IPA Delegation Agreement – Medi-Cal

The purpose of the following grid is to specify the activities delegated by Inland Empire Health Plan (IEHP) under the Delegation Agreement with respect to: (i) Quality Management and Improvement, (ii) Continuity and Coordination of Care, (iii) Utilization Management, (iv) Care Management, (v) California Children's Services, (vi) Credentialing and Recredentialing, (vii) Encounter Data, and (viii) Claims Adjudication. All Delegated activities are to be performed in accordance with currently applicable NCQA accreditation standards, DHCS regulatory requirements, DMHC regulatory requirements, and IEHP standards, as modified from time to time. IPA agrees to be accountable for all responsibilities delegated by IEHP and oversight of any sub-delegated activities, except as outlined in the Delegation Agreement. IPA will submit the reports to IEHP as described in the Required Reporting Elements of the Delegation Agreement to the Delegation Oversight Department through IEHP Secure File Transfer Protocol (SFTP) no later than the due date specified. The IPA will provide notice of report submission via email to Provider Services designated contacts. IEHP will oversee the IPA by performing annual audits. In the event deficiencies are identified through this oversight, IPA will provide a specific corrective action plan acceptable to IEHP. If IPA does not comply with the corrective action plan within the specified time frame, IEHP will take necessary steps up to and including revocation of delegation in whole or in part. The IPA is free to collect data as needed to perform delegated activities. IEHP will provide member experience and clinical performance data, upon request.

Inland Empire Health Plan

REQUIRED REPORTING ELEMENTS

Department	Required Documentation/Materials	Frequency	Submission Deadline	Point of Submission
Quality Management and Improvement	QM Program Description	Annually	Feb 15	SFTP Server
	QM Program Evaluation	Annually	Feb 28	
	GQ P4P Quality Workplan	Annually	As designated by P4P Program	
Utilization Management	Monthly Referral Tracking Log Monthly Denial Files Monthly Second Opinion Log Monthly Approval File Review Monthly Cancellation File Review*	Monthly	15th of each month *Cancellations on the 25th of each month	SFTP Server
	Quarterly UM Program Evaluation / HICE Report Quarterly UM Work Plan Update	Quarterly	May 15 August 15 November 15 February 15	
	Annual UM Program Description Annual UM Program Evaluation Annual UM Workplan / Initial / ICE Report IPA Oversight – Information Integrity Universe Report (NCQA UM11)	Annually	Feb 28	
	Discovery of Other Healthcare Coverage	As needed	Within (2) days of discovery	SFTP Server
Care Management	Monthly CM Log	Monthly	15th of each month	SFTP Server

* MUST PASS Element

	Monthly California Children's Services (CCS) Log Monthly CM Files for Review (Care Coordination, CCS and SPD)			
Encounter Data	5010 / Encounters	Monthly	Varies within the first days of the month. Refer to https://www.providerservices.iehp.org/en/resources/provider-resources/forms for details.	SFTP Server

Inland Empire Health Plan

REQUIRED REPORTING ELEMENTS

Department	Required Documentation/Materials	Frequency	Submission Deadline	Point of Submission
Credentialing and Recredentialing	Written and approved Credentialing, Recredentialing, Peer Review policies and Procedures	As Required	Within 30 days of the Credentialing Committee approval or prior to onsite and/or desktop DOA audit	SFTP server followed by an Email to CredentialingProfileSubmission@iehp.org
	Approved Delegated practitioners requesting to participate in the IEHP network must be submitted to IEHP by submitting a current profile, contract (1st and signature pages and any applicable addendums) and W-9		After Credentialing approval	
Credentialing and Recredentialing	Credentialing and Recredentialing activities for approved and terminated practitioners must be submitted to IEHP via IEHP Excel Recred Template identified in the IEHP Provider Manual, 05B – Practitioner Credentialing Requirements	Quarterly	May 15th August 15th November 15th February 15th By the 15th Quarterly with Committee approval	SFTP server followed by an Email to CredentialingProfileSubmission@iehp.org
Claims	Monthly Claims Timeliness Report	Monthly	15th of each month	SFTP Server
	Monthly Claims & PDR Detail Reports	Monthly	15th of each month	
	Quarterly Claims and Provider Payment Dispute Resolution Quarterly Statement of Deficiencies Report	Quarterly	April 30 July 31 October 31 January 31	
Claims	Annual Claims Payment and Provider Dispute Report	Annually	November 30	SFTP Server

* MUST PASS Element

Financial Compliance	IEHP Financial Template	Monthly	15th of every month for the preceding month's activity	SFTP Server
	Balance Sheet, Income Statement, Cash Flow Statement, Supporting Worksheets for IBNR Financial and Organizational Information Disclosures	Quarterly	May 15 Aug 15 Nov 15 Feb 15	
	Annual Audited Financial Statements, Including IBNR Certification	Annually	5 months after the end of IPA's Fiscal year	
Compliance	Compliance Program Description and copies of Compliance Training	Annually	As required for DOA	SFTP Server
	Fraud Waste and Abuse (FWA) Program Description and copies of FWA Training	Annually	As required for DOA	
	Sanction/Exclusion Screening Process policies and procedures	Annually	As required for DOA	
	Standards/Code of Conduct	Annually	As required for DOA	
	Compliance Committee Meeting minutes from the last 12 months, to include agenda and sign in sheet (attendance)	Annually	As required for DOA	
	Compliance Organizational Chart	Annually	As required for DOA	
	Annual Compliance Work Plan	Annually	As required for DOA	

	Audit and Monitoring Universe Report	Annually	As required for DOA	
	Annual Audit and Monitoring Plan	Annually	As required for DOA	
	Annual Risk Assessment Report	Annually	As required for DOA	
	Employee Universe Report	Annually	As required for DOA	
	Downstream Entity/Subcontractors Universe Report	Annually	As required for DOA	
	HIPAA Privacy Program Description and copies of HIPAA Trainings	Annually	As required for DOA	
	Confidentiality Statement	Annually	As required for DOA	
	Privacy Incident Universe Report	Annually	As required for DOA	

Inland Empire Health Plan

ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Quality Improvement Program Structure (NCQA QI 1, Elements A, B, C, D and E)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members and to oversee the QI program. A. The QI program description specifies: 1. The QI program structure a. The QI program's functional areas and their responsibilities. b. Reporting relationships of QI Department staff, QI Committee and any subcommittee. c. Resources and analytical support. d. QI activities. e. Collaborative QI activities, if any. f. How the QI and population health management (PHM) programs are related in terms of operations and oversight. 2. Involvement of a designated physician in the QI program. 3. Oversight of QI functions of the organization by the QI Committee.	Semi-Annual and Annual	IPA is not delegated for this function, however IEHP will review the IPA's Policies and Procedures. Semi-Annually and Annually as part of the DOA	See Corrective Action Plan (CAP) Requirements in MC_25A4.

Quality Improvement Program Structure (NCQA QI 1, Elements A, B, C, D and E continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	a. The program description defines the role, function and reporting relationships of the QI Committee and subcommittees, including committees associated with oversight of delegated activities. B. The IPA documents and executes a QI program annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives that address: a. Quality of clinical care. b. Safety of clinical care. c. Quality of service. d. Members' experience. 2. Time frame for each activity's completion. 3. Staff responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program.	Semi-Annual and Annual	IPA is not delegated for this function, however IEHP will review the IPA's Policies and Procedures. Semi-Annually and Annually as part of the DOA	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Quality Improvement Program Structure (NCQA QI 1, Elements A, B, C, D, and E continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual	C. The IPA conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. 2. Trending of measures of performance in the quality and safety of clinical care and quality of service. 3. Evaluation of the overall effectiveness of the QI program and its progress toward influencing networkwide safe	Semi-Annual and Annual	IPA is not delegated for this function, however IEHP will review the IPA's program description, Global Quality P4P work plan and policies and procedures Annually. Additional review of committee meetings as part of the DOA.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

Quality Improvement Program Structure (NCQA QI 1, Elements A, B, C, D and E continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual	clinical practices with a summary addressing: a. Adequacy of QI program resources. b. QI Committee and subcommittee structure. c. Practitioner participation and leadership involvement in the QI program. d. Need to restructure or change the QI program for the subsequent year. D. QI Committee Responsibilities: 1. Recommends policy decisions 2. Analyzes and evaluates the results of QI activities 3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow up, as appropriate. E. The IPA promotes Organizational Diversity, Equity and Inclusion.: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural competency, bias or inclusion.	Semi-Annual and Annual	IPA is not delegated for this function, however IEHP will review the IPA's program description, Global Quality P4P work plan and policies and procedures Semi-Annually and Annually. Additional review of committee meetings as part of the DOA.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT II: DELINEATION OF CONTINUITY AND COORDINATION OF CARE

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Continuity and Coordination of Medical Care and Continued Access to Care (NCQA QI 3 Element E and NET 4 Elements A and B)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	A. The IPA helps with members' transition to other care when their benefit ends, if necessary. B. The IPA uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system. 1. The IPA notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner. C. If a practitioner's contract is discontinued, the IPA allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.	Monthly through UM Logs	Annual audit of IPA policies and procedures and sample cases	See Corrective Action Plan (CAP) Requirements in MC_25A4.

ATTACHMENT II: DELINEATION OF CONTINUITY AND COORDINATION OF CARE

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Continuity and Coordination of Medical Care and Continued Access to Care (NCQA QI 3 Element E and NET 4 Elements A and B continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.	Monthly through UM Logs	Annual audit of IPA policies and procedures and sample cases	See Corrective Action Plan (CAP) Requirements in MC_25A4.

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Utilization Management Structure (NCQA UM 1 Elements A and B and another requirement reference)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial, and consistent manner. A. The IPA's UM program description includes the following: 1. A written description of the program structure: a. UM staff's assigned activities. b. UM staff who have the authority to deny coverage. c. Involvement of a designated physician d. The process for evaluating, approving and revising the UM program, and the staff responsible for each step. e. The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities. f. The IPA's process for handling appeals and making appeal determinations. 2. Involvement of a designated senior-level physician in UM program implementation, supervision, oversight and evaluation of the UM program. 3. The process of the oversight of the UM program by a UM Committee. The committee oversees the UM functions, and annually;	Semi Annual and Annually.	Annual audit of IPA policies and procedures, workplan, program, and committee meetings	See Corrective Action Plan (CAP) Requirements in MC_25A4.

Inland Empire Health Plan

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Utilization Management Structure (NCQA UM 1 Elements A)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	a. Evaluates the UM program structure, scope, processes and information sources used to determine benefit coverage and medical necessity. b. Reviews UM rates identified in UM 1B-E c. Identified needed actions based on the evaluation. 4. The program scope and process used to determine benefit coverage and medical necessity including: a. How the IPA develops and selects criteria b. How the IPA reviews, updates, and modifies criteria 5. The process for determining which items and services require prior authorization. 6. Information sources used to determine benefit coverage and medical necessity.	Semi Annual and Annually.	Annual audit of IPA policies and procedures, workplan, program, and committee meetings	See Corrective Action Plan (CAP) Requirements in MC_25A4.

Utilization Management Structure: Non-Behavioral Healthcare UM Rates (NCQA UM 1 Elements B)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	For requests requiring authorization, the IPA annually reports: 1. Overall approval rate.* a. The overall approval rate is the percentage of UM decisions that resulted in an approval. b. The organization uses the following formula: Overall approval rate = (Total number of authorization requests approved/Total number of authorization request decisions)*100. 2. Overall denial rate.* a. The **overall denial rate** is the percentage of UM decisions that resulted in a denial. b. The organization uses the following formula: Overall denial rate = (Total number of authorization requests denied / Total number of authorization request decisions) *100. c. *For factors 3–7,* timeliness of notification includes decision notification time frames and allowable extensions in *UM 5: Timeliness of UM Decisions.* 3. Overall timeliness of notification rate for denials. a. The IPA reports the rates of adherence to the time frames for all four request categories: - Urgent concurrent. - Urgent preservice. - Nonurgent preservice. - Post-service.	Annually.	Annual Review of UM Rates	See Corrective Action Plan (CAP) Requirements in MC_25A4.

		b. The IPA uses the following formula: (Total number of denied requests that met the notification time frame / Total number of UM denial decisions) *100. 4. Timeliness of notification rate for urgent concurrent denials. a. The IPA uses the following formula: (Total number of denied urgent concurrent requests that met the notification time frame / Total number of urgent concurrent denied requests) *100. 5. Timeliness of notification rate for urgent preservice denials. a. The IPA uses the following formula: (Total number of denied urgent preservice requests that met the notification time frame / Total number of urgent preservice denied requests) *100. 6. Timeliness of notification rate for non-urgent preservice denials. a. The organization uses the following formula: (Total number of denied nonurgent preservice requests that met the notification time frame / Total number of nonurgent preservice denied requests) *100. 7. Timeliness of notification rate for post-service denials. a. The IPA uses the following formula:			

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		(Total number of denied post-service requests that met the notification time frame / Total number of post-service requests denied) *100. *For factors 3–7,* NCQA measures timeliness of notification from the date when the IPA receives the request from the member or the member's authorized representative, even if the IPA does not have all the information necessary to make a decision, to the date when the notice was provided to the member and practitioner, as applicable.			
Utilization Management Structure: Evaluation of UM rates (NCQA UM 1 Element F)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA annually evaluates the following UM rates, and reports its findings: 1. Non-behavioral healthcare UM rates (Element B).	Annually.	Annual Review of UM Rates	See Corrective Action Plan (CAP) Requirements in MC_25A4.

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Clinical Criteria for UM Decisions (NCQA UM 2 Elements A, B and C)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. A. The IPA: 1. Has written UM decision-making criteria that are objective and based on medical evidence. 2. Has written policies for applying the criteria based on individual needs; considers at least the following individual characteristics when applying criteria: a. Age. b. Comorbidities. c. Complications. d. Progress of treatment. e. Psychosocial situation. f. Home environment, when applicable.	Monthly UM Logs	Annual audit of IPA policies and procedures, workplan, program, and committee meetings. Monthly log and focused denial file selection review.	See Corrective Action Plan (CAP) Requirements in MC_25A4.

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Clinical Criteria for UM Decisions (NCQA UM 2 Elements A, B, and C continued) California Health & Safety Code §1363.5	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	3. Has written policies for applying the criteria based on an assessment of the local delivery system. 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews the UM criteria and the procedures for applying them and updates the criteria when appropriate. B. The IPA: 1. Makes the UM criteria electronically available to its practitioners, and members upon request so they are available at the point of care . C. At least annually, the IPA: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. 2. Acts on opportunities to improve consistency, if applicable.	Monthly UM Logs	Annual audit of IPA policies and procedures, workplan, program, and committee meetings. Monthly log and focused denial file selection review.	See Corrective Action Plan (CAP) Requirements in MC_25A4.

Inland Empire Health Plan

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Communication Services (NCQA UM 3 Element A)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	Members and practitioners can access staff to discuss UM issues. A. The IPA provides the following communication services for members and practitioners: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. 2. Staff can receive inbound communication regarding UM issues after normal business hours. a. Telephone b. Email c. Fax d. Member web portal 3. Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. 4. TDD/TTY services for Members who need them. 5. The IPA refers Members to IEHP who need language assistance for Members to discuss UM issues.	N/A	Annual audit of IPA policies and procedures and Annual Appointment Availability and Access Study Survey	See Corrective Action Plan (CAP) Requirements in MC_25A4.

Appropriate Professionals (NCQA UM 4 Elements A, B, C* and F, MED 9 Element E)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	UM decisions are made by qualified health professionals. A. The IPA has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions. 2. Specifying the type of personnel responsible for each level of UM decision-making. B. The IPA has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training, or professional experience in medical or clinical practice. 2. A current California clinical license to practice or an administrative license to review UM cases. C. The IPA uses a physician or other health care professional, as appropriate, to review any nonbehavioral health denial based on medical necessity*. D. Use of Board-Certified Consultants 1. The IPA has written procedures for using board-certified consultants to assist in making medical necessity determinations. 2. The IPA provides evidence that it uses board-certified consultants for medical necessity determinations. CRITICAL FACTOR.	Monthly UM Logs	Annual audit of IPA policies and procedures, workplan, program, committee meetings and Ownership and Control documentation. Monthly log and focused denial and approval file selection review.	See Corrective Action Plan (CAP) Requirements in MC_25A4.

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Appropriate Professionals (NCQA UM 4 Elements A, B, C* and F, MED 9 Element E continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	E. The IPA distributes a statement to all Members and to all practitioners, providers and employees who make UM decisions, affirming the following: 1. UM decision making is based only on appropriateness of care and service and existence of coverage. 2. The IPA does not specifically reward practitioners or other individuals for issuing denials of coverage or care. 3. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.	Monthly UM Logs	Annual audit of IPA policies and procedures, workplan, program, committee meetings and Ownership and Control documentation. Monthly log and focused denial and approval file selection review.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

Timeliness of UM Decisions (NCQA UM 5 Element A*)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA makes utilization decisions in a timely manner to minimize any disruption in the provision of health care. A. The IPA adheres to the following time frames for notification of non-behavioral healthcare UM decisions*: a) Urgent Concurrent Decisions: The IPA gives electronic or written notification of the decision to Practitioners and Members within seventy two (72) hours of the request. b) Urgent Pre-Service Decisions: The IPA gives electronic or written notification of the decision to Practitioners and Members within seventy-two (72) hours of the request. c) Non-Urgent Pre-Service: The IPA to decision and written notification to be provided to both the member and provider within seven (7) calendar days following the receipt of the service request. d) Non – Urgent Concurrent: The IPA to decision and written notification to be provided to both the member and provider within seven (7) calendar days following the receipt of the service request. e) Post-Service Decisions: The IPA gives electronic or written notification of the decision to Practitioners and members and written notification to the Member within thirty (30) calendar days of the request.	Monthly	Annual audit of IPA policies and procedures, workplan, program, and committee meetings. Monthly log and focused denial and approval file selection review.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Clinical Information (NCQA UM 6 Element A)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA uses all information relevant to a member's care when it makes coverage decisions. A. There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.	Monthly	Annual audit of IPA policies and procedures, workplan, program, and committee meetings. Monthly log and focused denial and approval file selection review.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.
Denial Notices (NCQA UM 7 Elements A, B* and C*)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	Members and practitioners receive enough information to help them understand a decision to deny care or coverage and to decide whether to appeal the decision. A. The IPA gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. B. The IPA's written notification of nonbehavioral healthcare denials, provided to Members and their treating Practitioners, contains the following information*: 1. The specific reasons for the denial, in easily understandable language.	Monthly	Annual audit of IPA policies and procedures, workplan, program, and committee meetings. Monthly log and focused denial file review.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

* MUST PASS Element

Denial Notices (NCQA UM 7 Elements A, B* and C*continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	2. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based. 3. A statement that Members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request. C. The IPA's written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information*: 1. A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal. 2. An explanation of the appeal process, including Members' rights to representation and appeal time frames. a. Includes a statement that members may be represented by anyone they choose, including an attorney. b. Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsperson, if applicable. c. States the time frame for filing an appeal. d. States the organization's time frame for deciding the appeal. e. States the procedure for filing an appeal, including where to direct the appeal and information to include in the appeal. 3. A description of the expedited appeal process for urgent preservice or urgent	Monthly	Annual audit of IPA policies and procedures, workplan, program, and committee meetings. Monthly log and focused denial file review.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Denial Notices (NCQA UM 7 Elements A, B* and C* continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	concurrent denials. The denial notification states: a. The time frame for filing an expedited appeal. b. The IPA's time frame for deciding the expedited appeal. c. The procedure for filing an expedited appeal, including where to direct the appeal and information to include in the appeal. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.	Monthly	Annual audit of IPA policies and procedures, workplan, program, and committee meetings. Monthly log and focused denial file review.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

Protecting the Integrity of UM Denial Information (NCQA UM 11 Element A*)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	UM denial information integrity refers to maintaining and safeguarding information used in UM denial decision process (UM 4–UM 7) against inappropriate documentation and updates. The IPA has UM denial information integrity policies and procedures that specify*: 1. The scope of UM information. a) UM requests from members or their authorized representatives. b) UM request receipt date. c) Appropriate practitioner review. d) Use of board-certified consultants. e) Clinical information collected and reviewed. f) UM decision. g) UM decision notification date. h) UM denial notice. The IPA defines the dates of receipt and written notification for UM denial determinations resulting from medical necessity review, consistent with requirements in UM 5. 2. The staff responsible for performing UM activities. The IPA's policies and procedures specify the titles of staff who are: a) Responsible for documenting completion of UM activities. b) Authorized to modify (edit, update, delete) UM information. c) Responsible for oversight of UM information integrity functions, including auditing.	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

Protecting the Integrity of UM Denial Information (NCQA UM 12 Element A* continued)		3. The process for documenting updates to UM information. The IPA's policies and procedure: a. Specify when updates to existing UM information is appropriate (e.g., the member sends an updated request or correcting a typographical error). b. Describe the IPA's process for documenting the following when updates are made to UM information: - When (e.g., date and time) the information was updated. - What information was updated. - Why the information was updated. - Staff who updated the information. 4. Inappropriate documentation and updates. The IPA's policies and procedures specify that the following documentation and updates to UM information are inappropriate: a) Falsifying UM dates (e.g., receipt date, UM decision date, notification date). b) Creating documents without performing the required activities. c) Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices).			

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Protecting the Integrity of UM Denial Information (NCQA UM 11 Element A* continued)		d) Attributing review to someone who did not perform the activity (e.g., appropriate practitioner review). e) Updates to information by unauthorized individuals. 5. The IPA audits UM staff and the process for documenting and reporting identified information integrity issues. a) Specify that the IPA audits UM staff documentation and updates. - The IPA does not have to include the audit methodology, but must indicate that an annual or more frequent audit is performed. b) Describe the process for documenting and reporting inappropriate documentation and updates to: - The IPA's designated individual(s) when identified, and - The organization, when the IPA identifies fraud and misconduct. Specify consequences for inappropriate documentation and updates.			

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Protecting the Integrity of UM Appeal Information (NCQA UM 11 Element B*)	Not Applicable	Appeals is not delegated	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

* MUST PASS Element

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Information Integrity Training (NCQA UM 11 Element C)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA annually trains staff on: 1. Inappropriate documentation and updates. a) The IPA trains UM staff on inappropriate documentation and updates to UM information, as defined in Elements UM 11A and UM 11B, factor 4. 2. IPA audits of staff, documenting and reporting information integrity issues. The organization's training informs UM staff of: a) IPA audits of staff documentation and updates in UM files. b) The process for documenting and reporting inappropriate documentation and updates to: - The IPA's designated individual(s) when identified. - The organization, when the IPA identifies fraud and misconduct. - The consequences for inappropriate documentation and updates.	Annually, at minimum during DOA.	Focused denial file review and Annual DOA.	See Corrective Action Plan (CAP) Requirements in MA_25A3.

Audit and Analysis – Denial Information (NCQA UM 11 Element D)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA annually: 1. Audits for inappropriate documentation and updates to UM denial receipt and notification dates. a) The IPA annually audits for inappropriate documentation and updates (defined in Element A, factor 4) to: - UM request receipt dates (UM 5). - UM denial decision notification dates (UM 5, UM 7). The IPA defines the dates of receipt and notification for UM denial determinations resulting from medical necessity review, consistent with the requirements in UM 5. The audit universe includes files for UM denial decisions (based on the denial decision notification date) made during the look-back period, whether or not the files were updated. The organization randomly samples and audits 5% or 50 files, whichever is less, from the file universe. The IPA may choose to audit more UM denial files than NCQA requires. The organization provides an auditing and analysis report that includes: a) The report date. b. The title of individuals who conducted the audit.	Annually, at minimum during DOA.	Focused denial file review and Annual DOA.	See Corrective Action Plan (CAP) Requirements in MA_25A3.

		c. The 5% or 50 files auditing methodology. - Auditing period. - File audit universe size (described in the paragraph above). - Audit sample size. d. The audit log (as a referenced attachment). - The file identifier (case number). - The type of dates audited (i.e., receipt date, notification date). - Findings for each file. A rationale for inappropriate documentation or inappropriate updates. e. The number or percentage and total number or percentage of inappropriate findings by date type. The IPA must provide a completed audit report even if no inappropriate documentation and updates were found. 2. Conducts qualitative analysis of inappropriate documentation and updates to UM denial receipt and notification dates. The IPA annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause.			

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		a) The IPA's auditing and analysis report also includes: - Titles of UM staff involved in the qualitative analysis. - The cause of each finding.			

Improvement Actions – Denial Information (NCQA UM 11 Element E)		The IPA: 1. Implements corrective actions to address all inappropriate documentation and updates found in Element D. a) The IPA documents all actions taken or planned, including the time frame for actions, to address all inappropriate documentation and updates (findings) identified in Element D. One action may address more than one finding, if appropriate. Annual trainings (Element C) may not be the only corrective action. b) The IPA identifies the staff (by title) who are responsible for implementing corrective actions. 2. Conducts an audit of the effectiveness of corrective actions (factor 1) on the findings 3–6 months after completion of the annual audit in Element D. a) The IPA audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element D. The audit universe includes 3–6 months of UM denial files processed by the IPA since the annual audit completed for Element D. b) The IPA conducts a qualitative analysis if it identifies noncompliance with integrity during the follow-up audit. The IPA draws conclusions about the actions' overall effectiveness.	Annually, at minimum during DOA.	Focused denial file review and Annual DOA.	See Corrective Action Plan (CAP) Requirements in MA_25A3.

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ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Audit and Analysis – Appeal Information (NCQA UM 12 Element F)	Not Applicable	Appeals are not delegated.			
Improvement Actions – Appeal Information (NCQA UM 12 Element G)	Not Applicable	Appeals are not delegated.			
Second Opinions AB 12	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	Assembly Bill 12 (AB 12) states that there must be a written process to obtain Second Opinion from PCP and Specialist. 1. The IPA allows for a second opinion consultation, when a Member has questions/concerns regarding a diagnosis or plan of treatment, with an appropriately qualified health care provider if requested by the Member, or a health care provider who is treating the Member. The second opinion shall be with one of the IPA's contracted Providers unless the IPA does not have the appropriately qualified heath care provider in-network. In the event that the services cannot be provided in-network, the IPA must arrange for second opinion out-of-network with the same or equivalent Provider seen in-network.	Monthly	Monthly review of second opinion logs and annual audit of IPA policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT IV: DELINEATION OF CARE MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities

CM 1:
Care Management
	IEHP will provide IPAs with guidelines for Policies and Procedures, and guidelines for Care Management Training via IEHP Provider Manual.	▪ IPAs are not delegated to perform Complex Case Management (CCM).
		
		▪ IPAs must refer all CCM-eligible members to the IEHP for enrollment and management.
		
		Updated CCM eligibility criteria:
		▪ CCM criteria apply to members with two or more of the following conditions:
		  ▪ Diabetes
		  ▪ Hypertension
		  ▪ Depression
		▪ Members must also be stratified as high risk based on available data.
		
		▪ Member Identification: Use IPA data (e.g., diagnosis, utilization, SDOH indicators) to identify potential CCM members.
		
		Referral to IEHP:
		▪ Please send completed form to IEHP Care Management team at cmreferralteam@iehp.org.
		
		IPA Responsibilities for Non-CCM/ECM Members:
		
		In alignment with the DHCS Population Health Management (PHM) Policy Guide, IPAs are responsible for implementing Basic Population
			Monthly	Annual audit of IPA policies and procedures.
				
				Monthly CM log and targeted case file review.
					See Corrective Action Plan (CAP) Requirements in MC_25 A4.

		Health Management activities. These responsibilities include providing preventive and wellness care, sharing timely member data for risk stratification, coordinating care across settings, closing gaps in preventive and chronic care, connecting members to community resources, and ensuring culturally and linguistically appropriate services. Additionally, the IPA will engage members in care plans and education to support self-management and improved health outcomes, while adhering to all DHCS PHM standards, MCP policies, and reporting requirements to maintain compliance. IPAs must develop and implement guidelines for Care Management that provide the structure for care management processes and systems that will enable them to provide coordinated care for non-CCM/ECM members. IPAs must provide basic care management and care coordination for members, ensuring support without duplicating CCM/ECM functions. The Guidelines for Care Management must include the following elements: ▪ Description of Target Population: Clear definition of non-CCM/ECM members to be managed. This population must be distinct from CCM/ECM eligibility criteria. ▪ Staffing Structure: Roles and qualifications for IPA care management staff (e.g., coordinators, LVNs, non-licensed staff). ▪ Assessment Tool: Questionnaire or			

		screening process to identify needs. ▪ Care Planning: Structure for creating non-complex care plans, including essential components and progress tracking. ▪ Interdisciplinary Care Team (ICT): Engagement of PCPs, specialists, behavioral health, and community partners where appropriate. ▪ Participating in case conferences upon request. ▪ Care Transition Protocols ▪ Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols ▪ Guidelines for Care Management **Training for Personnel and Provider Network** ▪ Guidelines for Care Management Quality Performance Improvement Plan ▪ Measurable Goals and Health Outcomes ▪ Measuring Patient Experience of Care (Member Satisfaction) ▪ Ongoing Performance Improvement Evaluation; and ▪ Dissemination of Quality Improvement Performance			

		▪ IPA's must submit a monthly care management log that includes the following: 1. Member name (First, Last) 2. Member ID number 3. Date of Birth 4. Referral Source 5. Referral Reason 6. Case Status 7. Case Open Date 8. Referral Outcome 9. Referred to IEHP Programs.			
CM 2: "High Risk" SPD HRA Review		Health Risk Assessments (HRAs) The Health Plan is responsible for conducting the initial HRA for all newly enrolled members, using a Risk Stratification System to pre-stratify members. Members stratified as high risk will receive outreach from the Health Plan within 30 days of enrollment to complete the HRA. IPAs are responsible for reviewing completed HRAs for its attributed members and conducting appropriate follow-up to: • Identify unmet needs across the following domains: developmental, physical, behavioral health, mental health, substance use disorder, dementia, long-term services and supports, palliative care, oral health, vision, pharmacy, and social determinants of health. • Provide or coordinate access to needed services as appropriate.			

		• Ensure member needs identified in the HRA are addressed through basic care coordination or other IPA-level programs. • IPAs must document a minimum of three contact attempts within 30 days of HRA completion before determining whether the member is unable to be reached. • IPAs is responsible for identifying and referring members who may meet criteria for: Enhanced Care Management and/or Complex Case Management program enrollment. • For members who do not meet CCM or ECM criteria, the IPA must provide basic care coordination or non-complex care management to ensure needs are addressed and prevent escalation. • For members who meet palliative or hospice care service, IPAs must refer members to IEHP for review.			

ATTACHMENT V: DELINEATION OF CALIFORNIA CHILDREN'S SERVICES (CCS)

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
CCS 1: California Children's Services (CCS)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. IEHP will also provide a monthly CCS aging report	IPA's must maintain a log for new CCS referrals made by the IPA for Medi-Cal Members that includes the following: 1. Member Name (First, Last) & ID# 2. DOB 3. County 4. Date Identified 5. Date of CCS referral 6. CCS eligible diagnosis	Monthly	Annual audit of IPA policies and procedures. Monthly CCS log review.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Credentialing Policies (NCQA CR 1 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate has policies and procedures that specify: 1. The types of practitioners it credentials and recredentials. 2. The verification sources it uses. 3. The criteria for credentialing and recredentialing. 4. The process for making credentialing and recredentialing decisions. 5. The process for managing credentialing files that meet the organization's established criteria. 6. The criteria for practitioner sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed by the Credentialing Committee or other designated peer-review body. 7. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. 8. The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Credentialing Policies (NCQA CR 1 Element A continued)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	9. The process for notifying practitioners of the credentialing and recredentialing decision within 30 calendar days of the credentialing committee's decision. 10. The Medical Director or other designated physician's direct responsibility and participation in the credentialing program. 11. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. 12. The process for confirming listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty. 13. The process for documenting information and activities in credentialing files.	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Provider Credentialing/Recredentialing and Screening/Enrollment (DHCS All Plan Letter (APL) 19-004 supersedes APL 17-019, "Provider Credentialing/Recredentialing and Screening/Enrollment".)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The process for ensuring all practitioners participating in Medi-Cal lines of business, are enrolled with Medi-Cal directly, prior to submitting to IEHP for addition to the IEHP Medi-Cal network.	Ongoing	Upon review of the Provider submission package by the Delegate, IEHP will screen the provider to ensure the provider is currently enrolled with Medi-Cal directly.	
Practitioner Rights (NCQA CR 1 Element B)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate notifies practitioners about their right to: 1. Review information submitted to support their credentialing application. 2. Correct erroneous information. 3. Receive the status of their credentialing or recredentialing application, upon request.	Annually, at minimum	Audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
CMS/DHCS Performance Monitoring for Recredentialing (Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004 and Exhibit A, Attachment 4 of Plan Contract)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate's recredentialing policies and procedures require information from quality improvement activities and member complaints in the recredentialing decision making process. (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD 02-03 and Exhibit A, Attachment 4 of Plan Contract)	Annually, at minimum	Audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.
CMS/DHCS Medicare – Exclusions/Sanctions (Medicare Managed Care Manual, Chapter 6 § 60.2; DHCS All Plan Letter (APL) 19-004)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual	Delegate must have policies and procedures that prohibit employment or contracting with practitioners (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (practitioners or entities found on OIG Report).	Annually, at minimum	Audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Credentialing Committee (NCQA CR 2 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate'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 files that meet established criteria are reviewed and approved by a medical director, designated physician or Credentialing Committee.	Annually, at minimum	Audit of Delegate's policies and procedures and Credentialing Committee meeting minutes	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Verification of Credentials (NCQA CR 3 Element A*)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	A. Delegate verifies that the following are within the prescribed time limits*: 1. A current and valid license to practice. 2. A valid DEA or CDS certificate, if applicable. 3. Education and training as specified in the explanation. 4. Board Certification status, if applicable. 5. Work history. 6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner.	Annually, at minimum	IEHP reviews verification of credentials within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

* MUST PASS Element

Sanction and Exclusion Information (NCQA CR 3 Element B*, DHCS, CMS)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	B. Delegate verifies the following sanction information for credentialing*: 1. State sanctions, restrictions on licensure or limitations on scope of practice. 2. Medicare and Medicaid sanctions. a. Medicare and Medicaid Sanctions, OIG must be the verification source. b. Medicaid Sanctions, the Medi-Cal Suspended and Ineligible List must be the verification source. 3. Medicare and Medicaid Exclusions. a. The IPA obtains Medicaid exclusion information from the State Medicaid agency and from one of the following additional sources: - List of Excluded Individuals and Entities, maintained by OIG and available over the internet, ***or*** - NPDB. b. The organization obtains Medicare exclusion	Annually, at minimum	IEHP reviews verification of credentials within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		information from any of the following sources: - Medicare Exclusion Database. - List of Excluded Individuals and Entities, maintained by OIG and available over the internet. - NPDB.			

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ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Credentialing Application (NCQA CR 3 Element C*)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	A. Delegate verifies that applications for credentialing include the following*: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary actions. 5. Current malpractice insurance coverage. 6. Practitioner race, ethnicity and language. 7. Current and signed attestation confirming the correctness and completeness of the application.	Annually, at minimum	IEHP reviews application and attestation within a random sample of up to 40 initial credentialing files and 40 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Practitioner must have clinical privileges in good standing. CMS (Medicare Managed Care Manual, Chapter 6 § 60.3), DMHC (DMHC TAG 6/09/14), DHCS (All Plan Letter (APL) 17-019)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate verifies the practitioner has privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital. (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD Policy Letter 02-03 and DMHC TAG 10/11)	Annually, at minimum	IEHP reviews verification of credentials within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
CMS/DHCS Review of Performance Information (Medicare Managed Care Manual, Chapter 6 § 60.3; DHCS All Plan Letter (APL) 19-004)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate includes information from quality improvement activities and member complaints in the recredentialing decision-making process. (Source: Medicare Managed Care Manual, Chapter 6 § 60.3; MMCD 02-03 and Exhibit A: Attachment 4 of Plan Contract)	Annually, at minimum	IEHP reviews verification of credentials within a random sample of up to 30 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Recredentialing Cycle Length (NCQA CR 4 Element A*)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	A. Delegate conducts timely recredentialing. The length of the recredentialing cycle is within the required 36-month time frame*.	Annually, at minimum	IEHP reviews verification of credentials within a random sample of up to 40 initial credentialing files and 40 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

* MUST PASS Element

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Performance Standards and Thresholds (NCQA MED 3 Element A)	IEHP sets site performance standards and thresholds for: 1. Accessibility equipment. 2. Physical accessibility. 3. Physical appearance. 4. Adequacy of waiting and examining room space. 5. Adequacy of medical/treatment medical record keeping.	Delegate is responsible for ensuring the providers are compliant with IEHP Facility Site Review and Medical Record Audits.	Not Applicable	Not Applicable	Not Applicable

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Site Visits and Ongoing Monitoring (NCQA MED 3 Element B)	IEHP implements appropriate interventions by: 1. Continually monitoring member complaints for all practitioner sites. 2. Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met. 3. Instituting actions to improve offices that do not meet thresholds.	Delegate is responsible for ensuring the providers are compliant with IEHP Facility Site Review and Medical Record Audits.	Not Applicable	Not Applicable	Not Applicable

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Site Visits and Ongoing Monitoring (NCQA MED 3 Element B)	4. Evaluating the effectiveness of the actions at least every six months, until deficient offices meet the site standards and thresholds. 5. Documenting follow-up visits for offices that had subsequent deficiencies.	Delegate is responsible for ensuring the providers are compliant with IEHP Facility Site Review and Medical Record Audits.	Not Applicable	Not Applicable	Not Applicable

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Ongoing Monitoring and Interventions (NCQA CR 5 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality by: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing Medicare and Medicaid exclusions. 3. Collecting and reviewing sanctions or limitations and expirations on licensure. 4. Collecting and reviewing complaints. 5. Collecting and reviewing information from identified adverse events.	Annually, at minimum Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan's Credentialing Manager, with the delegate's plan of action for the identified provider and date it was reviewed by their Credentialing/Peer Review Committee.	IEHP reviews the organization's policies and procedures, monitoring reports, and documentation of interventions.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Appropriate Interventions (NCQA CR 5 Element B)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegate reports the findings from Element A to the Credentialing Committee, or other designated peer-review body, and implements interventions as needed.	Annually, at minimum	IEHP reviews the organization's policies and procedures, monitoring reports, and documentation of interventions.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
DHCS– Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS All Plan Letter, APL 19-004)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate verifies that their contracted providers have not been terminated as a Medi-Cal provider or have not been placed on the Suspended and Ineligible Provider List (Source: Exhibit A: Attachment 4, Plan Contract)	Annually, at minimum Delegate provides immediate notification of all providers identified through ongoing monitoring to the health plan's Credentialing Manager, with the delegate's plan of action for the identified provider and date the provider was reviewed by their Credentialing/Peer Review Committee.	IEHP reviews the organization's policies and procedures, monitoring reports, and documentation of interventions.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
DHCS Monitoring Death Master File (DHCS All Plan Letter (APL) 19-004)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. IEHP maintains a documented process for monitoring providers who are identified on the Death Master File	Delegate is required to submit SSN for all new and existing providers to screen against the Death Master File. (Source: Department of Health Care Services (DHCS) All Plan Letter (APL) APL 17-019 supersedes APL 16-012, "Provider Credentialing/Recredentialing and Screening/Enrollment)	Ongoing	Not Applicable	See Corrective Action Plan (CAP) Requirements in MC_25 A4

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
DHCS – Monitoring the Restricted Provider Database. (DHCS All Plan Letter (APL) 19-004)	IEHP will review the Restricted Provider Database, on a monthly basis, and notify the Delegate of any identified practitioners.	Delegated Practitioners identified with payment suspensions, reimbursements for Medi-Cal covered services will be withheld. If the Delegate continues to continue their contractual relationship with practitioners who pare placed on payment suspensions, the Delegate must allow out-of-network access to members currently assigned to the practitioner by approving the request. Delegated Practitioners placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations. Delegates must terminate their contract and submit appropriate documentation.	As needed	As needed	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Notification to Authorities and Practitioner Appeal Rights- Actions Against Practitioners (NCQA CR 6 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegates that have taken action against a practitioner for quality reasons reports the action to the appropriate authorities and offers the practitioner a formal appeal process. Delegate has policies and procedures for: 1. The range of actions available to the organization. 2. Making the appeal process known to practitioners.	Annually, at minimum	IEHP reviews evidence that the organization reports to authorities and the health plan's Credentialing Manager. IEHP reviews the organization's policies and procedures.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Review and Approval of Providers (NCQA CR 7 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the provider is not accredited.	Annually, at minimum	IEHP reviews Delegate's policies and procedures.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.
Medical Providers (NCQA CR 7 Element B)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate includes at least the following medical providers in its assessment: 1. Hospitals. 2. Home health agencies. 3. Skilled nursing facilities. 4. Free-standing surgical centers 5. Clinical Laboratories (IEHP Requirement)	Annually, at minimum	IEHP reviews Delegate's policies and procedures.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Assessing Medical Providers (NCQA CR 7 Element D)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate assesses contracted medical health care providers against the requirements and within the time frame in Element A. Delegate maintains a checklist, spreadsheet, or other record that it assessed providers against the requirements.	Annually, at minimum	IEHP reviews evidence that the organization assessed the providers in NCQA CR7 Element A.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.
Accreditation/Certification of Free-Standing Surgical Centers in California - CH & SC (California Health and Safety Code § 1248.1)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate has documentation of assessment of free-standing surgical centers to ensure that if the organization is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program, in compliance with California Health and Safety Code § 1248.1	Annually, at minimum	IEHP reviews evidence that the organization assessed the providers in NCQA CR7 Element A.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

Protecting the Integrity of Credentialing Information (NCQA CR 8 Element A)		The organization has credentialing information integrity policies and procedures that specify: 1. The scope of credentialing information. The IPA's policies and procedures specify protection of each of the following types of credentialing information: a) The practitioner application and attestation. b) Credentialing documents received from the source or agent. c) Documentation of credentialing activities: - Verification dates. - Report dates (e.g., sanctions, complaints, identified adverse events). - Credentialing decisions. - Credentialing decision dates. - Signature or initials of the verifier or reviewer. d) Credentialing Committee minutes. e) Documentation of clean file approval, if applicable. f) Credentialing checklist, if used. 2. The staff responsible for performing credentialing activities. The IPA's policies and procedures specify the titles of staff who are:	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

		a. Responsible for documenting credentialing activities. b. Authorized to modify (edit, update, delete) credentialing information. - Policies and procedures state if no staff are authorized to modify credentialing information under any circumstances. c. Responsible for oversight of credentialing information integrity functions, including auditing. 3. The process for documenting updates to credentialing information. The IPA's policies and procedures: a. Specify when updates to existing credentialing information is appropriate (e.g., to update expiring credentials). b. Describe the IPA's process for documenting the following when updates are made to credentialing information: - When (date and time) the information was updated. - What information was updated. - Why the information was updated. - Staff who updated the information. 4. Inappropriate documentation and updates. The IPA's policies and procedures specify that the following			

		documentation and updates to credentialing information are inappropriate: a) Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates). b) Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as a new credential). c) Fraudulently altering existing documents (e.g., credentialing minutes, clean file reports, ongoing monitoring reports). d) Attributing verification or review to an individual who did not perform the activity. e) Updates to information by unauthorized individuals. 5. The IPA audits CR staff and the process for documenting and reporting identified information integrity issues. a) Specify that the organization audits credentialing staff documentation and updates. - The organization does not have to include the audit methodology but must indicate that an annual audit is performed. b) Describe the process for documenting and reporting			

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		inappropriate and documentation and updates to: - The IPA's designated individual(s) when identified, and - The organization, when it identifies fraud and misconduct. c) Specify consequences for inappropriate documentation and updates.			

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Information Integrity Training (NCQA CR 8 Element B)		The IPA annually trains credentialing staff on: 1. Inappropriate documentation and updates. a) The IPA trains credentialing staff on inappropriate documentation and updates to UM information, as defined in Elements CR 8A, factor 4. 2. IPA audits of staff, documenting and reporting information integrity issues. The IPA's training informs UM staff of: a) IPA audits of staff documentation and updates in UM files. b) The process for documenting and reporting inappropriate documentation and updates to: - The IPA's designated individual(s) when identified. - The organization, when the IPA identifies fraud and misconduct. c) The consequences for inappropriate documentation and updates.	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

Audit and Analysis (NCQA CR 8 Element C)		The IPA annually: 1. Audits for inappropriate documentation and updates to credentialing information. The IPA annually audits credentialing information used in the credentialing process for the following inappropriate documentation and updates: a) Falsifying credentialing dates (e.g., licensure dates, credentialing decision dates, staff verifier dates, ongoing monitoring dates). b) Creating documents without performing the required activities. c) Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports). d) Attributing verification or review to an individual who did not perform the activity. e) Updates to information by unauthorized individuals. The audit universe includes practitioner files for all initial credentialing decisions and all recredentialing decisions made or due during the look-back period. The organization randomly audits a sample of practitioner files from the audit universe using 5% or 50 files, whichever is less. The random sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

		credentialed or recredentialed within the look-back period, the organization audits all files. The organization may choose to audit more practitioner files than NCQA requires. The organization provides an auditing and analysis report that includes: a) The report date. b) The title of individuals who conducted the audit. c) The 5% or 50 files auditing methodology. - Auditing period. - File audit universe size (described in the paragraph above). - Audit sample size. d) The audit log (as a referenced attachment) - File identifier (individual practitioner). - Type of credentialing information audited (e.g., licensure). e) Findings for each file. - A rationale for inappropriate documentation and updates. f) The number or percentage and total inappropriate documentation and updates by type of credentialing information.			

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		The IPA must provide a completed audit report even if no inappropriate documentation and updates were found. 2. Conducts qualitative analysis of inappropriate documentation and updates to UM denial receipt and notification dates. The IPA annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause. b) The IPA's auditing and analysis report also includes: - Titles of credentialing staff involved in the qualitative analysis. - The cause of each finding.			

Improvement Actions (NCQA CR 8 Element D)		The IPA: 1. Implements corrective actions to address all inappropriate documentation and updates found in Element C. a) The IPA documents corrective actions taken or planned, including dates of actions, to address all inappropriate documentation and updates (findings) identified in Element C. One action may address more than one finding, if appropriate. Annual training (Element B) may not be the only corrective action. b) The IPA identifies the staff (by title) who are responsible for implementing corrective actions. 2. Conducts an audit of the effectiveness of corrective actions (factor 1) on the findings 3–6 months after completion of the annual audit in Element C. a) The IPA audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		the annual audit completed for Element C. The audit universe includes practitioner files for all credentialing decisions made, or due to be made, 3–6 months after the annual audit. b) The IPA conducts a qualitative analysis if it identifies noncompliance with integrity policies and procedures during the follow-up audit.			

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Written Delegation Agreement (NCQA CR 9 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate remains responsible for credentialing and recredentialing its practitioners, even if its delegates all or part of these activities. The written delegation agreement: 1. Is mutually agreed upon. 2. Describes the delegated activities and the responsibilities of IEHP and the Delegated entity. 3. Requires at least semiannual reporting of the Delegated entity to IEHP. 4. Describes the process by IEHP evaluates the Delegated entity's performance. 5. Specifies that IEHP retains the right to approve, suspend and terminate individual practitioners, providers, and sites, even if IEHP delegates decision making	Annually, at minimum	IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Written Delegation Agreement (NCQA CR 9 Element A continued)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	6. Describes the remedies available to IEHP if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement	Annually, at minimum	IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.
Written Delegation Agreement	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegated entity retains the right to approve, suspend and terminate individual practitioners, providers, and sites in situation where it has delegated decision making. This right is reflected in the delegation document.	Annually, at minimum	IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Pre-delegation Evaluation (NCQA CR 9 Element B)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	For new delegation agreements initiated in the look-back period, IEHP evaluated delegate capacity to meet NCQA requirements before delegation began.	Annually, at minimum	IEHP reviews the delegates pre-delegation evaluation from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Review of Credentialing Activities (NCQA CR 9 Element C)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	For delegation agreements in effect for 12 months or longer, the organization: 1. Annually reviews the Delegate's credentialing policies and procedures. 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates the Delegates performance against NCQA standards for delegated activities. 4. Semi-annually evaluates regular reports. 5. Annually the organization monitors the delegate's credentialing information integrity to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures. 6. Annually the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	Annually, at minimum	IEHP reviews a sample of up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Opportunities for Improvement (NCQA CR 9 Element D)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	For delegation arrangements that have been in effect for more than12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.	Annually, at minimum	IEHP reviews reports for opportunities for improvement if applicable and appropriate actions to resolve issues from up to or four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.
Identification of HIV/AIDS Specialists – Written Process (CA H&SC §1374.16; DMHC TAG (QM-004). DHCS MMCD All-Plan Letter 01001)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate has a written policy and procedure describing the process that the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist, according to California State regulations on an annual basis	Annually, at minimum	IEHP reviews delegate policies and procedures.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Evidence of Implementation (CA H&SC §1374.16; DMHC TAG (QM-004). DHCS MMCD All-Plan Letter 01001)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	On an annual basis, delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS, specialist according to California State Regulations	Annually, at minimum	IEHP reviews evidence that the organization identified or reconfirmed the appropriate qualified physicians.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.
Distribution of Findings (CA H&SC §1374.16; DMHC TAG (QM-004). DHCS MMCD All-Plan Letter 01001)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate is to provide the list of identified qualifying physicians to the department responsible for authorizing standing referrals.	Annually, at minimum	IEHP reviews evidence that the organization provided the list of identified qualifying physicians to the department responsible for authorizing standing referrals.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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ATTACHMENT VII: DELINEATION OF ENCOUNTER DATA

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
ENC 1: Encounter Data Reporting		The IPA is required by DMHC, CMS and DHCS to submit Encounter Data for the effective management of IEHP health care delivery system. A. Data must be submitted using the HIPAA compliant 5010 837 file format. B. The Encounter Data must be complete and accurate. C. Submit complete Encounter data within ninety (90) days after each month of service.	Submit Encounter Data within ninety (90) days after each month of service	Initial Onsite Assessment Monthly assessment of encounter data submission rates	See Corrective Action Plan (CAP) Requirements in MC_25 A4. IEHP may withhold no more than one percent (1%) of the monthly Capitation Payment for failure to submit complete and accurate Encounter Data within ninety (90) days after each month of service.

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ATTACHMENT VIII: DELINEATION OF CLAIMS ADJUDICATION

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
AB1455: Claims Payment Performance and Dispute Resolution Mechanism	IEHP monitors the performance of the delegate in between audits through monthly and quarterly reporting. IEHP assesses compliance with regulatory and contractual requirements and performs comparative analysis and trends for possible indicators of potential or emerging patterns of unfair payment practices or inability to perform delegated functions.	The Delegate must accurately process claims and resolve disputes within contracted and regulatory timeframes as established by IEHP.	▪ Provide a copy of the Monthly Timeliness Report (MTR) by the 15th of each month. ▪ Provide a copy of the Monthly Claims and Disputes Detailed Report by the 15th of each month. ▪ Provide a copy of the Quarterly Provider Dispute Resolution (PDR) Report and Statement of Deficiencies Report by the 30th of the month following the end of the quarter. ▪ Provide a copy of the Annual Claims Payment and Provider Dispute	Please refer to MC_20G.	See Corrective Action Plan (CAP) Requirements in MC_20D.

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ATTACHMENT VIII: DELINEATION OF CLAIMS ADJUDICATION

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
			Mechanism Report (Annual Report) by November 30th of each year.		