2025 Credentialing Activities Report Instructions for Credentialing Delegates
Audit Look Back Period: July 2024 to June 2025

Delegates are required to roadmap all elements identified on the Credentialing Audit Tool. Delegates are strongly encouraged to print and thoroughly review these instructions before completing the Credentialing Audit Tool.

AUDIT INSTRUCTIONS:

- Prior to the scheduled audit dates, Delegates are required to submit the completed road map along with the policies referenced
- The areas in the Credentialing Audit Tool highlighted in **BLUE**, Delegates are required to populate with Name, Page, and Section of the policy or policies that meet that requirement.
- For elements not applicable to the delegate, indicate "N/A" in the section in **BLUE**, followed by the reason in the Comment column
- To receive auto-credit for NCQA elements, Delegate must provide a copy of their NCQA Certification/Accreditation AND Letter for the respective to the look-back period that documents areas of Certification/Accreditation eligible for auto-credit

EVIDENCE

Listed below are the Credentialing documents we will be reviewing as Evidence. Please ensure these documents are made available during the audit.

CR1.B. Practitioners Rights, Sample of Notification via:

- Application; or
- Contract; or
- Website; or
- Letter

CR1.D. Credentialing System Controls Reports must reflect the Delegate identified, analyzed and acted only on modifications to credentialing/recredentialing information

This element applies to both paper and electronic credentialing processes

- Scanned Report and provided as an attachment; or
- Excel file of inappropriate modifications; or
- Delegate may also provide their audit findings on the CR 1D SYSTEMS CONTROLS OVERSIGHT tab.

CR2.A. Credentialing Committee Minutes. One (1) set of minutes from each quarter, totaling four (4) sets of minutes within the look back period. IEHP will review for the following:

- Committee representation that includes participating practitioners in the network; and
- Specialist was consulted when applicable; and
- Evidence that the Credentialing Committee reviewed Credentials for practitioners who do not meet established thresholds.
- Evidence of the designated Medical Director's or designated physician's review and approval in the practitioners file or on a list of all practitioners who meet the established criteria

2025 Credentialing Activities Report Instructions for Credentialing Delegates

Audit Look Back Period: July 2024 to June 2025

CR3. Credentialing Verifications

- IEHP will select forty (40) initial credentialing files, thirty (30) for the NCQA File methodology and ten (10) additional files requested if there is a deficiency or additional elements are required for the review.
- IEHP will select forty (40) recredential files, thirty (30) for the NCQA File methodology and ten (10) additional files requested if there is a deficiency or additional elements are required for the review.
- IEHP will audit the files in the order they are listed on the Credentialing File Pull Lists.
- It is ***preferred*** for Delegates to review their files prior to the audit and bookmark their files to ensure compliance.
- IEHP reviews the verification of credentials within a random sample of up to forty (40) initial credentialing files and up to forty (40) recredentialing files for practitioners that were due for recredentialing during the look-back period.
- IEHP conducts onsite, virtual, and desktop file review in the presence and/or coordination with the organization's staff, if available, and works with the organization to resolve any disputes during the onsite survey.
- File review results may not be disputed or appealed once the survey is complete.
- All file review elements are "MUST-PASS ELEMENTS".

CR4. Recredentialing Cycle Length

- Evidence of previous credentialing decision via Decision letter, Medical Director Sign-off, or Credentialing Committee minutes.

CR5. Ongoing Monitoring and Interventions

- Evidence of Monitoring reports (i.e. Sanction logs), documentation of interventions

CR6. Notification to Authorities and Practitioner Appeal Rights.

Practitioner files suspended and/or terminated due to quality of care and their written notification when a professional review has been brought against a practitioner, including:

- Reason(s) for Action;
- Allow the practitioner to request a hearing/appeal and the timing for submitting the request; Reports to Authorities include, but are not limited to:
- Licensing Board Reports (i.e., 805 and 805.01 reports)
- National Practitioner Data Bank Reports
- Written notification to the practitioner that includes:

CR7. Assessment of Organizational Providers

- IEHP reviews evidence that the organization assessed the providers by providing documentation of a tracking mechanism(s) (checklist or spreadsheet) or file review.

CR8A. Delegation of Credentialing (CR), Written Delegation Agreement

- Written Delegation Agreement for all Sub-Delegation arrangements.

2025 Credentialing Activities Report Instructions for Credentialing Delegates

Audit Look Back Period: July 2024 to June 2025

CR8B. Pre-Delegation Evaluation, for new Delegation agreements. Evidence the organization evaluated delegate capacity to meet NCQA requirements before Delegation through:

- NCQA Health Plan Audit & evidence it was reviewed via Committee Minutes, email approval or other methods indicating acceptance of review; or
- A systematic method for conducting this evaluation.
- Delegates are required to submit a copy of their written Delegation Agreements for all sub-delegation arrangements.
- Delegates are required to provide evidence of Delegation Activities for all sub-delegation arrangements.

CR8C. Review of Delegate Credentialing Activities, Evidence of:

- Annual Review of its Delegates credentialing policies and procedures
- Annual audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect
- Annual evaluation of Delegate performance against NCQA standards for delegated activities
- Quarterly evaluates regular reports, as required for Medi-Cal lines of Business
- Semi-Annually evaluates regular reports
- Annual review, the organization monitors the delegate's credentialing system controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually.
- Annual review, the organization acts on all findings from factor 5 of reach delegate and implements quarterly monitoring process until each delegate demonstrates improvement for one finding over three (3) consecutive quarters.

CR8D. Opportunities for Improvement, for Delegation arrangements have been in effect for more than twelve (12) months, identified through:

- Organization's pre-delegation evaluation; or
- Annual evaluation; or
- File audits or ongoing reports; or
- Health Plan audits with opportunities for improvement, where the organization reviewed the corrective action plan (CAP) from the delegated entity and reviews to see if the audit and CAP were reviewed and approved (i.e., Committee minutes, email approval or other method indicating acceptance of review of the CAP.)

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

CA9. Identification of HIV/AIDS Specialists

- IEHP will review evidence that the Delegate identifies HIV/AIDS specialists on an annual basis, which includes review of the current and previous year's survey/spreadsheet/credentialing attestation/logs.
- IEHP will review the list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.
- Distribution of findings must be communicated within thirty (30) calendar days from the completion of the screening/survey assessment.

2025 AUDIT RESULTS

Review Date: _____

Delegate: _____
Reviewed by: _____

NCQA		POINTS RECEIVED	POINTS POSSIBLE	A	B	C	D	E
CR 1: Credentialing Policies		#DIV/0!	3	0	0	0	#####	
CR 2: Credentialing Committee		0	1	0				
CR 3: Credentialing Verification		0	0	*	*	*		
CR 4: Recredentialing Cycle Length		#DIV/0!	0	#####				
CR 5: Ongoing Monitoring and Interventions		0	1	0				
CR 6: Notification to Authorities and Practitioner Appeal Rights		0	1	0				
CR 7: Assessment of Organizational Providers		0	2	0	0	N/A	*	N/A
CR 8: Delegation of CR		0	3	0	N/A	0	0	
MUST PASS ELEMENTS	TOTAL	#DIV/0!	11	#####				

CMS/DHCS/DMHC REQUIREMENTS	CCA POINTS RECEIVED	MEDI-CAL POINTS RECEIVED	MEDICARE POINTS RECEIVED
CR 1: Credentialing Policies			
1. Recred Performance Monitoring	0	0	0
2. Medicare Opt Out Policy			0
3. OIG Sanction		0	0
CR 3: Credentialing Verification			
1. OIG Query		#DIV/0!	#DIV/0!
2. Medi-Cal Suspended & Ineligible Report	#DIV/0!	#DIV/0!	
3. Verification of Hospital Admitting Privileges	#DIV/0!	#DIV/0!	#DIV/0!
4. Opt Out Query (within 180 days)			#DIV/0!
5. Performance Monitoring at Recredentialing	#DIV/0!	#DIV/0!	#DIV/0!
CR 5: Ongoing Monitoring and Interventions			
1. Ongoing Monitoring for Providers who have Opted Out			*
2. Ongoing Monitoring of the Medi-Cal Suspended & Ineligible	*	*	*
3. Ongoing Monitoring of the SSA Death Master File	*	*	*
CR 6: Notification to Authorities and Practitioner Appeal Rights			
1. Ensure that the majority of hearing panel members are peers of the affected physician (a hearing officer does not meet intent)			*
CR 7: Assessment of Organizational Providers			
B. Documented processes for additional provider types - CMS			*
D. Assessment of additional CMS provider types			*
F. Accreditation/Certification of Free-Standing Surgical Centers	*	*	*
CR 8: Delegation of CR			
1. Sub-delegates must adhere to CMS regulations			0
2. Sub-delegates must submit quarterly rosters		0	
3. Review evidence of at least quarterly reporting of the delegated entity to the organization.		0	
CA 9: Identification of HIV/AIDS Specialists			
A. Written policy	*	*	*
B. Evidence of Implementation	*	*	*
C. Distribution of Findings	*	*	*
RECEIVED	#DIV/0!	#DIV/0!	#DIV/0!
POSSIBLE	1	4	4

MEDI-CAL	Actual	Poss	%
Policy & Procedure Review	#####	13.0	#####
File Review	#####	0.0	#####
OP Policy & File Review	0.0	2.0	0%
Total	#####	15.0	#####

MEDICARE	Actual	Poss	%
Policy & Procedure Review	#####	13.0	#####
File Review	#####	0.0	#####
OP Policy & File Review	0.0	2.0	0%
Total	#####	15.0	#####

CCA	Actual	Poss	%
Policy & Procedure Review	#####	10.0	#####
File Review	#####	0.0	#####
OP Policy & File Review	0.0	2.0	0%
Total	#####	12.0	#####

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

CR 1: Credentialing Policies

[CR 1 will be reviewed for all Certified or Accredited Organizations]

The organization has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to members

Document Location: Credentialing & Recredentialing Program, Policy and Procedure Manual and Medical Staff Bylaws, Rules and Regulation

Source: NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
A	**Practitioner Credentialing Guidelines**	**0**		
1	The types of practitioners it credentials and recredentials (List provider types covered in scope)	*	.	
2	The verification sources it uses	*	.	
3	The criteria for credentialing and recredentialing	*	.	
4	The process for making credentialing and recredentialing decision	*	.	
5	The process for managing credentialing files that meet the organization's established criteria	*	.	
6	The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.	*	.	

2025
CREDENTIALING AUDIT TOOL

Delegate: _____
Reviewed by: _____
Review Date: _____

7	The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.	*	.	
8	The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision.	*	.	
9	The medical director or other designated physician's direct responsibility and participation in the credentialing program	*	.	
10	The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law	*	.	
11	The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty	*	.	

MET (1):	**PARTIALLY MET (.5):**	**NOT MET (0):**
The organization meets 8-11 factors	The organization meets 5-7 factors	The organization meets 0-4 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____

Reviewed by: _____

B	Practitioner Rights	0		
	The organization notifies practitioners of their right to:			
1	Review information submitted to support their credentialing application	*	.	
2	Correct erroneous information	*	.	
3	Receive the status of their credentialing or recredentialing application, upon request	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factor

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

C	Credentialing System Controls (NEW)	0		
	(applies to paper and electronic proceses)			
	The organization's credentialing process describes:			
1	How primary source verification information is received, dated and stored	*	.	
2	How modified information is tracked and dated from its initial verification	*	.	
3	Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate	*	.	
4	The security controls in place to protect the information from unauthorized modification	*	.	
5	How the organization audits the processes and procedures in factors 1-4	*	.	

MUST PASS ELEMENT

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets all 5 factors	No scoring option	The organization meets 0-4 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS (All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract)

D	Credentialing System Controls Oversight (NEW)	#DIV/0!		
	(applies to paper and electronic proceses)		Factors 2 and 3 are NA if: • The organization did not identify any modifications that do not meet the organization's policies and procedures, or • All identified modifications met the organization's policies and procedures.	
	At least annually, the organization demonstrates that it monitors compliance with its CR controls, as described in Elemet C, Factor 5 by:	#DIV/0!		
1	Identifying all modifications that did not meet the policies and procedures	N/A	.	
2	Analyzing all modifications that did not meet the policies and procedures	N/A	.	
3	Acting on all findings	N/A	.	

MUST PASS ELEMENT

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets all 3 factors	No scoring option	The organization meets 0-2 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
E	**Practitioner Credentialing Guidelines**	**0**		
1	The organization's recredentialing policies and procedures require information from quality improvement activities and member complaints in the recredentialing decision making process.	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 60.2)

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
F	**Contracts - Opt-Out Provisions**	**0**		
1	The Medicare Advantage organization has policies and procedures to ensure that it only contracts with physicians who have not opted out.	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____

Reviewed by: _____

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 60.2); DHCS All Plan Letter APL 19-004)

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
G	**Medicare - Exclusions/Sanctions**	**0**		
1	The Medicare Advantage organization must have policies and procedures that prohibit employment or contracting with practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (practitioners or entities found on OIG Report)	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

CR 2: Credentialing Committee

The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.

Document Location: Credentialing Committee Minutes

Policy and Evidence Required for all Elements

Source: NCQA/CMS

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
A	**Credentialing Committee**	**0**		
	The organization's Credentialing Committee:			
1	Uses participating practitioners to provide advice and expertise for credentialing decisions.	*	.	
2	Reviews credentials for practitioners who do not meet established thresholds	*	.	
3	Ensures that meet files that meet estalished criteria are reviewed and approved by a medical director or designated physician.	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factor

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

CR 3: Credentialing Verification

The organization verifies credentialing information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.

Document Location: Practitioner Credentialing and Recredentialing files, Primary Source Verifications, Application and Attestation and Initial Sanction Information

Scores pull from the CR 3 File Review Tool Tab

Source: NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met N/A		Comments
A	**Verification of Credentials:**	*		
1	A current and valid license to practice	#DIV/0!		
2	A valid DEA (CA Address) or CDS certificate, if applicable	#DIV/0!		
3	Education and Training	#DIV/0!		
4	Board Certification Status	#DIV/0!		
5	Work History	#DIV/0!		
6	A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner	#DIV/0!		

MUST PASS ELEMENT

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
High (90-100%) on file review for at least 4 factors and medium (60-89%) for file review for any remaining factors	High (90-100%) or medium (60-89%) on file review for all 6 factors	Low (0-59%) on file review for any factor

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

B	Sanction Information	*		
1	State sanctions, restrictions on licensure and limitations on scope of practice	#DIV/0!		
2	Medicare and Medicaid Sanctions	#DIV/0!		

MUST PASS ELEMENT

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
High (90-100%) on file review for at least 1 factor and medium (60-89%) for file review for any remaining factor	Medium (60-89%) on file review for 2 factors	Low (0-59%) on file review for any factor

C	Credentialing Application	*		
1	Reasons for inability to perform the essential functions of the positions	#DIV/0!		
2	Lack of present illegal drug use	#DIV/0!		
3	History of loss of license and felony convictions	#DIV/0!		
4	History of loss or limitation of privileges or disciplinary actions	#DIV/0!		
5	Current malpractice insurance coverage that verifies coverage for the locations and specialties the practitioner is credentialed for	#DIV/0!		
6	Current and signed attestation confirming the correctness and completeness of the application	#DIV/0!		

MUST PASS ELEMENT

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
High (90-100%) on file review for at least 4 factors and medium (60-89%) for file review for any remaining factors	High (90-100%) or medium (60-89%) on file review for all 6 factors	Low (0-59%) on file review for any factor

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

Scores pull from the CR C3 Credentialing Files tab

Source: CMS; DHCS; DMHC

	Criteria	Compliance 1/0 1=Met 0=Not Met N/A		Comments
D	**CMS/DHCS/DMHC Requirements**			
1	OIG Query (CMS; DHCS)	#DIV/0!	#DIV/0!	
2	Medi-Cal Suspended & Ineligible Report (DHCS)	#DIV/0!	#DIV/0!	
3	Hospital Privileges (CMS; DMHC; DHCS)	#DIV/0!	#DIV/0!	
4	Medicare Opt-Out Query (CMS)	#DIV/0!	#DIV/0!	
5	EPLS/EEDP/SAM			
6	Performance Monitoring (CMS; DHCS)	#DIV/0!	#DIV/0!	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
High (90-100%) on file review	No scoring option	Medium (60-89%) or Low (0-59%) on file review

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

CR 4: Recredentialing Cycle Length

The organization formally recredentials its practitioners at least every 36 months.

Document Location: Practitioner Recredentialing files

Scores pull from the CR 3 File Review Tool

Source: NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met N/A		Comments
A	**Recredentialing Cycle Length**	**#DIV/0!**		
1	The length of the recredentialing cycle is within the required 36-month time frame	#DIV/0!		

MUST PASS ELEMENT

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
High (90-100%) on file review	High (90-100%) or medium (60-89%) on file review	Low (0-59%) on file review

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

SV: Practitioner Office Site Quality

The organization has a process to ensure that the offices of all practitioners meet its office-site standards.

IEHP does not delegate the responsibility of Practitoner Office Site Quality

Document Location: Credentialing & Recredentialing Program, Policy and Procedure Manual, Peer Review Policies, Medical Staff Bylaws, Rules and Regulation, Logs, Spreadsheets, Tracking Tools, Committee Minutes.

Source: CMS: (Medicare Managed Care Manual, Chapter 6 § 60.3; NCQA Medicaid MED 3: Practitioner Office Site Quality

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
A	**Performance standards and thresholds:**			
1	Accessibity Equipment			
2	Physician Accessibility			
3	Physical Appearance			
4	Adequacy of waiting and examining room space			
5	Adequacy of medical/treatment record keeping and confidentiality			
B	**Site Visits and Ongoing Monitoring**			
	The organization implements appropriate interventions by:			
1	Continually monitoring member complaints for all practitioner sites or established thresholds for targeting and monitoring practitioners			
2	Conducting site visits of offices within 60 days of determining that the complaint thresholds was met			
3	Instituting actions to improve offices that do not meet thresholds			
4	Evaluating the effectiveness of the actions at least every 6 months, until deficient offices meet the thresholds			
5	Documenting follow-up visits for offices that had subsequent deficiencies			

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

CR 5: Ongoing Monitoring and Interventions

Factors 1-4 requires both policy and evidence to be compliant

The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.

Document Location: Credentialing & Recredentialing Program, Policy and Procedure Manual, Peer Review Policies, Medical Staff Bylaws, Rules and Regulations, Logs, Spreadsheets, Tracking Tools, Committee Minutes

Source: NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
A	**Collecting and reviewing Medicare and Medicaid sanctions**	**0**		
1	Collecting and reviewing Medicare and Medicaid sanctions	*	.	
2	Collecting and reviewing sanctions and limitations on licensure	*	.	
3	Collecting and reviewing complaints	*	.	
4	Collecting and reviewing information from identified adverse events	*	.	
5	Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 0-2 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

Policy and Evidence Required for all Elements

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 60.3); DHCS: (Exhibit A Attachment 4 - Plan Contract, APL 19-004, Plan Contract)

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
B	**CMS Requirements**			
1	The delegate maintains a documented process for monitoring whether network practitioners have opted-out of accepting federal reimbursement for Medicare.	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

C	**Monitoring Medi-Cal Suspended and Ineligible Reports**			
	The delegate will verify that their contracted providers have not been terminated as Medi-Cal providers have not been placed on Suspended and Ineligible Provider List.			
1	The delegate has a policy for monitoring Medi-Cal Suspended and Ineligible Provider Reports	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____

Reviewed by: _____

D	Death Master Review			
	Delegates are required to check the Social Security Administration's Death Master File. This element is NA if the Delegate provides practitioner SSN during the Credentialing Submission process or via Credentialing Activities Reports			
1	The delegate has a policy and evidence for monitoring the Social Security Administration's Death Master File.	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

Source: DHCS: (APL 19-004, Provider Credentialing/Recredentialing and Screening/Enrollment)

CR 6: Notification to Authorities and Practitioner Appeal Rights

[CR 6 will be reviewed for all Certified or Accredited Organizations]

An organization that has taken actions against a practitioner for quality reasons the action to appropriate authorities and offers the practitioner a formal appeal process.

Document Location: Credentialing & Recredentialing Program, Policy and Procedure Manual, Peer Review Policies, Medical Staff Bylaws, Rules and Regulation, Risk/Legal Department Policies and Committee Minutes

Source: NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
A	**Actions Against Practitioners**	**0**		
1	The range of actions available to the organization	*	.	
2	Making the appeal process known to practitioners	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____

Reviewed by: _____

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 60.4)

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
B	**CMS Requirements**			
	The organization's policies and procedures regarding suspension or termination of participating physician require the organization to:			
1	Ensure that the majority of the hearing panel members are peers of the affected physician (a hearing officer does not meet intent)	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

CR 7: Assessment of Organizational Providers

The organization has written policies and procedures for the initial and ongoing assessment of providers with which it contracts

Document Location: Checklist, Spread Sheet Log, Files on Organizational Providers, Site Visit Reports and Committee Minutes.

Source: NCQA

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
A	**Policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least three years thereafter, it:**	**0**		
1	Confirms that the provider is in good standing with state and federal regulatory bodies	*	.	
2	Confirms that the provider has been reviewed and approved by an accrediting body	*	.	
3	Conducts an onsite assessment if the provider is not accredited.	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

B	Includes at least the following providers in its assessment:	0		
1	Hospitals	*	.	
2	Home Health Agencies	*	.	
3	Skilled Nursing Facilities	*	.	
4	Free-Standing Surgical Centers	*	.	
5	Clinical Laboratories (IEHP requirement)	*	.	

MET (1):	NOT APPLICABLE (N/A)	NOT MET (0):
Delegate is contracted with Organizational Providers and it states so in policy	Delegate is not contracted for Organizational Providers	Delegate is contracted, but Organizational Providers is not stated in the policy

C	Includes behavioral health facilities providing mental health or substances abuse services in the following settings:			
1	Inpatient			IEHP does not delegate this element
2	Residential			IEHP does not delegate this element
3	Ambulatory			IEHP does not delegate this element
D	**Assessing Medical Providers**	*		
1	Has documentation that it assessed contracted medical health care providers for at least three years thereafter. (The organization assesses contracted medical health care providers against the requirements and within the time frame in Element A.)	*	.	Review spreadsheet and note compliance. If files are reviewed complete the CR.7. Organizational Providers Tool and note the score in Column C.

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date: _____**

Reviewed by: _____

E	Behavioral Health Facilities Assessment			
1	Has documentation that it assessed contracted behavioral healthcare providers for at least three years thereafter. (The organization assesses contracted behavioral healthcare providers against the requirements and within the time frame in Element A.)			IEHP does not delegate this element

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____

Reviewed by: _____

Source: CMS (Medicare Managed Care Manual, Chapter 6 § 70)

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
B	**CMS Requirements**	*		
1	Hospices	*	.	
2	Clinical Laboratories	*	.	
3	Comprehensive Outpatient Rehabilitation Facilities (CORF)	*	.	
4	Outpatient Physical Therapy Providers	*	.	
5	Speech Pathology Providers	*	.	
6	End Stage renal disease service providers	*	.	
7	Outpatient Diabetes self-management training providers	*	.	
8	Portable X-Ray Suppliers	*	.	
9	Rural Health Clinics (RHC)	*	.	
10	Federally Qualified Health Centers (FQHC)	*	.	

MET (1):	NOT APPLICABLE (N/A)	NOT MET (0):
Delegate is contracted with Organizational Providers and it states so in policy	Delegate is not contracted for Organizational Providers	Delegate is contracted, but Organizational Providers is not stated in the policy

2025
CREDENTIALING AUDIT TOOL

Delegate: _____
Reviewed by: _____
Review Date: _____

C	Medical Providers Assessment - CMS	0		
1	Has documentation that it assessed contracted medical health care providers for at least three years thereafter	*	.	Review spreadsheet and note compliance. If files are reviewed complete the OP Tool and note the score in Column C.

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

D	Accreditation/Certification of Free-Standing Surgical Centers in California CH&SC			
1	The organization has documentation of assessment of free-standing surgical centers to ensure that if the organizational provider is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program	*	.	

MET (1):	PARTIALLY MET (.5):	NOT MET (0):
The organization meets 1 factor	No scoring option	The organization meets 0 factors

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date: _____**

Reviewed by: _____

Organizations to which the Provider Organization delegates any credentialing functions: Always note NA in the Scoring box, when a PO does not delegate any part of the credentialing process				
	Name	Type (i.e. MSO, CVO)	NCQA Cert Expiration Date	Delegation Agreement Effective Date

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

CR 8: Delegation of Credentialing

If the organization delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities.

Document Location: Letter of Agreement, Contract, Memorandum of Understanding, Audit Documentation, Committee Minutes

Scores pull from the CR.8. DELEGATION tab

Source: NCQA; CMS (Medicare Managed Care Chapter 11 § 110.2)

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
A	**Written Delegation Agreement:**	**Example: Score each delegate for each element below**	**1) ABC Medical Group, pg 3 2) ACME Physician Organization, pg 6. 3) Mercy Health Partners, pg. 2**	
1	Is mutually agreed upon	N/A	.	
2	Describes the delegated activities and the responsibilities of the organization and the delegated entity	N/A	.	
3	Requires at least semi-annual reporting of the delegated entity to the organization	N/A	.	
4	Describes the process by which the organization evaluates the delegated entity's performance	N/A	.	
5	Specifies the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making	N/A	.	
6	Describe the remedies available to the organization if the delegated entity does not fulfill its obligation, including revocation of the delegation agreement	N/A	.	
		0.0		If there are no delegation arrangements, score NA

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

Source: CMS (Medicare Managed Care Chapter 11 § 110.2); DHCS (MediCal ExhibitA, Attachment 4 of Plan Contract - QI Activities)

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
	CMS/DHCS Requirements	**Example:**	**1) ABC Medical Group, pg 3**	
1	Documentation in the agreement showing that sub-delegates must adhere to CMS regulations	N/A	.	If there are no delegation arrangements, score NA
2	The written delegation must require at least quarterly reporting of the delegated entity to the organization	N/A	.	If there are no delegation arrangements, score NA
3	Review evidence of at least quarterly reporting of the delegated entity to the organization.	N/A		
B	**Pre-Delegation Evaluation**	**Example: Score each delegate for each element below**	**1) ABC Medical Group, pg 3 2) ACME Physician Organization, pg 6. 3) Mercy Health Partners, pg. 2**	
1	For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.	N/A	.	If there are no pre-delegation arrangements, score NA

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date: _____**
Reviewed by: _____

C	Review of Credentialing Process for Delegate	Example: Score each delegate for each element below	1) ABC Medical Group, pg 3 2) ACME Physician Organization, pg 6. 3) Mercy Health Partners, pg. 2	
1	Annually audits credentialing policies and procedures	N/A	.	
2	Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.	N/A	.	
3	Annually evaluated delegate performance against NCQA standards for delegated activities	N/A	.	
4	Semi-annually evaluates regular reports, as specified in Element A. (N/A for NCQA CVO's)	N/A	.	
5	Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually.	N/A	.	
6	Annually acts on all findings from factor 5 for each delegate and implements quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	N/A	.	
		0.0		If there are no pre-delegation arrangements, score NA
D	**Opportunities for Improvement**	**Example:**	**1) ABC Medical Group, pg 3**	
1	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization has followed up on opportunities for improvement, if applicable	N/A	.	If there are no pre-delegation arrangements, score NA

2025
CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____
Reviewed by: _____

CA 9: Identification of HIV/AIDS Specialists

The organization documents and implements a method for identifying HIV/AIDS Specialists.

The organization is accountable for identifying practitioners who qualify as HIV/AIDS specialists to whom appropriate members may be given a standing or extended referral when the member's condition requires that specialist medical care over a prolonged period of time or its life-threatening, degenerative or disabling, to a specialist or specialty care center that has expertise in treating HIV/AIDS, in accordance with California Health and Safety Codes

Source: DMHC/DHCS

	Criteria	Compliance 1/0 1=Met 0=Not Met	Policy Reference *Name *Page *Section	Comments
A	**Written Policy**			
1	There is a written policy and procedure describing the process that the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist according to California State regulations, on an annual basis.	*	.	
B	**Evidence of Implementation**			
1	On an annual basis, the organization identifies or reconfirms the appropriately qualified physicians who meet the definitionof an HIV/AIDS specialist, according to California State regulations.	*	.	
C	**Distribution of Findings**			
1	The list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.	*	.	

CR 1 D. CREDENTIALING SYSTEM CONTROLS OVERSIGHT	
DELEGATE INFORMATION	
DELEGATE NAME:	
PERSON/TITLE WHO CONDUCTED OVERSIGHT:	
DATE OF OVERSIGHT:	
TIME PERIOD OF OVERSIGHT:	

INLAND EMPIRE HEALTH PLAN USE ONLY			
REVIEWER'S NAME	**REVIEW DATE**	**Are the Delegate's corrective action sufficient?**	**Quarterly Review Compliance**

PAPER FILES ☐ **ELECTRONIC SYSTEM** ☐ **BOTH** ☐

OVERSIGHT OF IDENTIFIED NON-COMPLIANT MODIFICATIONS

Date non-compliant modification was made	**Identifier** (delegate to provide something that can be used as an identifier of the record that was non-compliant for modifications, e.g. practitioner last name, initials, unique system #. etc.)	**Include description of the modification that did not meet the delegates policies, procedures and/or delegation agreement (each modification needs a line item)**	**Actions taken to correct the modifications that did not meet the delegates policies, procedures and/or delegation agreement**	**Qualitative Review** An examination of the underlying reason for (root cause analysis) the results, including identifying any deficiencies or processes that may create barriers to improvement or cause additional failures.	**Quantitative Review** (A comparison of numeric results against a standard or benchmark, (# of modifications vs # non-compliant modifications) trended over time. Must draw conclusions about what the results mean.	**Date of Quarterly monitoring on the findings**	**Results of Quarterly Monitoring**

Delegate: _____
Reviewed by: _____

2025 CR 3-4 FILE REVIEW TOOL

Review Date: _____

								3.A1	3.A1	3.A2	3.A3	3.A4	3.A5	3.A6	3.B1	3.B2	3.D1	3.D2	3.C1	3.C2	3.C3	3.C4	3.C5	3.C6	3.D3	3.D4	3.D6	4.A	
File No.	Name	Specialty	License Type	IEHP Decision Date	Decision Date	Previous Decision Date	180 calendar days Prior (Queries must be dated after this date)	License to Practice (Present)	License to Practice (Current)	DEA/CDS Certification	Education/Training	Board Certification	Work History	Malpractice History	State Sanctions, Restrictions on Licensure/Practice	Sanction Activity by Medicare and Medicaid	Sanction Activity by Medicare and Medicaid (CMS)	Medi-Cal Suspended & Ineligible List	Reasons for Inability to perform	Lack of present illegal drug use	History of Loss of License and felony convictions	History of loss or limitations of privileges	Current Malpractice Insurance Coverage	Current and signed Attestation	Hospital Admitting Privileges	Monitoring Physicians who have Opted Out	Review of Performance Information	Recredentialing Cycle	Comments
	POINTS RECEIVED							0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	POINTS POSSIBLE							0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	PERCENT COMPLIANT							#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
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Delegate: _____
Reviewed by: _____

2025 CR 3-4 FILE REVIEW TOOL

Review Date: _____

								3.A1	3.A1	3.A2	3.A3	3.A4	3.A5	3.A6	3.B1	3.B2	3.D1	3.D2	3.C1	3.C2	3.C3	3.C4	3.C5	3.C6	3.D3	3.D4	3.D6	4.A	
File No.	Name	Specialty	License Type	IEHP Decision Date	Decision Date	Previous Decision Date	180 calendar days Prior (Queries must be dated after this date)	License to Practice (Present)	License to Practice (Current)	DEA/CDS Certification	Education/Training	Board Certification	Work History	Malpractice History	State Sanctions, Restrictions on Licensure/Practice	Sanction Activity by Medicare and Medicaid	Sanction Activity by Medicare and Medicaid (CMS)	Medi-Cal Suspended & Ineligible List	Reasons for Inability to perform	Lack of present illegal drug use	History of Loss of License and felony convictions	History of loss or limitations of privileges	Current Malpractice Insurance Coverage	Current and signed Attestation	Hospital Admitting Privileges	Monitoring Physicians who have Opted Out	Review of Performance Information	Recredentialing Cycle	Comments
	POINTS RECEIVED							0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	POINTS POSSIBLE							0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	PERCENT COMPLIANT							#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
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2025 CR.7. OP TOOL

Delegate: _____

Reviewed by: _____

Review Date: _____

					7.A1	7.A1	7.A2-A3	CMS					
File #	Facility Name	Type of Organization	Cred "C"/Recred "R" [Recred files >36 months, all elements are non-compliant	Date of Completion or Cred Committee	License	OIG Query	Accreditation or Site Visit	CMS Certification # (Medicare only)	Actual File Score	Possible Score	% Compliant per File	File Pass 1 =>90% 0=<89%	Comments
1									0	0	N/A	N/A	
2									0	0	N/A	N/A	
3									0	0	N/A	N/A	
4									0	0	N/A	N/A	
5									0	0	N/A	N/A	
6									0	0	N/A	N/A	
7									0	0	N/A	N/A	
8									0	0	N/A	N/A	
9									0	0	N/A	N/A	
10									0	0	N/A	N/A	
11									0	0	N/A	N/A	
12									0	0	N/A	N/A	
13									0	0	N/A	N/A	
14									0	0	N/A	N/A	
15									0	0	N/A	N/A	
16									0	0	N/A	N/A	
17									0	0	N/A	N/A	
18									0	0	N/A	N/A	
19									0	0	N/A	N/A	
20									0	0	N/A	N/A	

CODING	
PRESENT	1
ABSENT	0
ELEMENT NOT APPLICABLE	N/A

ACTUAL SCORE	0	0	0	0
POSSIBLE SCORE	0	0	0	0
% COMPLIANT	N/A	N/A	N/A	N/A

Delegate: _____
Reviewed by: _____

Review Date: _____

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #1			Delegate #2			Delegate #3			Delegate #4		
Criteria															
A. Written delegation agreement: **• Delegation agreements implemented on or after January 1, 2022, must include a description of the delegate's system security controls.** **• Delegation Agreements in place prior to 1/1/2022, have until 7/1/2024 to update their agreements with the CR system control language. Prior to 7/1/2024, organizations may provide other documentation or the delegate's system controls policies.** **• All delegation agreements effective July 1, 2024, must include a description of CR system security controls.** ***(This is not applicable to entities that only store off-site files.)***				**Compliance** **1/0/N/A**	**Delegation Agreement (Page / Section)**	**Comments**	**Compliance** **1/0/N/A**	**Delegation Agreement (Page / Section)**	**Comments**	**Compliance** **1/0/N/A**	**Delegation Agreement (Page / Section)**	**Comments**	**Compliance** **1/0/N/A**	**Delegation Agreement (Page / Section)**	**Comments**
1. Is mutually agreed upon.	0	0	N/A												
2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. • Includes detailed language of specific credentialing activities	0	0	N/A												
3. Requires at least semiannual reporting of the delegated entity to the organization. • Information reported/activities delegated • How and to whom information is reported	0	0	N/A												
4. Describes the process by which the organization evaluates the delegated entity's performance; **AND** • The Agreement should, at a minimum, include the annual review of the delegate's policies and procedures and review of files, if applicable. • *The delegation agreement describes:* ○ *The delegate's CR system, controls in place to protect data from unauthorized modification as outlined in CR 1, Element C, Factor 4.* ○ *How the delegate monitors its credentialing system security controls at least annually, as required in CR 8, Element C, Factor 5.* ○ *How the PO monitors the delegate's credentialing system controls at least annually.* **If not included in the Delegation Agreement, then:** Policies and procedures describe the process for: • Limiting physical access to the credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources. • Preventing unauthorized access, changes to and release of credentialing information. • Password-protecting electronic systems, including user requirements to: ○ Use strong passwords. ○ Discourage staff from writing down passwords. ○ User IDs and passwords unique to each other. ○ Change passwords when requested by staff or if passwords are compromised. ○ Disable or remove passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.	0	0	N/A												

Delegate: _____
Reviewed by: _____

Review Date: _____

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #1			Delegate #2			Delegate #3			Delegate #4		
5. Specifies the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.	0	0	N/A												
6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligation, including revocation of the delegation agreement.	0	0	N/A												

CR 8. CMS Requirements/MediCal (DHCS)/CMC Delegation Agreement Requirements **Criteria**				**Compliance 1/0/N/A**	**Delegation Agreement (Page / Section)**	**Comments**	**Compliance 1/0/N/A**	**Delegation Agreement (Page / Section)**	**Comments**	**Compliance 1/0/N/A**	**Delegation Agreement (Page / Section)**	**Comments**	**Compliance 1/0/N/A**	**Delegation Agreement (Page / Section)**	**Comments**
1. Documentation in the agreement showing that sub-delegates must adhere to CMS regulations.	0	0	N/A												
2. The written delegation agreement must require at least quarterly reporting of the delegated entity to the organization. (DHCS)	0	0	N/A												
3. Review evidence of at least quarterly reporting of the delegated entity to the organization.	0	0	N/A												

CR 8.				**Compliance 1/0/N/A**	**Evidence of Oversight**	**Comments**	**Compliance 1/0/N/A**	**Evidence of Oversight**	**Comments**	**Compliance 1/0/N/A**	**Evidence of Oversight**	**Comments**	**Compliance 1/0/N/A**	**Evidence of Oversight**	**Comments**
B. Pre-Delegation Evaluation - For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began	0	0	N/A												
C. Review of Credentialing Process - for delegation arrangements in effect for 12 months or longer the organization:				**Compliance 1/0/N/A**	**Evidence of Oversight**	**Comments**	**Compliance 1/0/N/A**	**Evidence of Oversight**	**Comments**	**Compliance 1/0/N/A**	**Evidence of Oversight**	**Comments**	**Compliance 1/0/N/A**	**Evidence of Oversight**	**Comments**
1. Annually audits credentialing policies and procedures. (Auto-credit does not apply. There must be evidence of review.)	0	0	N/A												
2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A												
3. Annually evaluated delegate performance against NCQA standards for delegated activities. (Auto-credit for NCQA/Accredited/Certified)	0	0	N/A												
4. Semi-annually evaluates regular reports, as specified in Element A. (Mark compliant for NCQA CVO's)	0	0	N/A												
5. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually.	0	0	N/A												
6. Annually acts on all findings from factor 5 for each delegate and implements quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	0	0	N/A												

D. Opportunities for Improvement - For delegation arrangements that have been in effect for more that 12 months, at least once in each of the past 2 years, the organization and followed up on opportunities for improvement, if applicable.	0	0	N/A												