - VER (Status)
 - Vision Referral Request

18. PROVIDER NETWORK

G. Provider Resources

- Diabetes Care
- ICD Codes
- 7) Pharmacy
 - Rx PA/CD Authorization Request
 - Medi-Cal Formulary & Healthy Kids Formulary
 - CMC Formulary
 - Prior Authorization Criteria
 - Pharmaceutical Services
- 8) Claims Status
- 9) Behavioral Health
 - Referral Request Form
 - COC Treatment Plan
 - Claims Submission
 - BHICCI Program
 - Roster
 - Reporting Dashboard
 - Member Review Report
 - Care Team Member Report
- 10) Referrals
 - Status
 - Request
- 11) Finance
 - Capitation Reports
 - GQ P4P PMPM
 - Claims Remittance Advice (RAs)
 - P4P RAs
 - Prop 56 RAs
- 12) Census Reports
- 13) Pay for Performance (P4P)

18. PROVIDER NETWORK

G. Provider Resources

- P4P Entry
 - DualChoice Annual Visit
 - Cervical Cytology Screen
 - Perinatal & Postpartum
 - PM160
 - Yellow Card
- P4P Status
 - Asthma
 - Diabetes
 - DualChoice Annual Visit
 - Cervical Cytology Screen
 - Perinatal & Postpartum
 - PM160
 - Yellow Card

14) Health Education

- Request

15) Clinical Resources and Tools

16) Reports

- GQ P4P

18. PROVIDER NETWORK

G. Provider Resources

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	September 1, 1996
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2022 2023

18. PROVIDER NETWORK

H. Hospital Affiliations

APPLIES TO:

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

POLICY:

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

PROCEDURES:

- A. IPAs must submit a complete PCP credentialing information to IEHP for those PCPs meeting the requirements of Section A above, as specified in Section 25, “Credentialing and Recredentialing.”
- B. Upon receipt of the credentialing information, IEHP reviews each packet in accordance with Section 25, “Credentialing and Recredentialing” and verifies that the IPA has:
1. A minimum of five (5) PCPs who, as a group, can provide care to Members of all ages and genders (based on the line of business), who admit to the designated Hospital or have admitting arrangements to Hospitalist.
 2. A complete specialty network under contract to see Members at the designated Hospital, as stated in Policy 18F, “Specialty Network Requirements.”

18. PROVIDER NETWORK

H. Hospital Affiliations

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

18. PROVIDER NETWORK

H. Hospital Affiliations

- L. In certain instances when emergency medical condition arises that requires medical care, to ensure uninterrupted care to Members from a Specialist not currently contracted, IEHP reserves the right to impose payment requirements on the IPA at the IEHP specified rate.
- M. On occasional basis, where a health care service was provided by a non-contracted Hospitalist or Specialist at a non-contracted hospital, this unique relationship requires IPAs to pay the Hospitalist or Specialist at the IEHP specified rate.

18. PROVIDER NETWORK

H. Hospital Affiliations

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2021-2023

18. PROVIDER NETWORK

I. Leave of Absence

APPLIES TO:

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

POLICY:

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

PROCEDURES:

- A. IPAs must ensure an adequate plan of coverage for all PCPs absent from their practice for less than two (2) weeks. Adequate coverage is not utilizing network urgent cares or the emergency room for Member care. Adequate coverage must include:
 - 1. Use of a credentialed IEHP PCP in the appropriate specialty for the practice, either at the PCP site or at another approved IEHP PCP site.
 - 2. The covering PCP must be available at the original PCP site, or another IEHP approved site, at least sixteen (16) hours per week.
 - 3. If coverage is not provided at the same office, a process for informing Members of the covering PCP’s name, phone number and office address utilizing the assigned PCP’s phone number (e.g., voice message) and site (e.g., signs, notices) must be in place.
- B. PCPs planning a leave of absence greater than two (2) weeks must inform their IPA at least sixty (60) days in advance.

18. PROVIDER NETWORK

I. Leave of Absence

- C. IPAs must submit a written coverage plan to IEHP no less than two (2) weeks prior to the PCP's leave date for all PCPs whose leave of absence is greater than two (2) weeks. The coverage plan must include at a minimum:
1. Name and location of the credentialed IEHP PCP providing coverage.
 2. If the covering PCP is not at the same location as the PCP on leave, the plan for informing Members of the covering PCP's name, phone number and office address.
 3. The timeframe coverage is needed.
 4. Any significant change in schedule or hours of coverage from the original PCP site.
- D. For PCPs on a leave of absence greater than ninety (90) days, the IPA must submit either:
1. A plan for reassigning Members to another credentialed IEHP PCP within appropriate geographic proximity and specialty type of PCP; or
 2. A specific request to keep the assigned Members with the original PCP with supporting documentation as to why this is in the best interest of the Members and including a plan for interim coverage.
- E. IPAs must provide IEHP a written Member transfer plan within five (5) days when a PCP leaves his/her practice without timely notice.
1. If the IPA plans to have current Members transferred to the covering PCP who is not credentialed for participation in the IEHP network, complete credentialing information must be submitted to IEHP within four (4) weeks of the original event.
- F. IEHP reviews all submitted plans and either approves, denies, or requests additional information within five (5) working days of the receipt of the information from the IPA. If the coverage plan is denied, IEHP may determine reassignment of the Members.
- G. PCPs must complete an IEHP PCP leave of absence coverage form at the time of recredentialing so that IEHP has a record of who will provide services during the PCP's future leave of absence. The PCP must advise the PSR of any changes to this plan if they occur in the interim.

18. PROVIDER NETWORK

I. Leave of Absence

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 20 <u>2022</u> 23

18. PROVIDER NETWORK

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

APPLIES TO:

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

POLICY:

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

DEFINITION:

Block Transfer: A transfer or redirection of two thousand (2,000) or more Members from a terminated IPA or hospital to one or more contracted Providers that takes place as a result of the termination or non-renewal of a Provider contract.¹

PROCEDURES:

PCP Termination

- A. If IEHP is initiating the termination of the PCP due to site review failure, expiration of any credentialing requirements, insufficient access, peer review or quality of care issues or other reasons deemed appropriate by IEHP, and all appeal levels have been exhausted, IEHP notifies the PCP and the IPA (if applicable) that the PCP is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, "Peer Review Termination Letter" in Section ~~185~~). A copy of the notification to the PCP is sent to the IPA.
- B. IEHP sends affected Members a letter notifying them of the PCP termination no later than thirty (30) days prior to the effective date (See Attachments, "Member PCP Termination

¹ 28 California Code of Regulations (CCR) § 1300.67.1.3

18. PROVIDER NETWORK

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

Notification Letter – English” and “Member PCP Termination Notification Letter – Spanish” in Section 18). The letter provides the Member with the opportunity to contact IEHP to select a different PCP at least thirty (30) days prior to the effective date of termination of the Member’s current PCP from the IEHP network.²

1. In situations where immediate termination of the PCP is required, IEHP makes a good faith effort to allow Members sufficient notice to select a new PCP, however, in order to ensure that there is no interruption in care for the Member, IEHP may immediately transfer the Member and allow the Member to select a PCP retroactively.
- C. IEHP makes an effort to transfer the existing enrollment of the terminated PCP to other PCPs within the terminated PCP’s IPA network. The final decision regarding Member transfers rests with IEHP.³
- D. If Members cannot be transferred within the IPA network due to age limitations, geographic location or other determination by IEHP, IEHP reassigns Members to a new PCP within IEHP’s geographic service area who has the capacity and can accommodate the affected Members. IEHP does not guarantee that Members remain part of the IPA’s network.
- E. Once IEHP establishes an effective date for the PCP termination and Member transfer, IEHP:
 1. Sends the IPA written notification regarding the effective date of termination and transfer of Members who have not selected another PCP (See Attachments, “Compliant Termination Letter” and “Non-Compliant Termination Letter” in Section 18.)
 2. Sends the affected Members a letter notifying them of the change in PCP thirty (30) days in advance of the new effective date. The letter again informs Members of their right to select their own PCP (See Attachments, “Member PCP Termination Notification Letter – English” and “Member PCP Termination Notification Letter – Spanish” in Section 18). Members may contact IEHP Member Services at (877) 273-4347 to select another PCP.

Specialist Termination

- A. If IEHP is initiating the termination of a Specialist due to peer review or quality of care issues and expiration of any credentialing requirements, IEHP notifies the Specialist and their IPA (if applicable) that the Specialist is being terminated from the IEHP network and the effective date of termination (See Attachment, “Peer Review Termination Letter” in Section 18.5.)
- B. Upon receipt of the termination notice from IEHP, the IPA must notify Members of the termination in accordance with policy 18D2, “IPA Reported Provider Changes - Specialty Practitioner Termination.” The notice to Members must be sent no later than thirty (30) days prior to the effective date and must include the option for Members to continue care with their existing Provider for up to ninety (90) days in accordance with policy 12A5, “Care

²Coordinated Care Initiative (CCI) Three Way Contract September 2019, Section 2.11

³Ibid.

18. PROVIDER NETWORK

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

Management Requirements - Continuity of Care.” A sample Member notification is included as Attachments, “Specialist Termed Member Notification – English” and “Specialist Termed Member Notification – Spanish” in Section 18.

Vision Provider Termination

- A. If IEHP is initiating the termination of the Vision Provider due to expiration of any credentialing requirements, peer review or quality of care issues or other reasons deemed appropriate by IEHP, and all appeal levels have been exhausted, IEHP notifies the Vision Provider that the Vision Provider is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, “Peer Review Termination Letter” in Section 185).⁴

Behavioral Health Provider Termination

- A. If IEHP is initiating the termination of the Behavioral Health (BH) Provider due to expiration of any credentialing requirements, peer review or quality of care issues or other reasons deemed appropriate by IEHP, and all appeal levels have been exhausted, IEHP notifies the BH Provider that the BH Provider is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, “Peer Review Termination Letter” in Section 185).
- B. When a BH Provider is being terminated, the BH Provider or the BH Provider’s office needs to cooperate with IEHP BH Department in developing a transition plan for impacted IEHP Members that ensures Members are not abandoned and that BH Providers are compliant with their licensing board requirements and maintain ethical standards of practice. In order to coordinate the transition of IEHP Members, BH Providers may be required to provide a list of active IEHP Members who will need to be transitioned to another BH Provider, treatment records, and/or medication lists with the IEHP BH Department.

Block Transfers⁵

- A. In the event that the termination of a Provider impacts two thousand (2,000) or more Members, IEHP will complete a block transfer as follows:
1. Provide all assigned Members with no less than a written notice thirty (30) calendar days in advance of the contract termination, including language regarding their rights to continue obtaining care with existing Providers. In the case of a Hospital termination, all assigned Members who reside within a fifteen (15) mile or thirty (30) minutes travel time radius⁶ of the Hospital or linked to that Hospital, will be sent a written notice regarding

⁴ ~~CCI Three Way Contract September 2019, Section 2.11~~

⁵ Title 42 Code of Federal Regulations (CFR) § 438.207(c)(3)

⁶ CMS Medicare-Medicaid Plan (MMP) Application & Annual Requirements, CY 2021 MMP Health Service Delivery Network Adequacy Standards Criteria Reference Table

18. PROVIDER NETWORK

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

the termination of the Hospital contractual relationship.

2. If, after sending the required notice to Members, IEHP reaches an agreement with the Provider to enter a new contract or to not terminate their contract prior to the termination date, IEHP will return Members' assignment to their original Provider.
3. Re-assign all block transferred Members within geographic access standards, as applicable.
4. Send notification to Compliance Department via email.
5. Compliance will notify Centers for Medicare and Medicaid Services (CMS) and California Department of Health Care Services (DHCS) of the block transfers.^{7,8}

⁷ Title 28, California Code of Regulations (CCR) §1300.67.1.3, subdivision (b)

⁸ 42 CFR §438.207 (e)

18. PROVIDER NETWORK

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

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2021 <u>2023</u>

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

APPLIES TO:

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

POLICY:

- A. IEHP is responsible for the initial and ongoing assessment of Hospitals directly contracted with IEHP.
- B. Prior to contracting, IEHP verifies the services available, accreditation status and/or Centers for Medicare and Medicaid Services (CMS) or ~~state-State~~ survey report, license, and good standing with ~~state-State~~ and ~~federal-Federal~~ regulatory bodies and in compliance with the most current National Committee for Quality Assurance (NCQA) and CMS standards, prior to contracting with such organization.¹
- C. IEHP reconfirms the status of all contracted Hospitals concurrently upon expiration and every contract renewal period, ~~and for at least every 36 months but no less than every three (3) years.~~²
- D. IEHP maintains the appropriate records to document the verification process for contracted Hospitals per the most recent NCQA and CMS guidelines and IEHP requirements.³
- E. IEHP does not contract with prospective Hospitals if they have been sanctioned, suspended, or excluded from participation in the Medicare or Medi-Cal/Medicaid Program by the U.S. Department of Health and Human Services, Office of Inspector General (OIG) list of excluded individuals and Entities (LEIE), Restricted Provider Database (RPD), DHCS Medical Suspended & Ineligible Provider list, and Systems for Award Management (SAM).^{4,5,6}
- F. IEHP does not contract with prospective Hospitals and entities for the IEHP Medicare line of business if the ~~provider-Provider~~ is on the CMS Preclusion List or has opted-out of the Medicare Program. However, IEHP will consider contracting for the Medi-Cal line of business.⁷
- G. IEHP does not contract with Hospitals if they appear on the Provider decertification list provided by the Department of Health Care Services (DHCS). Hospitals listed on the decertification list are no longer certified to receive payment from the Medi-Cal Program for services rendered to Medi-Cal beneficiaries as the effective date noted for each Provider.

¹ National Committee for Quality Assurance (NCQA), 2024~~2~~ HP Standards and Guidelines, CR 7, Element A, Factor 1

² Ibid.

³ NCQA, 2024~~2~~ HP Standards and Guidelines, CR 7, Element D

⁴ Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019 and 16-012, “Provider Credentialing/Recertification and Screening/Enrollment”

⁵ DHCS APL 21-003 Supersedes APL 16-001 and 06-007, “Medi-Cal Network Provider and Subcontractor Terminations”

⁶ [Medicare Managed Care Manual, “Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks,” Section 60.2](#)

⁷ [Title 42 Code of Federal Regulations \(CFR\) § 422.222](#)

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

IEHP reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Provider Agreement.⁸

- H. IEHP does not contract with Hospitals if they appear on the list of indicated Providers provided by DHCS. If the Hospital is under investigation and a credible allegation of fraud has been found against the facility, as a result of this investigation IEHP will temporarily suspend/suppress the Hospital contract from the network pending resolution of the fraud allegation.⁹
- I. Any Hospital Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the IEHP's provider network. However, IEHP may consider contracting when the suspension and/or exclusion has been lifted.¹⁰

PROCEDURES:

- A. Hospitals must submit evidence of services provided, accreditation status and/or CMS site survey, license status, and regulatory standing at the time the Hospital applies to participate in IEHP's network. Copies of the Hospital's accreditation certificate, state license and most recent CMS or state survey report results satisfy this requirement.¹¹
- B. To contract with and remain in the IEHP network, the Hospital must provide:
1. Inpatient Services
 - a. Intensive Care Unit;
 - b. Medical Service, Surgical Service or combined Medical/Surgical Service;
 - c. Pediatric Service; and
 - d. Obstetrics/Perinatal Unit (or established arrangements for care approved by the IEHP Chief Medical Officer).
 2. Outpatient Services
 - a. Basic Emergency Department physician on-duty; or
 - b. Standby Emergency Department (applicable only for Hospitals located in remote areas), with IEHP Chief Medical Officer (CMO) approval.
- C. If Hospital offers Behavioral Health services, the following applies:
1. Inpatient Services
 - a. Inpatient hospitalization in semi-private accommodation, unless a private room is medically necessary;

⁸ [DHCS APL 21-003Ibid.](#)

⁹ [DHCS APL 21-003Ibid.](#)

¹⁰ DHCS APL 19-004

¹¹ NCQA, 2021 HP Standards and Guidelines, CR 7, Element A, Factor 1

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

- b. Secure inpatient psychiatric unit;
 - c. Psychiatric and substance abuse services;
 - d. Ancillary services and supplies, including laboratory and x-ray services;
 - e. Administration of outpatient prescription drugs (take home medications) in instances where continuation of hospital-based treatment must not be interrupted: three (3) day supply minimum; and
 - f. Administration of blood, blood plasma, or its derivatives, including cost of blood, blood plasma, or its derivatives.
2. Outpatient Services
- a. Structured outpatient Behavioral Health Program;
 - b. Partial hospitalization services; and
 - c. Others.
- D. ~~IEHP The Hospital accepts an accreditation report or letter form the regulatory and accrediting bodies regarding the status of the Hospital, as evidence that the Hospital has been reviewed and approved by~~ must be an accredited body. Accreditation and licensure must be maintained throughout the duration of the Hospital's participation in the IEHP network by one of the following accrediting agencies:¹²
1. IEHP recognizes the following Hospital accrediting agencies:
 - ~~1.a.~~ The Joint Commission (TJC);
 - ~~2.b.~~ Healthcare Facilities Accreditation Program (HFAP);
 - ~~3.c.~~ Behavioral Health—Commission on Accreditation of Rehabilitation Facilities (CARF);
 - ~~4.d.~~ Det Norske Veritas Healthcare (DNV); and
 - ~~5.e.~~ Center for Improvement in Healthcare Quality (CIHQ).¹³
 2. An onsite quality assessment must be conducted if at the Hospital is not accredited by an agency not listed above, the Hospital and IEHP must agree upon an alternate solution that meets IEHP's requirements, including the requirement to complete a CMS or state State quality review of the Hospital, as applicable, in addition to meeting other standards as defined by IEHP.¹⁴ IEHP's onsite quality assessment criteria for Hospitals includes, but is not limited to:

¹² NCQA, 2022 HP Standards and Guidelines, CR 7, Element A, Factor 2

¹³ ~~NCQA, 2022 HP Standards and Guidelines, CR 7, Element A, Factor 2~~

¹⁴ NCQA, 2022 HP Standards and Guidelines, CR 7, Element A, Factor 3

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

a. A CMS or state quality review in lieu of a site visit under the following circumstances (if IEHP chooses to substitute the site visit 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.

2) IEHP obtains a survey report or letter from CMS or the state, from either the Hospital or the agency, stating that the facility was reviewed and passed inspection.

- The report meets IEHP quality assessment criteria or standards.

b. A Medicare certification number is not acceptable for use in lieu of a site visit if a facility is not accredited.

~~E.c.~~ IEHP 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>).¹⁵

~~E.E.~~ As part of the application review process, and again during each contract renewal period but no less than every three (3) years, IEHP verifies that each Hospital has:¹⁶

1. A current and unencumbered license;
2. Current certification The Joint Commission, HFAP, CARF, DNV, CIHQ, as applicable, or an alternative accreditation or CMS or state quality review as determined by IEHP; and
3. No Medicare/Medicaid sanctions against them.

~~G.F.~~ IEHP expects the Hospital to maintain its accreditation and license status in good standing and/or current at all times during the Hospital's participation in the IEHP network. The Hospital is responsible for providing IEHP with copies of its renewed license and accreditation within thirty (30) days following the expiration of the license and accreditation.

1. Licensing and Accreditation must be re-verified at a minimum every three (3) years from the date of the original verification to confirm the Hospital continues to be in good standing with the State and Federal regulatory bodies.¹⁷

¹⁵ [NCOA, 2022 HP Standards and Guidelines, CR 7, Element A, Factor 3](#)

¹⁶ [NCOA, 2024~~2~~ HP Standards and Guidelines, CR 7, Element A, Factor 1](#)

¹⁷ [Ibid. NCOA, 2021~~2~~ HP Standards and Guidelines, CR 7, Element A, Factor 1](#)

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

H.G. Hospital must have no sanctions that may impact participation, from any of the following Federal and State Databases:^{18,19}

1. List of Excluded Individuals/Entities (LEIE)
2. System for Award Management (SAM) List
3. DHCS Medi-Cal Suspended and Ineligible List
4. CMS Preclusion List

H.H. On a monthly basis, the Contracts Administration Specialist, or designee will submit a file on the 5th day each month prepared by Health Care Informatics (HCI) containing ~~of~~ contracted Hospitals to be screened by the sanction screening service, OIG Compliance Now.

1. Review of the Compliance OIG or Medicare/Medicaid Sanctions must be completed and documented on the spreadsheet or the file for any adverse actions. The monthly review of the OIG report as part of the “Ongoing Monitoring” for contracted facilities.
2. IEHP prohibits employment or contracting with Hospitals (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (practitioners or entities found on OIG Reports).

H.I. On a monthly basis, the Contracts Administration Specialist, or designee will review the Restricted Provider Database (RPD) to determine the exclusion status of all Entities and verify all IPA’s in the IEHP Network maintain good standing in the Medicare or Medi-Cal/Medicaid Program.²⁰

K.J. IEHP reserves the right to perform facility site review when quality of care issues arise and to deny Hospital’s participation in the IEHP network if IEHP requirements are not met.

L.K. If during the contract period, IEHP becomes aware of a change in the accreditation and/or CMS or state survey, license or certification status, or sanctions, fraudulent activity or other legal or remedial actions have been taken against any Hospital, the Contract Administration Specialist must take the following steps:

1. Notify the Director of Provider Contracting, Provider Contracting Manager, Contracts Administration Manager, and the Compliance Department at DGStateProgram@IEHP.org within five (5) days of discovering our Provider/Hospital has been added to a disciplinary list.
2. The Director of Provider Contracting informs the Hospital in writing that it is in violation of its contract with IEHP and begins the cure process. Depending on the seriousness of the offense, IEHP:

¹⁸ DHCS APL 21-003

¹⁹ DHCS APL 19-004

²⁰ Ibid.

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

- a. Reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Agreement.²¹
- b. May report the termination of the contract to regulatory agencies as per contractual requirements. Any services provided after the date of exclusion shall not be reimbursable or may be subject to recoupment.

²¹ DHCS APL 21-003

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K. Hospital Network Participation Standards

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	January 1, 2007
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2023 2

18. PROVIDER NETWORK

L. Providers Charging Members

APPLIES TO:

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

POLICY:

~~A “Health Care Provider” means any Practitioner or professional person, Acute Care Hospital organization, health facility, Ancillary Provider or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.~~

- A. IEHP prohibits contracted Health Care Providers from charging and/or collecting payment from an IEHP DualChoice Member, or other persons on behalf of the Member, for missed appointments.

~~C.B.~~ IEHP prohibits contracted Health Care Providers from charging and/or collecting payment from an IEHP DualChoice Member, or other persons on behalf of the Member, for filling out forms related to the delivery of medical care. Any Provider of health care services shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or any person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.

~~D.C.~~ According to California Health and Safety Code, Section 123110.b (~~See Attachment, “California Health and Safe Code 123110” in Section 18~~), any Member or Member’s representative shall be entitled to copies of all or any portion of the Member medical records that he or she has a right to inspect, upon presenting a written request to the Health Care Provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed twenty-five cents (\$0.25) per page or fifty cents (\$0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. The Health Care Provider shall ensure that the copies are transmitted within fifteen (15) days after receiving the written request.¹

~~E.D.~~ In circumstances where charging a Member for completion of a form is allowed, fees should be nominal and not to exceed twenty-five cents (\$0.25) per page with a maximum charged allowed of twenty dollars (\$20).

~~F.E.~~ Under no circumstances can a Health Care Provider deny or refuse service to an IEHP Member for non-payment of a missed appointment or lack of payment for co-payments and owed balance or deductibles, as applicable.

~~G.F.~~ Any contracted Health Care Provider who hasis furnished documentation of a person’s enrollment in the IEHP DualChoice program, shall not seek reimbursement nor attempt to obtain payment for any covered services provided to the IEHP Member other than the participating health plan.

¹ California Health and Safety Code, Section 123110.b

18. PROVIDER NETWORK

L. Providers Charging Members

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

DEFINITIONS:

H.A. “Health Care Provider” means any Practitioner or professional person, Acute Care Hospital organization, health facility, Ancillary Provider or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.

PROCEDURES:

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

18. PROVIDER NETWORK

L. Providers Charging Members

5. Other forms related to the delivery of medical care;
 6. Any forms required for a Member to qualify as eligible for IEHP DualChoice including, but not limited to, Cal Works Forms (CW 61 or an equivalent);
 7. Any forms to facilitate transportation, including applications for paratransit service and Department of Motor Vehicles Disabled Placard Applications;
 8. In-Home Support Services (IHSS) Medical Certification Form SOC 873;
 9. Any forms related to Long-Term Services and Supports (LTSS) benefits including Community Base Adult Services (CBAS).
 10. Emotional Support Animal letter for housing authority/landlord completed by Behavioral Health Providers.²
- F. Providers can charge IEHP Members a nominal fee for filling out any of the following forms:
1. History and Physical form that is school specific;
 2. Sports Physical;
 3. Disability forms; and
 4. Utility Company Medical Baseline Program Applications.
- G. A Health Care Provider that is not paid at billed charges may not pursue any balance billing or collection actions against any IEHP Member. Such collections actions may include:
1. Sending or mailing bills to IEHP Member;
 2. Calling any IEHP Member with demands to pay outstanding balance; and
 3. Referrals to collection agency.
- H. If the Provider of service continues to charge a Member in violation of this policy after being notified to stop, or sends the Member's account to a collections agency, IEHP reserves the right to inform CMS or other regulatory agencies of the violation. In addition, the billing of Members is in violation of IEHP policy, and IEHP takes all necessary actions, up to and including termination of the Provider's participation with IEHP to ensure that such actions stop.

² Americans with Disabilities Act, the Fair Housing Act, and the Rehabilitation Act of 1973

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L. Providers Charging Members

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	July 1, 2012
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2020 <u>2023</u>

18. PROVIDER NETWORK

M. Outsourcing Standards and Requirements

APPLIES TO:

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

POLICY:

- A. Outsourcing is a business practice where a service is performed from an outside organization. The outsourced vendor provides services to contracted IPAs in IEHP’s network.
1. Onshore Outsourcing is allowed for services from a third- party located within California.
 2. Onshore Outsourcing outside of California is allowed for obtaining services from a third-party outside the IPA or IEHP but located within the Continental United States.
- B. IPAs or IEHP are prohibited from Offshore Outsourcing any services outside of the continental United States.
- C. With respect to the onshore outsourcing of IEHP PHI and/or PII, IPAs must perform due diligence on any vendors considered for outsourcing PHI and/or PII before any agreements or contracts are executed to ensure such agreements comply with IEHP’s established standards and requirements.
1. Any IPAs wishing to outsource any service involving PHI and/or PII must obtain written approval from IEHP prior to utilizing such vendors as outlined in “Procedures” below. Without prior written approval from IEHP, the IPA is not permitted to outsource any of the work outlined in the IPA Agreement. If services were ongoing prior to the IPA’s contract with IEHP, the Delegated IPA shall seek immediate approval by IEHP to apply retrospectively.
 2. IPAs must ensure that any vendor to whom it has onshore outsourced services involving IEHP PHI or PII complies with all applicable state and federal privacy laws, such as HIPAA.
 3. IEHP does not permit the transmission or accessibility of IEHP Member PHI and/or PII outside of the Continental United States.
- D. With respect to the onshore outsourcing of clinical services (i.e. utilization management services), the IPAs must ensure compliance with all State of California requirements regarding in-state clinical licensure.
- E. IEHP is firmly committed to complying with all applicable legal and contractual obligations under all state and federal programs, laws, regulations, and directives applicable to Medi-Cal, ~~Medicare-Dual-Choice~~ and other lines-of-business in which IEHP may choose to participate.

18. PROVIDER NETWORK

M. Outsourcing Standards and Requirements

As a result, IPAs outsourcing services involving IEHP PHI and/or PII, or clinical services, are expected to comply, and require their vendors to comply, with all such applicable obligations.

DEFINITION:

- A. Offshore subcontractor: is defined as First tier, downstream, related entity located outside of the Continental United States.
- B. First Tier Entity: is defined as any party that enters into a written arrangement with IEHP to provide administrative services or health care services to IEHP Members.
- C. Downstream Entity: is defined as any party that enters into a written arrangement with persons or entities involved in with administrative or health care services, below the level of the arrangement between IEHP and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

PROCEDURES:

- A. As to outsourcing of business services/activities involving IEHP PHI and/or PII: IPAs seeking to obtain approval of a vendor who will use and/or disclose IEHP PHI and/or PII shall submit a written request to IEHP.
 - 1. The IPA shall first conduct a background check and verify vendor's services through a minimum of two (2) references. The background check shall consist of:
 - a. Corporate history, reputation, capabilities and financial stability.
 - b. Verification the vendor is eligible to participate in state and federal health care programs and does not appear on the US Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) or the General Services Administration (GSA) System for Award Management (SAM) exclusion list.
 - c. Any subcontracted or outsourced activities provided or currently being provided to comparable entities to ensure the entity meets/is meeting all state, federal, and IEHP/IPA contractual requirements.
 - d. Assessment of what information/tools is necessary for the vendor to deliver the said product and/or service, and whether the vendor maintains such information/tools.
 - 2. Should vendor pass the step outlined in subsection "Policy" above, the IPA shall perform a detailed assessment of the vendor's ability to maintain data security (i.e. administrative, technical, and physical safeguards required by HIPAA). This assessment may include but is not limited to:
 - a. Review of the entity's current data security and privacy training program.

18. PROVIDER NETWORK

M. Outsourcing Standards and Requirements

- b. Review of technical specifications of anti-virus, firewall and other software being utilized to prevent intrusion.
 - c. Review of company's policy on securing communications.
 3. If the vendor's ability to maintain data security has been successfully assessed, the IPA and the vendor shall enter into an agreement (subject to IEHP's approval) that, at minimum, addresses the following:
 - a. The product and/or service to be delivered by the vendor to the IPA.
 - b. A statement clearly indicating vendor's agreement to comply with all applicable provisions under HIPAA and California law relating to the privacy and/or security of the IEHP PHI.
 - c. Subcontractual contract requirements as outlined in the IEHP/IPA contract.
 4. Once the IPA has conducted the due diligence outlined above, the IPA shall submit a written report detailing all areas and items assessed and the findings.
 5. Decisions to accept the vendor to whom the IPA wishes to onshore outsource business services/activities involving IEHP PHI and/or PII are subject to review by the IEHP Compliance Department, Delegation Oversight Department, and approval by IEHP's ~~Chief Network Officer~~ and IEHP's [Director of Delegation Oversight and](#) Chief Operating Officer ~~(COO)~~ [or Director of Provider Network and Communications](#).
 6. IEHP will complete the initial review within 30 days and determine if we can move forward with seeking any applicable regulatory approval from appropriate regulatory agencies.
- B. As to outsourcing of clinical services or functions: IPAs shall be required to ensure compliance of all vendors as outlined under "Policy", Section C" and shall demonstrate such compliance as requested by IEHP.
- C. Final Decision:
 1. IEHP reserves the right to request, modify or terminate the IPA agreement at any time if the IPA is non-compliant with IEHP's requirements under this policy.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	July 1, 2015
Chief Title: Chief Operating Officer	Revised Date:	January 1, 2023 4

18. PROVIDER NETWORK

N. IPA Medical Director Responsibilities

APPLIES TO:

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

POLICY:

- A. IEHP and its delegated IPAs must maintain a fulltime Medical Director whose responsibilities shall include, but not be limited to the following:¹
1. Ensuring medical decisions are:
 - a. Rendered by qualified medical personnel; and
 - b. Are not influenced by fiscal or administrative management considerations;
 2. Ensuring that the medical care provided meets the standards for acceptable medical care;
 3. Ensuring that medical protocols and rules of conduct for medical personnel are followed;
 4. Developing and implementing medical policy;
 5. Resolving grievances related to medical quality of care;
 6. Directly involved in the implementation of Quality Improvement (QI) activities; and
 7. Actively participating in the functioning of the health plan or their IPA.

PROCEDURES:

- A. The Medical Director serves as the physician liaison between the IPA and IEHP, Skilled Nursing Facilities (SNFs), Hospitals and other network Providers.
- B. The Medical Director is highly encouraged to network with IEHP and Medical Directors from Delegated IPAs to stay current with recent managed care/industry trends and best practices and act as the communicator back to their organization.
- C. The Medical Director shall serve as chair for clinical committees such as Credentialing, Utilization Management (UM), Quality Management (QM), or Peer Review committees, as applicable.
- D. The Medical Director identifies IPA network gaps in primary and specialty care coverage and ensures access to care for IEHP Members. The medical Director maintains an open professional relationship with the IPA Physician network.
- E. The Medical Director should be involved in tracking and trending of potential fraud, waste and abuse involving IEHP Members and Providers.
- F. Preference should be given to hiring Medical Directors with Primary Care experience.

¹ Title 22, California Code of Regulations (CCR) § 53857

18. PROVIDER NETWORK

N. IPA Medical Director Responsibilities

- G. **Utilization Management** - The Medical Director ensures that the utilization management process meets the standards and requirements outlined in Policy 25E1, “Utilization Management – Delegation and Monitoring.” These includes but are not limited to:
1. Timely and appropriate review and decision-making on all authorization requests;
 2. Physician-level review of denials and partial approvals (modifications) on the basis of medical necessity;
 3. Appropriate and consistent application of IEHP-approved authorization criteria using the hierarchy appropriate to the line of business;
 4. Medical Director-level consultation with the requesting Provider for medical services, as necessary; and
 5. Providing clinical expertise for Members requiring complex medical care, higher level of care and out of network services.
- H. **Quality Management** - The Medical Director ensures their direct involvement in the implementation of QI activities through the following, at minimum:
1. Having oversight of the IPA Quality Improvement process, policy and strategy;
 2. Reviewing all Provider and IPA grievances for adverse trends or Potential Quality Incidents (PQIs);
 3. Understanding community standards for medical care and providing input on all PQI cases; and
 4. Fundamental understanding of National Committee on Quality Assurance (NCQA) metrics, Medicare regulations and is ~~involvement~~ involved in the IPA metric improvement strategy.
 4. 4.
 5. Regular participation in Behavioral Health & Care Management Interdisciplinary Case Conferences, providing clinical expertise toward the goal of improved Member health outcomes.
 6. 6.5.

18. PROVIDER NETWORK

N. IPA Medical Director Responsibilities

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective date:	January 1, 2016
Chief Title: Chief Medical Officer	Revision date:	January 1, 2024 2023

18. PROVIDER NETWORK

O. Provider Disruptive Behavior

APPLIES TO:

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

POLICY:

- A. Inland Empire Health Plan (IEHP) is committed to fostering an environment where IEHP Members receive access to quality and accessible healthcare services. IEHP is further committed to supporting a culture where IEHP's Providers, Members, and staff are treated in a professional, collegial, and caring manner. Toward these goals, IEHP maintains a Provider Disruptive Behavior Policy that prohibits any behavior that could be perceived as hostile, disruptive, inappropriate, harassing, or that does not endeavor to meet the highest standards of professionalism, prevents IEHP from complying with any statutory, regulatory, or contractual requirements, or interferes with IEHP's mission to provide its Members with quality and accessible healthcare services.
- B. Provider Expectations
1. Treat all individuals encountered in the course of administering or providing healthcare services to Members (including, but not limited to, Members, Members' family members, Members' friends, and IEHP staff) with courtesy, honesty, and respect, and conduct themselves in a professional, collegial, and cooperative manner as outlined below.
 2. Refrain from conduct that may reasonably be considered disruptive, inappropriate, or offensive to the workplace or Member care. Such conduct may be verbal or non-verbal.

PURPOSE:

- A. The purpose of this policy is to:
1. Outline the expectations of Providers during interactions with Members, IEHP staff, and other related individuals in the course of administering or providing healthcare services;
 2. Provide definitions/examples of disruptive and inappropriate conduct; and
 3. List the procedures to identify and resolve any alleged disruptive or inappropriate behavior.
- B. Disruptive behavior or inappropriate conduct may be grounds for disciplinary action, up to and including the termination of a contract.
- C. Definitions/examples of prohibited disruptive and inappropriate conduct include, but are not limited to:
1. Profane, angry, threatening, intimidating, abusive, disrespectful, degrading, insulting, demeaning, belittling, disruptive, or inappropriate language or behavior, whether verbal or non-verbal (including facial expressions, body language, or other non-verbal gestures or forms of bodily expression);

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2. Inappropriate or similarly offensive physical acts or contact, or a threat thereof;
3. Non-constructive criticism or comments about, or the passing of severe judgment on IEHP staff or Members, in or absent their presence, that is threatening, inappropriate, insulting, intimidating, or otherwise disruptive;
4. Inappropriate or disruptive arguments or discussions with Members, Members' family members, Members' friends, or IEHP staff;
5. Language or behavior that others would describe as bullying or harassing, including but not limited to, yelling or the use of obscenities;
6. Insensitive, inappropriate, or disruptive comments or discussions, whether verbal or non-verbal, about a Member's medical condition, appearance, or situation;
7. Insensitive, inappropriate, or disruptive comments or discussions about or directed to IEHP staff or Members, whether verbal or non-verbal, regarding race, ethnicity, sexual orientation or any other protected class or group of people;
8. Any behavior or conduct that creates a hostile environment for IEHP staff or Members, disrupts the efficient and effective delivery of quality and timely access to healthcare services, or otherwise jeopardizes Member care;
9. Refusal to work collaboratively or cooperatively with IEHP staff or Members, or creating rigid or inflexible barriers to requests for assistance and/or cooperation; and
10. Any behavior or conduct that jeopardizes or denigrates IEHP's name, brand, or reputation.

PROCEDURES:

- A. Alleged incidences of inappropriate or disruptive conduct may be addressed in accordance with the following procedures:
 1. When an incident is reported, collegial intervention (i.e., counseling, warnings, and meetings and/or discussions with the Provider) should be the first step. However, there may be a single incident of inappropriate conduct, or the continuation of such conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in this Policy precludes the immediate action of IEHP or the elimination of any step in the below Procedures or Policy when dealing with a complaint or incident about inappropriate conduct.
 2. Upon learning of the occurrence of an incidence of inappropriate conduct, IEHP shall request that the individual who reported the incident document it in writing. Alternatively, IEHP may designate a member of its staff to document the incident as reported. The documentation should include as much detail as possible, including:
 - a. The date, time, and location of the incident(s);

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- b. A factual, objective description of the inappropriate or disruptive behavior(s);
 - c. The name of any Provider, Member, Member's family member, Member's friend, or IEHP staff who may have been involved in the incident(s), including any Provider, Member, Member's family member, Member's friend, or IEHP staff who may have witnessed the incident(s);
 - d. The circumstances around as well as those which specifically precipitated the incident(s);
 - e. The names of any other witnesses to the incident(s);
 - f. Consequences, if any, of the conduct as it relates to the delivery or administration of healthcare services, the prevention of IEHP from complying with any statutory, regulatory, or contractual requirements, the jeopardizing or denigration of IEHP's name, brand, or reputation, or the contribution towards a hostile environment;
 - g. Any responsive action(s) taken to intervene in, or remedy, the incident(s) including date, time, place, action, and the name(s) of those intervening; and
 - h. The name, title, signature, and date of the individual reporting and/or documenting the complaint of inappropriate conduct.
3. IEHP will review the report and may elect to meet or confer with the individual who reported the incident(s) or the individual who prepared the report, if different.
 4. If, in IEHP's sole discretion, it is determined that an incident of inappropriate conduct has occurred, IEHP may proceed with any or all of the following options including, but not limited to:
 - a. Notify the Provider that a complaint has been received;
 - b. Meet and confer with the Provider to obtain additional information about the incident(s) or conduct in question;
 - c. Send the Provider a letter of guidance about the incident(s);
 - d. Send the Provider a letter of warning or reprimand;
 - e. Meet and confer with the Provider and/or other individuals involved in the incident(s) in order to counsel the Provider about the concerns and the necessity to correct the conduct in question; and
 - f. Terminate the Provider's contract.
 5. If IEHP prepares any documentation for a Provider's file regarding the incident(s), or IEHP's efforts to address the concerns with the Provider, the Provider shall be apprised of that documentation and an opportunity to respond in writing. The Provider's response shall be kept in the Provider's file.

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6. If additional complaints are received concerning a Provider about related or unrelated conduct prohibited by the Policy, IEHP may continue to utilize the collegial steps noted above as long as IEHP believes there is a reasonable likelihood that these efforts will resolve the conduct in question. At any point, however, IEHP may elect to take immediate action or eliminate steps in the above Procedures or Policy when dealing with a complaint.

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

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APPLIES TO:

- A. This policy applies to Inland Empire Health Plan (IEHP) Primary Care Providers (PCPs), Specialists, and Behavioral Health Providers, as well as IEHP network Federally Qualified Health Centers (~~FQHCs~~), Tribal ~~Federally Qualified Health Centers Providers~~ (TFQHCPs), Rural Health Clinics (RHCs) or Indian Health Services (IHS) sites, unless specified otherwise.

POLICY:

- A. IEHP utilizes telehealth as an option for Members to obtain access to necessary health care services.
- B. IEHP and its ~~delegates~~ Delegates must ensure that all ~~health-care~~ Providers comply with applicable state and federal laws and regulations and contractual requirements when providing telehealth services.

DEFINITIONS:

- A. “Virtual Care” may encompass modalities also referred to as “telemedicine” or “telehealth,” and includes store-and-forward encounters, the use of live video, remote patient monitoring, and mobile health (mHealth). It is anticipated that, going forward, Virtual Care will be an expected and routine part of care delivery.
- B. “Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member’s health care while the Member is at an originating site and the ~~health-care~~ Provider is at a distant site. Telehealth supports Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.
- C. “Asynchronous store and forward” means the transmission of a Member’s medical information from an originating site to the ~~health-care~~ Provider at a distant site without the presence of the Member.¹ Consultations via asynchronous electronic transmission initiated directly by Members, including through mobile phone applications, are not covered under this policy.
- D. “Synchronous interaction” means a real-time interaction between a Member and a ~~health-care~~ Provider located at a distant site.
- E. “Distant site” means a site where a ~~health-care~~ Provider who provides health care services is located while providing these services via a telecommunications system.² The distant site for purposes of telehealth can be different from the administrative location.
- F. “Originating site” means a site where a Member is located at the time health care services are

¹ Title 42 Code of Federal Regulations (CFR) § 410.78(a)

² 42 CFR § 410.78

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provided via a telecommunications system or where the asynchronous store and forward service originates.³ For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the Member or by the ~~health care~~ Provider is not limited. The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the Member's home. A ~~health care~~ Provider is not required to be present at the originating site unless determined medically necessary by the Provider at the distant site.

PROCEDURES:

A. Provider Requirements

1. ~~The health care~~ Provider rendering IEHP covered benefits or services via a telehealth modality must be contracted with and credentialed by IEHP, licensed in California,⁴ enrolled as a Medi-Cal rendering Provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal Provider group. The enrolled Medi-Cal Provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community.
2. ~~The health care~~ Provider rendering IEHP covered benefits or services provided via a telehealth modality must meet the requirements under California law in which the Provider is considered to be licensed, for example, Providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission for Certifying Agencies.⁵

B. Documentation Requirements

1. ~~All Health Care Practitioners~~ Providers providing covered benefits or services to IEHP Members must maintain appropriate documentation of services rendered to substantiate the corresponding technical and professional components of billed procedure codes. Documentation of benefits or services delivered via telehealth should be the same as documentation of services provided to IEHP Members in-person. This documentation should be maintained in the Member's medical record. The distant site Provider can bill for IEHP covered benefits or services delivered via telehealth using the appropriate procedure codes with the corresponding modifier (as defined by DHCS) and is responsible for maintaining appropriate supporting documentation.
2. ~~Health Care~~ Providers at the distant site must determine that the covered IEHP service or benefit being delivered via telehealth meets the procedural definition and components procedure code(s) associated with the IEHP covered benefit or service ~~or benefit~~ as well as any other requirements described in this section of the IEHP Provider manual.

³ 42 CFR § 410.78.

⁴ Ibid.

⁵ [California Business and Professions Code \(Bus. & Prof. Code\) §2290.5\(a\)\(3\)](#)

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3. ~~Health-care~~ Providers are not required to document a barrier to an in-person visit for IEHP coverage of services provided via telehealth.
4. ~~Health-care~~ Providers at the distant site are not required to document cost effectiveness of telehealth to be reimbursed for telehealth services or store and forward services.
5. Documentation for Asynchronous Store and Forward Services⁶
 - a. For teleophthalmology, teledermatology services, or benefits delivered via asynchronous store and forward, ~~health-care~~ Providers must also meet the following requirements:
 - 1) A Member receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant Specialist.
 - 2) Provider shall receive an interactive communication with the distant Specialist Provider upon request.
 - 3) If requested, communication with the distant Specialist Provider may occur either at the time of the consultation or within thirty (30) days of the Member's notification of the results of the consultation.
6. Member Consent⁷⁻⁸
 - a. ~~In addition, Health-Care~~ Providers must ~~also~~ inform ~~the Members~~ prior to the initial deliver of covered benefits or services via telehealth about the use of telehealth and obtain verbal or written consent from the Member for the use of telehealth as an acceptable mode of delivering health care services.
 - b. If a ~~Health-Care~~ Provider, whether at the originating site or distant site, maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of covered benefits or services, then this is sufficient for documentation of Member consent and should be kept in the Member's medical file.
 - c. The consent shall be documented in the Member's medical and be available to IEHP and/or CMS -upon request.
 - d. In addition to documenting consent prior to initial delivery of covered benefits or services via telehealth. Providers are also required to explain the following to Members:
 - 1) Member's right to access covered benefits or services delivered via telehealth or in-person visit;
 - 2) That use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Member without affecting their ability to access

⁶ California Welfare and Institutions Code (Welf. & Inst. Code) § 14132.725(b)

⁷ ~~California Welfare and Institutions Code (Welf. & Inst. Code) § 14132.725(b)~~-CA Bus. & Prof. Code § 2290.5(b)

⁸ ~~CA Business and Professions Code (Bus. & Prof. Code) § 2290.5(b)~~.

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covered benefits or services in the future;

3) The availability of Non-Medical Transportation to in-person visits; and

4) The potential limitations or risks related to receiving covered benefits or services through telehealth as compared to an in-person visit, if applicable.

e.—

7. Place of Service

- a. ~~Health care~~ Providers are required to document the appropriate Place of Service code as defined by DHCS on the claim, which indicates that services were provided or received via a telecommunications system.

C. Establishing New Patients via Telehealth

1. Members may be established as new patients via telehealth through the following ways:

a. All Providers may establish new patient relationships via synchronous video telehealth visits.

b. All Providers may establish new patient relationships via audio-only synchronous interaction only when one (1) or more of the following criteria applies:

1) The visit is related to sensitive services:

- Mental or behavioral health;
- Sexual and reproductive health;
- Sexually transmitted infections;
- Substance use disorder;
- Gender-affirming care;
- Intimate partner violence; and
- Other services.

See Policy 9D, “Access to Services with Special Arrangements” for more information regarding sensitive services.

2) The Member requests an audio-only modality.

3) The Member attests they do not have access to video.

2. FQHCs, including RHCs and THPs may establish new patient relationships through an asynchronous store and forward modality,⁹ if the visit meets all of the following conditions:

a. The Member is physically present at a Provider’s site, or at an intermittent site of the

⁹ CA Bus. & Prof. Code § 2290.5(a)

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Provider, at the time the covered service is performed;

- b. The individual who creates the Member's medical records at the originating site is an employee or subcontractor of the Provider, or other person lawfully authorized by the Provider to create a Member's medical record;
- c. The Provider determines that the billing Provider is able to meet the applicable standard of care; and
- d. A Member who receives covered services via telehealth must otherwise be eligible to receive in-person services from that Provider.

C.D. Reimbursable Telehealth Services

1. IEHP covered benefits or services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Code System (HCPCS) codes and subject to all existing IEHP coverage and reimbursement policies, including any prior authorization requirements, may be provided via a telehealth modality, as outlined in this section, if all of the following are satisfied:
 - a. The treating ~~health-care~~ Provider at the distant site believes that the benefits or services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
 - b. The Member has provided verbal or written consent;
 - b.c. The benefits or services delivered via telehealth meet the procedural definition and components of the ~~procedure-CPT-4 or HCPCS~~ code(s), as defined DHCS, associated with the IEHP covered ~~benefits or services or benefit~~, as well as any extended guidelines as described in this section of the IEHP Provider manual; and
 - e.d. The covered benefits or services provided via telehealth meet all state and federal laws regarding confidentiality of health care information and a Member's right to their own medical information.
2. IEHP must reimburse Providers at the same rate, whether a covered service is provided in-person or through telehealth, if the service is the same, unless otherwise agreed upon by IEHP and the Provider.
3. IEHP must reimburse Providers for a covered service rendered via telephone or video at the same rate for in-person visits, provided that the modality by which the service is rendered (telephone versus video) is medically appropriate for the Member, unless otherwise agreed to by IEHP and the Provider.
4. All Providers, with the exception of FQHCs, RHCs and THPs are allowed to be reimbursed for consultations provided via a telehealth modality.
- 2.5. Covered benefits or services provided via a telehealth modality are reimbursable when billed in one of two (2) ways:
 - a. For services or benefits provided via synchronous, interactive audio and telecommunications systems, the ~~health-care~~ Provider bills with the appropriate

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modifier for this service as specified by DHCS.

- b. For services or benefits provided via asynchronous store and forward telecommunications systems, the ~~health-care~~ Provider bills with the appropriate modifier for this service as specified by DHCS.

3-6. Examples of Services Not Appropriate for Telehealth:

- a. Certain types of benefits or services that would not be expected to be appropriately delivered via telehealth include, but are not limited to, benefits or services that are performed in an operating room or while the Member is under anesthesia, require direct visualization or instrumentation of bodily structures, involve sampling of tissue or insertion/removal of medical devices and/or otherwise require the in-person presence of the Member for any reason.

7. Effective January 1, 2024, all Provider furnishing applicable covered benefits or services via audio-only synchronous interactions must also offer those same services via video synchronous interactions as to preserve Member choice. To preserve a Member's right to access covered services in-person, a Provider furnishing services through video synchronous interaction or audio-only synchronous interaction must do one of the following:

- a. Offer those same services via in-person, face-to-face contact;
- b. Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.
- a. _____

D-E. Billing Requirements

1. Synchronous, Interactive Audio and Telecommunications Systems:

- a. ~~Health-care~~ Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the ~~health-care~~ Provider at the distant site and the Member at the originating site. The audio-video telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the procedure code billed.
- b. Evaluation and Management (E&M) and all other covered IEHP services provided at the originating site (in-person with the Member) during a telehealth transmission are billed according to standard IEHP policies (without telehealth modifiers as specified by DHCS). Please see 20A, "Claims Processing". The E&M service must be in real-time or near real-time (delay in seconds or minutes) to qualify as an interactive two-way transfer of medical data and information between the Member and ~~health-care~~ Provider
- c. The presence of a ~~health-care~~ Provider is not required at the originating site as a

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condition of payment unless the ~~health-care~~ Provider at the originating site is medically necessary as determined by the health care Provider at the distant site.¹⁰

2. Asynchronous Store and Forward Telecommunications Systems:
 - a. For billing purposes, ~~health-care~~ Providers must ensure that the documentation, typically images, sent via store and forward be specific to the Member's condition and adequate for meeting the procedural definition and components of the procedure code that is billed. In addition, all services billed via store and forward are subject to all existing IEHP coverage and reimbursement policies, including any prior authorization requirements. Please see policy 20A, "Claims Processing".
3. Originating Site and Transmission Fees
 - a. The originating site facility fee is reimbursable only to the originating site when billed with the procedure code specified by DHCS for this service (telehealth originating site facility fee). Transmission costs incurred from providing telehealth services via audio/video communication is reimbursable when billed with the procedure code specified by DHCS for these services (telehealth transmission, per minute, professional services billed separately).
 - b. Originating Site and Transmission Fee Restrictions
 - 1) Restrictions for billing originating site and transmission costs are as follows:
 - Originating site: once per day, same Member, same Provider.
 - Transmission fee (at originating site and distant site): maximum of 90 minutes per day (1 unit = 1 minute), same Member, same Provider.
 - If billing store and forward, Providers at the originating site may bill the originating site fee but may not bill for the transmission fee.
4. Claims reimbursement for FQHC and Tribal FQHC sites follow state guidelines.¹¹

¹⁰ 42 CFR § 410.78.

¹¹ Centers for Medicare and Medicaid Services (CMS) Health and Human Services (HHS), 42 CFR Parts 403, 405, 410, 411, 414, 415, 423, 424, and 425

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Chief Approval: Signature on File	Original Effective Date:	January 1, 2021
Chief Title: Chief Medical Officer	Revision Date:	January 1, 2023

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<u>INLAND EMPIRE HEALTH PLAN</u>		
<u>Chief Approval: Signature on File</u>	<u>Original Effective Date:</u>	<u>January 1, 2021</u>
<u>Chief Title: Chief Medical Officer</u>	<u>Revision Date:</u>	<u>July 12, 2023</u> <u>January 1, 2023</u>

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 - 1. eConsult Services
-

APPLIES TO:

- A. This policy applies to IEHP Direct Primary Care Providers (PCPs) and Specialist Reviewers, as well as IEHP network Federally Qualified Health Centers (FQHCs), Tribal ~~Federally Qualified Health Centers Providers~~ (TFQHCsTHPs), Rural Health Clinics (RHCs) or Indian Health Services (IHS) sites.

POLICY:

- A. IEHP provides an eConsult platform and workflow that allows IEHP Direct PCPs to request electronically the opinion and/or advice of another health care provider (Specialist Reviewer) with specialty expertise to assist in the diagnosis and/or management of the Member's health care.

PURPOSE:

- A. To ensure that IEHP Members in need of care, as determined by their PCP, receive timely access to care.

DEFINITION:

- A. eConsults – These fall under the auspice of store and forward Virtual Care. eConsults are asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant or Specialist Reviewer) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. eConsults between health care Providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. eConsults are permissible only between health care Providers.
- B. Specialist Reviewer - A Specialist Provider who has agreed to engage in an asynchronous dialogue with a PCP with the goals of sharing clinical expertise, providing case-based learning and improving timely access to quality specialty care.
- C. "Asynchronous store and forward" - The transmission of a Member's medical information from an originating site to the health care Provider at a distant site without the presence of the Member. Consultations via asynchronous electronic transmission initiated directly by Members, including through mobile phone applications, are not covered under this policy.

PROCEDURES:

- A. eConsult is a tool to facilitate Provider-to-Provider interaction in order to reduce Member visit wait times, unnecessary visits and improve access to Specialists.

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B. All Providers, with the exception of FQHCs, RHCs, and THPs, are allowed to be reimbursed for consultations provided via eConsults.

B.C. Members cannot initiate eConsults as they are interprofessional interactions, and therefore eConsults may be initiated by PCPs or Specialists Providers. Providers, including FQHCs, RHCs, and THPs are permitted to be reimbursed for brief virtual communications that consist of a brief communication with a member who is not physically present (face-to-face) at the Fee-for-Services rate for services requiring prior authorization. Prior authorization for proposed services or referrals call for the following:

1. Verification of Member eligibility;
2. Written documentation by the PCP or Specialist of medical necessity for service, procedure, or referral; and
3. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial for the proposed service or referral.

C.D. Request for referrals submitted to IEHP Direct for most specialty care may first go through the eConsult process, in which the requesting Provider (typically the PCP) engages in an asynchronous dialog with a Specialty Reviewer. The workflow is described here:

1. Member is seen by their PCP and a potential need for specialty care is established.
2. PCP submits an eConsult to a Specialty Reviewer.
 - a. eConsult may be submitted while the Member is in the office or once the Member has left. PCPs will have two (2) working days from the date the Member is seen to submit an eConsult along with all supporting documentation.
 - b. PCP and staff members must sign into eConsult using their assigned username and password.
 - c. All users must have an individual email address to access the eConsult portal and are not to share their passwords.
3. The eConsult includes the Member's medical history, chief complaint, medical details relevant to the Member's complaint, and a clinical dialog with the Specialty Reviewer.
 - a. The PCP at the originating site must create and maintain the following:
 - 1) A record that the eConsult is the result of patient care that has occurred or will occur and relates to ongoing Member management; and
 - 2) A record of a request for an eConsult by the PCP at the originating site.
4. The Specialist Reviewer is required to respond to the PCP within seventy-two (72) hours of receiving the eConsult.
 - a. The Specialty Reviewer at the distant site must create and maintain the following:
 - 1) A record of the review and analysis of the transmitted medical information with

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written documentation of date of service and time spent; and

- 2) A written report of case findings and recommendations with conveyance to the originating site.

D.-E. Outcome of the eConsult may include continued management of the Member's condition by the PCP or a recommendation that the Member be seen by a Specialist.

1. If the Specialty Reviewer recommends a coordination of care by the PCP by means of medication and/or therapeutic treatment, the PCP completes ("closes") the eConsult and manages the Member's condition accordingly.
 - a. PCP will contact and manage the Member's condition as recommended by the Specialist Reviewer.
2. If the Specialty Reviewer recommends a face-to-face visit with a Specialist, the PCP staff submits a referral request to IEHP. Please see 14D, "Pre-Service Referral Authorization Process."

E.-F. Members may require a face-to-face visit with a Specialist after a clinical conversation has determined the care cannot be managed by the PCP in the primary care setting.

1. An eConsult is not separately reportable or reimbursable if any of the following are true:
 - a. The Specialty Reviewer saw the patient within the last fourteen (14) days;
 - b. The eConsult results in a transfer of care or other face-to-face service with the Specialty Reviewer within the next fourteen (14) days or next available appointment date of the Specialist Reviewer; or
 - c. The Specialty Reviewer did not spend at least five (5) minutes of medical consultative time, and it did not result in a written report.
2. An eConsult is not reimbursable more than once in a seven-day period for the same patient and Provider.

F.-G. IEHP and its IPAs provide for Members a 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.¹

¹ Knox-Keene Health Care Service Plan Act of 1975, § 1383.15

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- P. Virtual Care
 - 1. eConsult Services

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on File</i>	Original Effective Date:	January 1, 2020
Chief Title: Chief Medical Officer	Revision Date:	January <u>July 12</u> , 2023



INLAND EMPIRE HEALTH PLAN

[Date]

[DOCTOR NAME]

[ADDRESS]

[CITY, CA ZIP]

RE: Change in Hospital Affiliation

Dear [PCP Name]:

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

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

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

Sincerely,

[PSR Name]

Provider Services Representative

cc: [Hospital]

[IPA]

[First Name, Last Name], Chief Operating Officer, IEHP

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

[IPA File]

[PCP File]



INLAND EMPIRE HEALTH PLAN

[Date]

[DOCTOR NAME]

[ADDRESS]

[CITY, CA ZIP]

RE: Change in IPA Affiliation

Dear Dr. [PCP Name]:

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

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

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

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

Sincerely,

[PSR Name]

Provider Services Representative

cc: [Old IPA Name]
[New IPA Name]
[First Name Last Name], Chief Operating Officer , IEHP
[First Name Last Name], Director of Provider Relations, IEHP
[IPA File]
[PCP File]



INLAND EMPIRE HEALTH PLAN

[Date]

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

RE: [PCP Name & Number] TERMINATION

Dear [Delegated IPA Contact Name]:

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

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

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

Sincerely,

[PSR Name]
Provider Service Representative

cc: [PCP Name]
[Hospital]
[First Name Last Name], Chief Operating Officer, IEHP
[First Name Last Name], Director of Provider Relations, IEHP



[DATE]

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

RE: [PCP NAME] – Enrollment Status Change

Dear [IPA Contact Name/Provider Name]:

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

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

Sincerely,

[PSR NAME]
Provider Services Representative

cc: PCP
IPA
[FIRST NAME LAST NAME], Chief Operating Officer, IEHP
[FIRST NAME LAST NAME], Director of Provider Relations, IEHP
PCP File

HOSPITAL GEOGRAPHIC SERVICE AREAS

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

Chino Valley Medical Center	S2
Desert Valley Hospital	S3
Bear Valley Community Healthcare	S1
Hi Desert Medical Center	S3
San Antonio Community Hospital (Medicare only)	S2

HOSPITAL GEOGRAPHIC SERVICE AREAS

R1 Riverside Proper

Moreno Valley, Nuevo, Perris, Riverside

R2 Low Desert

Amboy, Cathedral City, Coachella, Desert Hot Springs, Indian Wells, Indio, Joshua Tree, La Quinta, Landers, Marine Corp Base, Mecca, Morongo Valley, North Palm Springs, Palm Desert, Palm Springs, Pioneer Town, Rancho Mirage, Thermal, Thousand Palms, Twenty-nine Palms, Whitewater, Yucca Valley

R3 Corona/Temecula/Hemet Region

Aguanga, Anza, Corona, Fallbrook, Hemet, Homeland, Idyllwild, Lake Elsinore, Menifee, Mira Loma, Mountain Center, Murrieta, Norco, San Jacinto, Sun City, Temecula, Wildomar, Winchester

R4 Palo Verde Valley

Blythe, Desert Center

S1 San Bernardino Proper

Angelus Oaks, Banning, Beaumont, Big Bear City, Big Bear Lake, Bloomington, Blue Jay, Bryn Mawr, Cabazon, Calimesa, Cedar Glen, Cedarpines Park, Colton, Crest Park, Crestline, Fawnskin, Fontana, Forest Falls, Grand Terrace, Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Loma Linda University, Mentone, Patton, Redlands, Rialto, Rimforest, Running Springs, San Bernardino, Sky Forest, Sugar Loaf, Twin Peaks, Veteran's Hospital, Yucaipa

S2 West San Bernardino

Chino, Chino Hills, Claremont, Guasti, Hacienda Heights, La Verne,
Montclair, Mount Baldy, Ontario, Pomona, Rancho Cucamonga, Upland

S3 High Desert

Adelanto, Apple Valley, Baker, Barstow, Daggett, Fort Irwin, Helendale,
Hesperia, Hinkley, Lucerne Valley, Ludlow, Lytle Creek, Newberry
Springs, Oro Grande, Phelan, Pinon Hills, Victorville, Wrightwood,
Yermo

S4 Mohave Valley

Big River, Cima, Essex, Mountain Pass, Needles, Nipton, Parker Dam,
Red Mountain, Roland Heights, Trona.



IEHP PCP Leave of Absence Coverage Form

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

I, _____, have entered into an Agreement with
(PCP Name)
_____ who will be available to my
(Covering Provider's Name /or Group Name)

IEHP patients for direction of care during my absence.

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

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

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

Physician Name

Date

IPA HOSPITAL LINK RESPONSIBILITY GRID

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



[DATE]

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

RE: [PCP NAME] – Enrollment Status Change

Dear [IPA Contact Name/Provider Name]:

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

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

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

Sincerely,

[PSR NAME]
Provider Services Representative

cc: PCP
IPA
[FIRST NAME LAST NAME], Chief Operating Officer, IEHP
[FIRST NAME LAST NAME], Director of Provider Relations, IEHP
PCP File



January 17, 2019

«IEHP_ID»
«Med_Name»
«Add_2» «Add_1»
«City», «STATE» «Zip_code»

Dear «Greeting02»,

We're writing to let you know that your current Primary Care Doctor, Dr. «OLDPCPNAME», located at «OldPCPAdd», «OldPCPCity» will be leaving IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) as of «mleffec».

What does this change mean to you?

To make sure there will be no break in your care, IEHP DualChoice has assigned a new Primary Care Doctor, Dr. «Newpcpname». If you wish to change your new Doctor, please go to My IEHP Health Account at www.iehp.org or call IEHP DualChoice Member Services.

Listed below are Dr. «NEWPCPNAME»'s office location, and the name and address of the hospital where you should go to get care.

<u>Dr. «NEWPCPNAME»</u>	<u>«NewHos»</u>
«NewPAdd»	«NewHosAdd»
«NewPCity», «NewPState» «NewPZip»	«NewHosCity», «NewHosSte» «NewHosZip»
«NewPPhone»	«NewHosPhne»

We will mail you a new IEHP DualChoice Member Card. When you get the new card, destroy the old one. If you do not get the new card, please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347), 8am – 8pm (PST), 7 days a week, including holidays. TTY users should call 1-800-718-4347.

Be assured – all your benefits will stay the same.

If you are receiving care for one of the items on the list below or have certain services already scheduled after «mleffec», you can request permission to continue receiving those medical services. To learn more about continuity of care and eligibility qualifications, please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347), 8am – 8pm (PST), 7 days a week, including holidays. TTY users should call 1-800-718-4347.

- Pregnancy
- Treatment for a serious chronic condition
- Treatment for an acute chronic condition

- Treatment that may require prompt medical attention
- Care of a newborn child up to 36 months of age
- Terminal illness
- Surgery or procedure that IEHP DualChoice authorized

California Department of Managed Health Care

If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact IEHP DualChoice Member Services, and if you have further questions, you are encouraged to contact the **Department of Managed Health Care**, which protects HMO consumers, by telephone at its toll-free number, **1-888-HMO-2219 (1-888-466-2219)**, or at a TTY number for the hearing impaired at **1-877-688-9891**, or online at www.hmohelp.ca.gov.

California Department of Health Care Services (DHCS) Office of the Ombudsman

For help with Cal MediConnect, you may call the California Department of Health Care Services (CDHCS) Ombudsman Office at 1-888-501-3077. The Ombudsman Office helps people with Cal MediConnect make use of their rights and responsibilities.

Thank you for trusting IEHP to take care of your health care needs.

Sincerely,

IEHP DualChoice Member Services
Inland Empire Health Plan

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

H5355_CMC_19_1169772



17 de enero de 2019

«IEHP_ID»
«Med_Name»
«Add_2» «Add_1»
«City», «STATE» «Zip_code»

Estimado «Greeting02»:

Le escribimos para informarle que su Doctor de Cuidado Primario, Dr. «OLDPCPNAME», ubicado en «OldPCPAdd», «OldPCPCity» dejará a IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) a partir del «mleffec».

¿Qué significa esto para usted?

Para asegurarnos de que no haya interrupción en su atención médica, le hemos asignado un nuevo Doctor de Cuidado Primario, Dr. «NEWPCPNAME». Si desea cambiar a un Doctor diferente del que le hemos asignado, por favor vaya a Mi Cuenta de Salud de IEHP DualChoice en www.iehp.org o llame a Servicios Para Miembros de IEHP DualChoice.

Abajo se encuentra el domicilio y número de teléfono del Dr. «NEWPCPNAME», así como el nombre y domicilio del hospital «Greeting04», a donde debe acudir para recibir atención médica.

<u>Dr. «NEWPCPNAME»</u>	«NewHos»
«NewPAdd»	«NewHosAdd»
«NewPCity», «NewPState» «NewPZip»	«NewHosCity», «NewHosSte» «NewHosZip»
«NewPPhone»	«NewHosPhne»

Le enviaremos por correo su nueva Tarjeta para Miembros de IEHP DualChoice. Cuando reciba la tarjeta nueva, destruya la anterior. Si no recibe la tarjeta nueva, por favor llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347), de 8am-8pm, (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347.

Puede estar seguro de que todos los beneficios seguirán siendo los mismos.

Si está recibiendo atención para uno de los artículos de la lista a continuación o tiene ciertos servicios ya programados después de «mleffec», puede solicitar permiso para continuar recibiendo esos servicios médicos. Para obtener más información sobre la continuidad de atención médica y requisitos de

elegibilidad, llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347), de 8am-8pm, (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347.

- Embarazo
- Tratamiento para una condición crónica grave.
- Tratamiento para una afección crónica aguda.
- Tratamiento que puede requerir atención médica inmediata.
- Cuidado de un recién nacido hasta los 36 meses de edad.
- Enfermedad terminal
- Cirugía o procedimiento autorizado por IEHP DualChoice.

Departamento de Atención Médica Coordinada (Department of Managed Health Care)

Si usted ha estado recibiendo servicios de algún proveedor de atención médica, entonces podría tener derecho a continuar atendiendo con su proveedor por un periodo de tiempo designado. Por favor, comuníquese con Servicios para Miembros de IEHP DualChoice, y si tiene preguntas adicionales, no dude en comunicarse con el **Departamento de Atención Médica Coordinada (Department of Managed Health Care)**, el cual protege a los usuarios de HMO, a la línea telefónica gratuita al **1-888-HMO-2219 (1-888-466-2219)**, o al número de TTY para personas con dificultades auditivas al **1-877-688-9891**, o en línea en **www.hmohelp.ca.gov**.

Oficina de Defensoría del Departamento de Servicios de Atención Médica (Department of Health Care Services [CDHCS] Ombudsman Office)

Para obtener ayuda con respecto a asuntos de Cal MediConnect, usted puede llamar a la Oficina de Defensoría del Departamento de Servicios de Atención Médica (Department of Health Care Services [CDHCS] Ombudsman Office) al 1-888-501-3077. La Oficina de Defensoría ayuda a que las personas con Cal MediConnect hagan uso de sus derechos y responsabilidades.

Gracias por confiar en IEHP DualChoice para atender sus necesidades de atención médica.

Sinceramente,

Servicios para Miembros de IEHP DualChoice
Inland Empire Health Plan

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

H5355_CMC_19_1169772S



[Date]

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

RE: [PCP NAME] TERMINATION

Dear [IPA Contact Name]:

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

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

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

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

Sincerely,

PSR Name
Provider Services Representative

cc: PCP Name
[First Name Last Name], Chief Operating Officer, IEHP
[First Name Last Name], Director of Provider Relations, IEHP
PCP File



[DATE]

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

RE: [PCP NAME] – Enrollment Status Change

Dear [IPA Contact Name/Provider Name]:

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

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

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

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

Sincerely,

PSR NAME
Provider Services Representative

cc: PCP
IPA
[FIRST NAME LAST NAME], Chief Operating Officer, IEHP
[FIRST NAME LAST NAME], Director of Provider Relations, IEHP
PCP File



~~September 13, 2022~~~~September 9, 2021~~

«FISRT_NAME» «LAST_NAME»
«ADDRESS_1» «ADDRESS_2»
«CITY», «STATE» «ZIP_CODE»

«IEHP_ID»

Dear «FirstName»,

A change in our Provider Network might affect your health care. Dr. «SpecName», «PDDESC2» Specialist, located at «PAdd1» «PAdd2», «PCity», will no longer be serving IEHP Members as of «MLEffec».

To make sure there is no break in your health care, please call your Primary Care Doctor right away for help finding a new «PDDESC2» Specialist if you need one.

If you are getting care now, you may be able to keep seeing Dr. «SpecName» until your Doctor can help you find a new «PDDESC2» Specialist. It is very important that you talk about this with your Doctor as soon as you can.

Please do not wait. This change may affect your care. Call your Doctor today.

If you have any questions, call IEHP Member Services at 1-800-440-IEHP(4347). TTY users should call 1-800-718-4347.

You can be sure; all your benefits will stay the same. Thank you for trusting IEHP with your health care needs.

Sincerely,

IEHP Member Services
OPS_25_EA_SPT_«SpecialistID»

IMPORTANT INFORMATION about Billings, Authorizations for Services, and your right to Continued Care is printed on the back of this letter. Please be sure to read it.

¿Prefiere esta información en Español? Llame a Servicios para Miembros de IEHP al «Member_Services_Phn».



~~13 de septiembre de 2022~~ ~~09 de septiembre de 2021~~

«FISRT_NAME» «LAST_NAME»
«ADDRESS_1» «ADDRESS_2»
«CITY», «STATE» «ZIP_CODE»

«IEHP_ID»

Estimado/a «FirstName»:

Un cambio en nuestra Red de Proveedores podría afectar su atención médica. El/la Dr./Dra. «SpecName», Especialista en «PDDESC2», ubicado/a en «PAdd1» «PAdd2», «PCity», ya no atenderá a los Miembros de IEHP a partir del «MLEffec».

Con el propósito de asegurarnos de que no se interrumpa su atención médica, por favor llame a su Doctor de Cuidado Primario de inmediato para que le ayude a encontrar un nuevo Especialista en «Pddesc2» si lo necesita.

Si actualmente está recibiendo atención, es posible que pueda seguir acudiendo con el/la Dr./Dra. «SpecName» hasta que su Doctor/a pueda ayudarle a encontrar un nuevo Especialista en «PDDESC2». Es muy importante que hable acerca de esto con su Doctor/a lo más pronto que pueda.

Por favor no espere. Este cambio puede afectar su atención médica. Llame a su Doctor hoy mismo.

Si tiene alguna pregunta, comuníquese a Servicios para Miembros de IEHP al 1-800-440-IEHP(4347). Los usuarios de TTY deben llamar al 1-800-718-4347.

Puede estar seguro/a de que todos los beneficios de usted seguirán siendo los mismos. Gracias por confiar en IEHP para atender sus necesidades de atención médica.

Atentamente,

Servicios para Miembros de IEHP
OPS_25_SA_SPT_«SpecialistID»

Al reverso de esta carta encontrará INFORMACIÓN IMPORTANTE sobre Facturación, Autorización de Servicios y su derecho a Continuidad de la Atención Médica. Por favor, asegúrese de leerla.

¿Prefiere esta información en inglés? Llame a Servicios para Miembros de IEHP al «Member_Services_Phn».

Specialty Network Review

IPA | HOSPITAL

Original IEHP Findings				IPA Response		
CORE SPECIALTY NETWORK				CORE SPECIALTY NETWORK		
SPECIALTY	TOTAL # OF PROVIDERS	# OF PROVIDERS ON UNIQUE CONTRACTS	STATUS	CONTRACTED PROVIDERS	POTENTIAL PROVIDERS	NOTES
Allergy and Immunology***						
Cardiology						
Dermatology***						
Endocrinology						
Gastroenterology						
General Surgery						
Infectious Disease						
Nephrology						
Neurology						
OB/GYN						
Orthopedics Surgery						
Otolaryngology (ENT)						
Ophthalmology						
Oncology/Hematology						
Physical Medicine and Rehabilitation						
Pulmonary Medicine						
Rheumatology						
Urology						

Specialty Network Review

IPA | HOSPITAL

Original IEHP Findings				IPA Response		
GEOGRAPHIC SPECIALTY NETWORK				GEOGRAPHIC SPECIALTY NETWORK		
SPECIALTY	TOTAL # OF PROVIDERS	# OF PROVIDERS ON UNIQUE CONTRACTS	STATUS	CONTRACTED PROVIDERS	POTENTIAL PROVIDERS	NOTES
Bariatric Surgery						
Cardiac/Thoracic Surgery						
Genetics						
Neurosurgery (if the hospital provides this service)						
Pain Management						
Pediatric Subspecialties**						
1. Pediatric Cardiology						
2. Pediatric Gastroenterology						
3. Pediatric Ophthalmology						
4. Pediatric Neurology						
5. Pediatric Orthopedics						
Pediatric Surgery						
Physical & Speech Therapy						
Plastic Surgery						
Podiatry***						
Ancillary Providers						

