25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

1. Delegated Activities

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Delegates. ~~Members.~~

POLICY:

A. ~~Annually,~~ IEHP evaluates and audits contracted Delegates in accordance with current applicable National Committee for Quality Assurance (NCQA) accreditation standards, and Department of Health Care Services (DHCS) regulatory requirements, and IEHP standards, modified on an as needed basis.

B. Delegates agree to be accountable for all responsibilities delegated by IEHP and oversight of any sub-delegated activities, including periodic reporting, as specified in the Delegation Agreement~~.~~

~~C. Delegates agree to provide periodic reports to IEHP as specified in the Delegation Agreement.~~

~~D. In the event deficiencies are identified through this oversight, Delegates will provide a specific corrective action plan acceptable to IEHP within a specified timeframe.~~

~~E. IEHP monitors Delegates' compliance with reporting requirements on a monthly basis.~~

DEFINITION:

~~A.~~ Delegate- A medical group, health plan, ~~i~~Independent ~~p~~Physician ~~a~~Association (IPA), individual or entity contracted with IEHP to provide administrative services or health care services for a Medi-Cal eligible IEHP Member. ~~Delegate is defined as an organization authorized to perform certain functions on IEHP's behalf.~~

A.

PROCEDURES:

A. IEHP performs an initial, monthly, and annual audits in the following ~~Delegated~~ delegated ~~Activities~~activities:

1. Quality Management;
2. Utilization Management;
3. Credentialing and Re-credentialing;

~~4. Compliance;~~

~~5. HIPAA Security~~

~~6.~~4. Care Management; and

~~7.~~5. Claims Process and Payment~~; and~~.

~~8. Financial Viability.~~

B. IEHP performs initial, monthly annual and as needed audits of the following regulatory requirements:

1. Compliance (Fraud, Waste, and Abuse Program);

2. HIPAA Security; and

3. Financial Viability.

~~B.~~C. Each of the above activities describes the elements being evaluated, the frequency of the reporting requirements, and the period of time being evaluated.

1. For each activity, IEHP has identified the documented reporting requirements and delegated activities (See Attachments, "IPA Delegation Agreement – Medi-Cal" and "IPA Reporting Requirements Schedule – Medi-Cal" in Section 25).

D. Delegates identified to be deficient in a delegated activity are required to submit a Corrective Action Plan (CAP). See Policy 25A4, "Delegation Oversight – Corrective Action Plan Requirements.

~~C.~~E. If Delegates are unable to correct or comply with the corrective action plan within the specified timeframe, IEHP will take necessary steps up to and including revocation of delegation in whole or in part.

~~D.~~F. Failure to submit documentation by the required due dates or failure to participate in a scheduled audit may result in an automatic failure of the audit.

~~E.~~G. IEHP ~~meets with~~provides each Delegate ~~to discuss~~ with~~–~~ the results of auditing and monitoring activities within thirty (30) calendar days of the scheduled audit date.~~s.~~ ~~and presents all relevant supporting documentation. Meeting date and location to be specified by IEHP.~~

~~F.~~H. Delegates can appeal the results of any oversight activity, specialized study, audit and any required CAPs or sanctions to IEHP within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

1. Delegated Activities

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2009
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, ~~2022~~2023

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Delegation Oversight Audit

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Delegates.

POLICY:

A. IEHP delegates certain Utilization Management (UM), Care Management (CM), Credentialing/Re-credentialing (CR) activities and activities for Quality Management (QM), Compliance and Fraud, Waste and Abuse (FWA) Program, and HIPAA Privacy ~~Program~~ & Security Program to contracted Delegates that meet IEHP delegation requirements and comply with the most current National Committee for Quality Assurance (NCQA) Health Plan Standards, Department of Health Care Services (DHCS) (when applicable), Department of Managed Health Care (DMHC) (when applicable), Centers for Medicare and Medicaid Services (CMS) (when applicable), and IEHP Standards.

B. IEHP does not delegate Quality Management and Improvement (QI), Preventive Health, Medical Records, Compliance or Member Experience to any non-NCQA accredited entities; however, IEHP does require contracted Delegates to perform specific activities related to these areas.

C. IEHP audits the Delegates' performance in QI, UM, Credentialing/Re-credentialing, Compliance and Fraud, Waste and Abuse (FWA) Programs, HIPAA Privacy ~~Program~~ & Security Program, CM, ~~and~~ Claims, and related activities through the Delegation Oversight Audits performed on an annual basis.[1]

D. IEHP may waive elements of the annual audit for NCQA accredited or certified entities.

E. The Delegation Oversight Audit is used as part of the pre-contractual audit for Delegates applying for participation with IEHP.

F. The Delegation Oversight Audits are performed by IEHP Provider Services, Compliance, Credentialing, QI, UM, and CM Delegation Oversight Staff ~~using~~ utilizing the most current NCQA, DHCS, DMHC, CMS (when applicable), and IEHP standards.

G. Focused audits may be performed as indicated whenever a quality issue is identified or at the discretion of the Delegation Oversight Committee, Chief Compliance Officer, Executive Compliance Committee, or the IEHP Chief Medical and Chief Quality Officers.

H. IEHP reserves the right to revoke delegated responsibilities and take other necessary action up to and including termination of contract from those Delegates that fail to meet IEHP requirements.

[1] Title 42 Code of Federal Regulations (CFR) § 438.230

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

2. Delegation Oversight Audit

DEFINITION:

A. Delegate - A medical group, Health Plan, ~~Delegated~~ IPA, or any contracted organization delegated to provide services. A medical group, health plan, ~~i~~Independent ~~p~~Physician ~~a~~Association (IPA), individual or entity contracted with IEHP to provide administrative services or health care services for a Medi-Cal eligible IEHP Member.

PROCEDURES:

A. IEHP audits each Delegate prior to contracting and at least annually to verify compliance with IEHP requirements and continued ability to perform delegated functions.

~~B. IEHP conducts the Delegation Oversight Audit utilizing the most current NCQA, DHCS, DMHC, CMS (when applicable), and IEHP standards.~~

~~C.~~B. The Delegation Oversight Audit evaluates the Delegates' capabilities in UM, CM, Credentialing and elements of QI, Compliance, FWA, and HIPAA Privacy & Security.

~~D.~~C. IEHP is responsible for coordinating and scheduling the audits with the Delegate's staff.

~~E.~~D. IEHP notifies the Delegate in writing, at least thirty (~~3~~(30)~~0~~) days in advance of the scheduled audit. The Delegate receives audit preparation instructions (See Attachment, "Delegation Oversight Audit Preparation Instructions - Medi-Cal" and "Delegation Oversight Audit Preparation Instructions – Medi-Cal (NCQA Certified)" in Section 25) regarding the types of documents to be available at the time of the audit and standard forms to be completed and returned to IEHP prior to the audit.[2]

1. Delegate Biographical Information (See Attachment, "Delegated Biographical Information Sheet" in Section 25).
2. Delegate Sub-Contracted Service by Facility/Agency (See Attachment, "Subcontracted Facility Services and Delegated Functions" in Section 25).
3. QI documents:
   a. Quality Management and Quality Improvement Program Description;[3,4]
   b. Quality Management ~~-~~Global Quality Pay-For-Performance (P4P) Work Plan~~-~~;
   c. Quality Management Program Annual Evaluation;[5]

[2] 46 CFR § 438.230
[3] National Committee for Quality Assurance (NCQA), 2022~~1~~ HP Standards and Guidelines, QI 1, Element A, Factors 1-~~5~~6
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (-Final Rule 27), ~~Contract Amendment January 2018,~~ Exhibit A Attachment 4, Provision 7, Delegation of Quality Improvement ~~System~~Activities
[5] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element C, Factors 1-3

d. Quality Improvement (QI) Committee and subcommittee meeting minutes, agenda, sign in sheet, and signed confidentiality statement from the auditing period:[6]

1) Recommendation of policy decisions;[7]

2) Review and evaluation of QI activities;[8]

3) Practitioner participation in the QI program through planning, design, implementation, or review; and[9]

4) Identification and follow up of needed actions.[10]

e. Semi-Annual Health Plan ~~R~~reports from the audit period;

f. Notification of Termination policy and evidence that Members were notified of ~~practitioner~~ Practitioner termination;

g. Studies, audits, and surveys completed from the audit period; and

h. Standards of Medical Care Access Policies and Procedures.

4. UM documents:

a. Annual UM Program Description[11, 12]

b. UM Annual Work Plan;[13]

c. UM Annual Evaluation;[14]

d. Policies and Procedures;

e. Referral Universe for audit file selection;

f. Committee meeting minutes from the audit period:

1) Board of Directors;

2) Utilization Management Committee; and

3) UM Subcommittee meeting minutes.

[6] DHCS-IEHP Two-Plan Contract, 1/10/20 (-Final Rule 27) ~~Contract Amendment January 2018~~, Exhibit A, Attachment 4, Provision 4, Quality Improvement ~~System~~Committee
[7] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element D, Factor 1
[8] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element D, Factor 2
[9] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element D, Factor 3
[10] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element D, Factors 3-5~~4~~
[11] NCQA, 2022~~1~~ HP Standards and Guidelines, UM 1, Element A, Factors 1-6
[12] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule 27), ~~DHCS Final Rule Contract Amendment January 2018,~~ Exhibit A Attachment 5, Provision 1, Utilization Management Program
[13] NCQA, 2022~~1~~ HP Standards and Guidelines, UM 13, Element A, Factor 3
[14] NCQA, 2022~~1~~ HP Standards and Guidelines, UM 1, Element B

g. Annual Inter-Rater Reliability (IRR) Audit;

h. Semi-Annual Health Plan ~~R~~reports for the audit period:

i. Two (2) examples that demonstrate the use of Board-Certified Consultants to assist with medical necessity determinations;[15]

j. Criteria for Length of Stay and Medical Necessity used during the past two (2) years;

k. Fifteen (15) Approved, Partially Approved, Denied, and Cancelled files selected by IEHP. The Delegate is responsible for walking IEHP through each referral via the Delegate's medical management system;

l. Fifteen (15) BH Approved, Partially Approved, Denied, and Cancelled files selected by IEHP. The Delegate is responsible for walking IEHP through each referral via the Delegate's live medical management system;

m. Submission of request for UM criteria log;

~~m.~~n. Utilization Management statistics from the audit period;

~~n.~~o. Evidence, other than via a denial letter, that the Providers have been notified that they may contact a Physician reviewer to discuss denial decisions;

~~o.~~p. Provider communications from the audit period;

q. Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO)) and Employees (Registered Nurse (RN), Licensed Vocational Nurse (LVN)) who make UM Decisions~~.~~[16],[17]

r. Copies of most recent referral inventory reporting used to manage turnaround time requirements for processing of IEHP referrals;

s. Copies of most recent mailroom policies;

t. Evidence of meeting Denial System Controls requirements, as outlined in the Delegation Agreement;

~~p.~~u. Evidence of meeting Denial and Appeal System Controls Oversight requirements, as outlined in the Delegation Agreement.

5. Care Management documents:

a. Program Plan and Description and CM policies and procedures ~~(if different from UM)~~;

[15] NCQA, 2022~~1~~ HP Standards and Guidelines, UM 4, Element F, Factor 2
[16] ~~NCQA, 2022 1 HP Standards and Guidelines, UM 4, Element B, Factor 2~~
[17] NCQA, 20221 HP Standards and Guidelines, UM 4, Element B, Factor 2

~~b. CM logs and California Children's Services (CCS) logs (IEHP will utilize previously submitted monthly logs and other available data sources);~~

~~c.~~b. ~~-~~Ten (10) SPD CM and/or Care Coordination files;

~~d.~~c. Five (5) sample cases of California Children's Services (CCS) ~~files~~identified from previously submitted logs; ~~and~~[18]

d. Five (5) sample cases of Carve Out/ referrals to Waiver Programs~~/Transition of Care.~~; and

e. Five (5) sample cases with documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services.

6. Credentialing documents:

a. Policies and Procedures;[19]

b. Credentialing System Controls Oversight requirements~~Reports~~;

~~a.~~c. Credentialing System Controls requirements;

~~b.~~d. Committee meeting minutes including date and voting attendees from the specified look-back period, including:

1) Board of Directors;

2) Quality Management Committee ~~minutes~~;

3) Credentialing Committee; and

4) Peer Review Committee.

~~c.~~e. A spreadsheet of all credentialed and recredentialed Practitioners for the specified look-back period (Applicable to Kaiser, MD Live and ASH Specialty Network)

~~d.~~f. Credentialing and re-credentialing files – five percent (5%) or a minimum of forty (40) credentialing and forty (40) re-credentialing files randomly selected by IEHP;

~~e.~~g. Practitioner files of those terminated for quality issues during the specified look-back period;

~~f.~~h. Practitioner files that have appealed ~~a~~ decision issues during the specified look-back period;

[18] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule 27),~~Department of Health Care Services (DHCS) IEHP Two-Plan Contract, 1/10/20 (Final Rule A27),~~ Exhibit A, Attachment 11, Provision 9, California Children's Services (CCS)

[19] NCQA, 202~~1~~2 HP Standards and Guidelines, CR ~~1~~8, Element A, Factors 1-11

~~g.~~i. Healthc ~~C~~are Delivery Organizational Files where the IPA is responsible for claims payment for those Organizational Providers, which include but are not limited to:

1) Laboratory files;
2) Hospital files;
3) Home Health files;
4) Skilled Nursing Facility (SNF) files; and
5) Free standing Surgical Center files.

~~h.~~j. Credentialing delegation data, if applicable;[20]

~~i.~~k. Delegate's checklist, spreadsheet or other record that shows evidence the organization assessed its organizational providers.

~~j.~~l. Documentation of ongoing monitoring of sanctions, complaints, and quality issues for the specified look-back period;

~~k.~~m. Human Immunodeficiency Virus (HIV/AIDS) Annual Survey to include the written process, Evidence of Implementation and Distribution of Findings; and

~~l.~~n. Delegation Agreements between the Delegate and its Sub-delegate(s).[21]

7. Compliance and Fraud, Waste and Abuse (FWA) Documents:
   a. Compliance ~~Policies~~ policies & ~~Procedures~~procedures;
   b. Fraud, Waste and Abuse (FWA) ~~Policies~~ policies & ~~Procedures~~procedures;
   c. Sanction/Exclusion Screening Process policies and procedures;
   d. Standards/Code of Conduct;
   e. Copies of Compliance and FWA Training provided during the audit period;
   f. Compliance Committee Meeting minutes from the last twelve (12) months to include agenda and sign in sheet (attendance);
   g. Evidence of Regulatory Exclusion Checks;
   ~~g.~~h. Annual Compliance Work Plan;
   ~~h.~~i. Annual Audit and Monitoring ~~Plan~~Universe;
   ~~i.~~j. Annual Risk Assessment Report;
   ~~j.~~k. Employee and Governing Body Universe: Submit a list of all current employees, volunteers/interns (who performed job duties related to IEHP's lines of business),

[20] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element A, Factor 2
[21] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element A, Factor 1

and Governing Body Members~~who have performed job duties related to IEHP's lines of business~~. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The definition of employees includes full and part time employees as well as temporary employees, contractors, interns, or volunteers~~. Members of the Governing Body/Board of Directors should also be included~~;

~~k.~~l. Audit & Monitoring Universe: Submit a list of all audits and monitoring ~~(A&M)~~ activities ~~of~~ the IPA's conducted of its delegated functions, including those that were started or completed during the audit period or a copy of the IPA's Audit and Monitoring Plans for the audit period;

~~l.~~m. Downstream Entity/Subcontractors Universe: Submit a list of all downstream entities/subcontractors contracted with the IPA and/or MSO anytime during the audit period, including Individual/Entity Name, detailed description of service provided, contract start and end dates (if applicable);

~~m.~~n. A sample of ten (10) ~~employees~~ individuals (five (5) hired/started within the audit period and five (5) hired/started prior to the audit period) will be selected from the Employee Universe by IEHP for which documented evidence of the following will be requested:

~~1) New Hires:~~

- 1) Pre-hire Screening of the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and Medi-Cal Suspended & Ineligible Provider List (S&I).
- 2) Completion of Compliance and FWA Training within ninety (90) days of ~~-~~hire or start.
- 3) Evidence the Standards/Code of Conduct ~~distribution~~ was received by these individuals within ninety (90) days of hire or start.

~~2) Established Employees~~

~~1)~~4) Monthly Screening performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of three consecutive months.

~~2)~~5) Completion of Annual Compliance and FWA training

~~3)~~6) Annual distribution of the Standards/Codes of Conduct.

~~n.~~o. A sample of five (5) audits and/or monitoring activities will be selected from the IPA's Audit and Monitoring Plans or ~~A&M~~Audit & Monitoring Activities Universe. Evidence of the following will be required:

1) Results/Finding Reports;

2) Activity~~ies~~ outcomes were ~~reported~~ shared with~~to~~ an oversight body, senior leadership, and/or the ~~board of directors~~IPA's Governing Body and c~~C~~orrective actions, if applicable.

~~o.~~p. A sample of three (3) ~~FDR~~Downstream Entities/Subcontractors will be selected from the ~~FDR~~ Downstream Entity/Subcontractor Universe. Evidence of the following will be required:

1) ~~Auditing or monitoring~~Compliance oversight activities were conducted;

2) Activity outcomes were reported to an oversight body, senior leadership, or~~and~~ the ~~board of directors~~IPA's Governing Body and c~~C~~orrective actions were taken, if applicable.

8. Health Insurance Portability and Accountability Act (HIPAA) Privacy Documents

a. Employee and Governing Body Universe;

~~a.~~b. HIPAA Privacy and Security ~~Policies~~ policies & ~~Procedures~~procedures;

~~b.~~c. Copies of HIPAA Privacy Training provided during the audit period;

~~c.~~d. Privacy Incident Universe: Submit a list of reported suspected privacy incidents impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period.~~;~~

1) A sample of five (5) privacy investigations will be selected from the Privacy Incidents Universe. Evidence of the following will be required:

- Date incident was reported to the Privacy/Compliance Office/Officer;
- Completion of a Privacy Incident Risk Assessment for issue/investigation;
- Notification was sent to IEHP ~~with~~ in accordance with HIPAA BAA Requirements of discovery of a suspected breach; and
- Corrective actions taken, if applicable.

2) A sample of ten (10) employees (five (5) hired within the audit period and five (5) hired prior to the audit period) will be selected from the *Employee Universe* by the IEHP Auditor for which evidence of the following will be

requested:

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

9. IT Security
   a. The name of the medical management system(s) used for the utilization management, care management, and claims functions.
10. Other general organizational documents:
    a. Organizational chart(s);
    b. Current job descriptions relevant to audit;
    c. Delegation agreements with any subcontracted practitioner, or entity to which the IPA subcontracts any function (i.e., UM, Credentialing); and
    d. Ownership and Control documentation submitted annually to IEHP.
11. Provider Directory (applies to Kaiser Permanente, and American Specialty Health (ASH):
    a. Report during the lookback period of the annual audit of identified/reported inaccuracies and the timeframe of the correction.[22] ~~in compliance with California Health and Safety Code § 1367.27.~~

F. In preparation for the audit the IPA should:
1. Familiarize themselves with NCQA, DHCS (when applicable), DMHC, CMS (when applicable) and IEHP specific standards; and
2. Conduct self-audits to ~~Audit themselves to make sure~~ensure they meet ~~the~~ current standards.

G. All Delegates are required~~-~~ to provide a written roadmap of where each element is located in the policies and procedures. All sections of the audit tool must be road mapped upon submission.~~prior to the reviewers going on site.~~

H. At the time of the audit, the Delegate must have:
1. All requested documents ready; and

[22] Health and Safety Code § 1367.27

2. Have appropriate staff available for each functional area that is being audited. ~~(the staff need not be present with the auditors for the entire audit).~~

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

1. The Delegates policies and procedures for completeness and compliance with NCQA, DHCS (when applicable), DMHC, CMS (when applicable) and IEHP standards;
2. Committee and Subcommittee Minutes (as applicable);
3. The prior authorization/referral/denial/appeal process for the following:
   a. Timeliness of UM and appeal decisions for non-urgent and urgent pre-service, concurrent, and retrospective reviews;
   b. Professional review of clinical information;
   c. Clinical criteria for UM and appeal decisions;
   d. Medical information – relevant clinical information collected to support UM and appeal decision-making;
   e. Denial notices – clear documentation and communication of reasons for each denial and appeal decision, alternative treatment offered, and correct appeal language;
   f. Evidence of use of board-certified consultants for medical necessity decisions when applicable; and [23]
   g. Evidence of current license for Providers and Employees (RN and LVN) who make UM decisions.[24]
4. Care Management (CM) files for demonstration of the CM process for:
   a. Case finding;
   b. Assessment and problem identification;
   c. Care Plans and attainable goals;
   d. Appropriateness of goals/time frames/monthly updates/follow ups;
   e. Implementation;
   f. Monitoring;
   g. Outcomes;
   h. Recommended referral services;

[23] NCQA, 2022~~1~~ HP Standards and Guidelines, UM 4, Element F, Factor 2
[24] NCQA, 2022~~1~~ HP Standards and Guidelines, UM 4, Element B, Factor 2

i. Five (5) Sample Cases of Carve Out/Waiver Programs/; and

j. California Children Services (CCS logs).

5. Credentialing and re-credentialing files:

   a. All necessary primary source verifications have been performed within the required one ~~hundred~~ hundred-eighty (180) calendar day timeframe;

   b. All required queries have been performed through appropriate verification sources;

   c. All credentialing and re-credentialing packets have been approved by the Delegates Credentialing Committee;

   d. All pertinent Quality Assurance (QA), grievance and Member information specific to a given Practitioner, as available, have been considered during the credentialing and re-credentialing process;

   e. Processes are in place to ensure Provider documentation including licenses, Drug Enforcement Administration (DEA) certificate, Board Certification and malpractice insurance, are kept current;

   f. Processes are in place to ensure documentation on subcontracted organizational Providers is verified at time of contracting and at least every three (3) years thereafter;

   g. Re-credentialing of Practitioners was performed within required thirty-six (36) months timeframe; and

   h. There is sufficient documentation within each credentialing file to confirm that all primary source verifications, queries and other information reviewed pertinent to the credentialing or re-credentialing decision were received prior to and used in the credentialing and/or re-credentialing decision.

6. Randomly selected Health Care Delivery Organization Provider files (i.e., Home Health, laboratory) to verify the following:

   a. Confirms that the Provider is in good standing with state and federal regulatory bodies; to include review of Sanctions that would prevent the Provider from participation in the IEHP network.

   b. Confirms that the Provider has been reviewed and approved by an accrediting body (e.g., The Joint Commission (TJC), Accreditation Association for Ambulatory Health Care (AAAHC)), as stated in Policy 25B7, “Credentialing Standards - Assessment of Organizational Providers”; and

   c. Conducts an onsite quality assessment if the Provider is not accredited. The onsite quality assessment will be conducted by Delegates Quality Management

Department. Delegates' assessment process and assessment criteria for each non-accredited Provider with which it contracts will include a process for ensuring that the Provider credentials its Providers, in accordance ~~to~~ with NCQA guidelines. A CMS (when applicable) or state review may be used in lieu of a site visit and may not be greater than three (3) years old at the time of verification/approval.

7. Compliance Verifications

   a. Training: General Compliance, FWA, HIPAA Privacy Trainings for new hires and annually for current employees (Temporary or Permanent), Providers, Governing Board, Contractors and Volunteers.

   b. Distribution of the Standards of Conduct for new hires and annually for current employees.

   c. Confidentiality Statement for new hires prior to access to PHI and annually thereafter.

   d. Samples from the A&M activities, Privacy incidents and ~~FDR~~ Downstream Entities/Subcontractors universe will be tested.

   e. Screening: Proof of sanctions and exclusions screenings for all new hires and current employees (Temporary or Permanent), ~~Providers,~~ Governing ~~Board~~Body Members, Contractors, and Volunteers.

J. IEHP ~~uses~~ may uses the IEHP Credentialing Delegation Oversight Audit (DOA) Tool, Compliance and FWA DOA Audit Tool, Privacy DOA Audit Tool, and the QM/UM/CM DOA Audit Tool which is based upon current NCQA, DHCS (when applicable), DMHC, CMS (when applicable) and IEHP standards or other resources as deemed necessary to sufficiently document information from the examined policies and procedures, committee minutes, files and other documents to NCQA and Medi-Cal specific standards, as well as to support the conclusions reached.

K. The Delegate receives an exit interview with the IEHP auditors at the completion of ~~the~~ each session of Delegation Oversight A~~a~~udit. This interview identifies areas found to be deficient giving the Delegate an opportunity to provide additional information to clear the deficiency within two (2) business days and and highlighting opportunities for improvements that need to be addressed through the Corrective Action Plan (CAP) process.

L. Within thirty (30) calendar days of the audit, the Delegate receives written notification of the results. The written notification includes a cover letter and ~~a~~ completed audit tools noting any deficiencies found during the audit. The cover letter notes the timeframes for corrective action, and any other pertinent information.

M. Scoring categories for each of the Delegation Oversight Audit are as follows:

1. Full Compliance 90-100%
2. ~~Partial Compliance 80-89%~~
3. ~~2.~~ Non-compliance <90~~79~~%

N. Failure to submit required documentation by the due dates or failure to participate in scheduled audit dates may result in automatic failure of an audit.

O. All Delegates that score 90% or greater pass that section of the audit. A CAP is required for all scores below 90%. However, a CAP may be issued at the discretion of IEHP regardless of the score, even if the score is at 90% or above. Failure to meet the minimum threshold for any must- pass elements for Credentialing, will result in a CAP response to be submitted to IEHP within thirty (30) calendar days after the receipt of the Delegation Audit Results and must meet IEHP approval. Following the CAP acceptance, IEHP ~~will~~ may schedule a focused audit within six (6) months of the CAP Acceptance, that focuses on the failed must-pass elements (not at the factor level), i.e., all element factors, will be reviewed in addition to the factor (s) that failed the must-pass requirement. The look back period is from the date of the implementation of the Corrective Action Plan up to the one month prior to the focused audit. In addition, any Delegate that receives non-compliance in the credentialing portion of the audit is subject to further action up to termination of their IEHP contract. All CAPs submitted to IEHP must meet the Corrective Action Plan ~~Requirements~~requirements. (See Policy ~~25D3~~25A4, "~~Quality Management~~Delegation Oversight - Corrective Action Plan Requirements.")

P. Focused audits may occur between annual audits in the following circumstances:

1. Deficiencies noted as a result of the annual audit, as applicable;
2. Review of documents submitted to IEHP indicates potentially significant changes to the Delegate program; and
3. Any other circumstance or quality issue identified that in the judgment of IEHP, requires a focused audit.

Q. If the Delegate is unable to meet the requirements at the second focused re-audit, IEHP may do one (1) of the following:

1. Immediately freeze the Delegate to new Member enrollment, as applicable;
2. Send a thirty (30) day breach of contract notice with specific cure requirements;
3. Rescind delegated status of Delegate, as applicable;
4. Terminate the IEHP contract with the Delegate; or
5. Not renew the contract.

R. Delegates who wish to appeal the results of the Delegation Oversight Audit must do so in writing within thirty (30) calendar days of receiving their results to the Provider Delegation Manager. Delegates must cite reasons for their appeal, including disputed items or deficiencies.

S. Delegates who consistently fail to meet IEHP standards, as confirmed through annual and/or focused audits or other oversight activities, are subject to actions up to and including rescission of delegated functions, non-renewal of the IEHP contract or termination of the Delegates participation in the IEHP network.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2001
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

3. IPA Performance Evaluation Tool

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal IPAs.

POLICY:

A. Annually IEHP evaluates each contracted IPA using the Performance Evaluation Tool (PET) to determine the overall performance and compliance with its IEHP contract, including compliance with IEHP policies and procedures.

B. The PET is a standardized scoring mechanism that IEHP uses to evaluate and compare each IPA's health care delivery system and managed care capabilities in relation to compliance with IEHP standards.

C. IEHP uses the PET to evaluate whether an IPA's contract should be renewed and to determine the length of term of an IPA's contract with IEHP, if applicable.

PROCEDURES:

A. IEHP evaluates each IPA annually or as required when evaluating for renewal of a contract.

B. IEHP reviews the following functional areas:

1. Claims;
2. Communication;
3. Encounter Data;
4. Finance;
5. Grievance and Appeals;
6. Delegation Oversight Audit Results (including monthly, focused, and annual audits); and
7. IPA Reporting and Member Access Audit.

C. Each of the above categories is divided into specific subcategories. These subcategories describe the elements being scored, the frequency such data is collected, and the period of time being evaluated.

1. For each element, IEHP has identified its expectations and the level (score) to be achieved (See Attachment, "IPA Performance Evaluation Tool" in Section 25 for a sample tool).
2. The categories related to measures of an IPA's competence and quality of Member care (e.g., IPA Reporting and Member Access Audit and the IPA Delegation Oversight Audit Results) are weighted more heavily to ensure the IPAs maintain IEHP's quality standards and meet regulatory requirements.

3. The data collected throughout the contract year is comprised of reports, summaries and scores of each IPA's performance and ability in meeting its delegated responsibilities, including results of monitoring and oversight activities, quality studies and medical management audits.

D. IEHP uses the PET results to determine contract renewal terms (years) for each IPA. Term lengths are based on the following:

Providers achieving total scores of:	Are awarded a contract term of:
95% or above	3 years
85% to 94.99%	2 years
80% to 84.99%	1 year
Less than 80%	Non-renewal

E. IEHP provides each IPA with their PET ~~Tool~~ results. IEHP may meet individually with an IPA to discuss the results of its score and to review all relevant supporting documentation. This meeting can take place at the Joint Operations Meeting (JOM) or at a specific meeting called by IEHP.

F. After all PET scoring is complete, IEHP presents a summary to the IEHP Governing Board. This includes any IPA whose contract is not being renewed as a result of the PET score.

G. IPAs whose contracts are being non-renewed are notified in writing by the IEHP Chief Executive Officer (CEO).

H. IPAs that do not agree with the final outcome, may appeal to IEHP See Policy ~~16C~~16D, "IPA, Hospital and Practitioner Grievance and Appeals Resolution Process."

I. IEHP reserves the right to change, modify or remove the elements of PET at any time. All decisions regarding the rules and requirements under the IPA PET are at the sole discretion of IEHP.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	April 1, 1999
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2021

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

4. Corrective Action Plan Requirements

APPLIES TO:

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

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and Federal laws, National Committee for Quality Assurance (NCQA) accreditation, contractual and reporting requirements.[1,2]

B. IEHP's Delegation Oversight (DO) department is responsible for the oversight, monitoring and tracking of all assessments and Corrective Action Plans (CAPs).

C. The ~~Corrective Action Plan~~CAP ~~Process~~ process is the first level of action taken by IEHP to remediate identified performance deficiencies identified through the auditing and monitoring of ~~r~~ Delegates.

D. Delegates who fail to achieve established threshold requirements for any delegated function for (2) consecutive months will be issued a Corrective Action Plan (CAP) or Immediate Corrective Action Plan (ICAP).

E. IEHP may issue a CAP for a decline in performance or identified risk in any given month. CAPs are required to remediate deficiencies identified during monthly monitoring and auditing activities, focused and/or clinical audits, and the annual Delegation Oversight Audits (DOA).

DEFINITION:

~~A.~~ Delegate is a medical group, health plan, ~~i~~Independent ~~p~~Physician ~~a~~Association (IPA), individual or entity contracted with IEHP to provide administrative services or health care services for a Medi-Cal eligible IEHP Member. ~~Delegate – For the purpose of this policy, a delegate is defined as a health plan, IPA, medical group, or any contracted organization delegated to perform certain functions on IEHP's behalf.~~

~~B.~~A. Corrective Action Plan (CAP) is a written statement identifying the deficiency, root cause and description of the detailed plan of action that is developed to achieve targeted outcomes to correct the deficiency, and the operational results of that action which ensure the deficient practices are not repeated. For deficiencies that required long term corrective action or a period of longer than thirty (30) calendar days to remedy or operationalize, the Delegate must demonstrate it has taken remedial action and is making progress toward achieving acceptable

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, "Subcontractual Relationships and Delegation"
[2] Title 42 Code of Federal Regulations (CFR) §438.230

level of compliance. The CAP must include the date when full compliance is expected to be achieved.

PROCEDURES:

Delegation Oversight Audit CAP

A. IEHP monitors Delegate compliance with requirements set forth by IEHP, Department of Health Care Services (DHCS) and National Committee for Quality Assurance (NCQA) through its annual DOA. –The DOA includes oversight for QM, UM, Credentialing, Compliance, and Care Management. See Policy 25A2, "Delegation Oversight – Audit." Scoring categories for each section of the DOA are as follows:

1. Full Compliance 90-100%
2. Non-compliance <90%

B. All Delegates with scores less than 100% may be required to submit a CAP to remedy any deficiencies noted on the audit tool.

1. The Delegates must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies for each section.
2. A CAP is considered complete only if all deficiencies from each section are present and submitted together. These sections are as follows:
    a. QM;
    b. UM;
    c. Medi-Cal Addendum;
    d. Compliance;
    e. HIPAA Security;
    f. Credentialing & Recredentialing; and
    g. Care Management.
3. The Delegates are responsible for coordination of its CAP response with each of its internal departments responsible for addressing audit deficiencies.
4. IEHP does not accept CAPs for DOA and deficiencies when received in individual sections. These are returned to the Delegates and considered delinquent until a complete and all-inclusive CAP is received.
5. Each section of the CAP response must be clearly identified with supporting documentation attached and clearly labeled.
6. The CAP must be submitted to IEHP within thirty (30) calendar days of written notification by IEHP of the audit results. Information shall include:

a. The DOA score received for each section;

b. A list of the deficiencies identified by IEHP;

c. Root cause analysis for the deficiency;

d. How the deficiency is corrected along with supporting documentation, including policies and procedures, training agenda, material and sign-in sheets when applicable;

e. Completion dates for each of the corrective actions;

f. Identification of the person responsible for completing the corrective action; and

g. Follow-up or monitoring plan to ensure that the corrective action plan is successful.

7. Upon receipt of the initial CAP, IEHP reviews the CAP and either approves or denies the CAP in writing within thirty (30) calendar days of receipt.

8. If an IPA submits a CAP that is in full compliance (above 90%) with no specific identified risk and all prior deficiencies addressed, then the audit is considered complete and will be accepted.

9. If the CAP is denied:

   a. IEHP will communicate all remaining deficiencies to the Delegates, with a written request for a second CAP.

   b. Delegates requiring a second CAP may be frozen to new Member assignment until a CAP is received and approved.

   c. The Delegates are required to resubmit a second CAP within fifteen (15) calendar days to IEHP.

10. Upon receipt of the second CAP by IEHP:

    a. If the second CAP is approved, the CAP process is closed. If applicable, the Delegates are then re-opened to new Member assignment.

    b. If the second CAP is denied, the Delegates may be placed in a contract cure process that gives the Delegates thirty (30) calendar days to adequately correct the deficiencies.

C. Delegates wishing to appeal the results of the initial DOA must do so in writing to IEHP's Director of Delegation Oversight or designee within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.

D. After receiving a written appeal, the Director of Delegation Oversight or designee responds to the appealing Delegates in writing, noting the status of the appeal. Once an appeal is received, all additional documentation submitted by the Delegates is reviewed and, if

appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.

Other Oversight Activities or Focused and/or Clinical Audits

A. Other QM monitoring activities that could result in CAPs include but are not limited to:

1. Monthly, Quarterly, Semi-Annual and Annual report submissions;
2. UM, CM and Claims focused file audits;
3. Grievance and Appeal audits;
4. Compliance audits;
5. HIPAA Security audits;
6. Twenty-four (24) hour access studies;
7. Language competency audits;
8. Clinical audits (including asthma, diabetes, etc.);
9. Specific quality studies;
10. Focused audits;
11. Pharmacy audits;
12. Audits determined necessary by the Delegation Oversight Committee;
13. Follow up audits; and/or
14. Universe and Log Data Quality and Validation Audits.

B. IEHP reviews results of each audit or study and identifies deficiencies as noted in IEHP policies and procedures.

C. IEHP may issue a CAP for a decline in performance or identified risk in any given month.

1. Delegated Entities are evaluated and monitored for performance on an ongoing basis through the various sources, to include but not limited to:

a. Pre-Delegation Audits

b. Annual Audits

c. Focused Audits

d. Clinical Audits

e. Delegate Reporting

~~B.~~

~~C.~~D. Within thirty (30) calendar days of the audit or study, the Delegates receive written notification of the results including any required CAPs or sanctions. The written notification includes a cover letter and a completed audit tool (when applicable) noting any deficiencies found during the audit. Identified deficiencies will include requests for standard CAP and/or Immediate CAP (ICAP) (See Attachment "DOA CAP Response Form" in Section 25). The cover letter defines the timeframes for corrective action, and any other pertinent information.

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

~~6.~~

~~7.~~6. If the CAP is incomplete~~denied~~:

a. IEHP will communicate all remaining deficiencies to the Delegates with a written request for an updated ~~second~~ CAP including ~~P.~~requests for additional documentation and/ or any other documents as part of the CAP response.

~~b. Delegates requiring a second CAP may be frozen to new Member assignment until a CAP is received and approved.~~

~~c.~~b. For standard CAP findings, the Delegates are required to resubmit an ~~second~~ updated CAP response within fifteen (15) calendar days to IEHP. For ICAP findings, the Delegate is required to submit an ~~second~~ updated CAP response within (72) hours to IEHP.

7. If the CAP is considered complete:

   a. IEHP sends notification to the Delegate of the accepted CAP.

   b. An accepted CAP may remain open to allow monitoring for sustained improvement.

~~8. Upon receipt of the second CAP by IEHP:~~

   ~~a. If the second CAP response is approved, the CAP process is closed. If applicable, the Delegates are then re-opened to new Member enrollment.~~

   ~~b. If the second CAP response is denied, the Delegates may be placed in a contract cure process that gives the Delegates thirty (30) calendar days to adequately correct the deficiencies.~~

~~D.~~E. Delegates can appeal the results of any oversight activity, specialized study, audit and any required CAPs or sanctions to IEHP within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.

~~E.~~F. After receiving a written appeal, IEHP's Director of Delegation Oversight or Delegation Oversight Manager responds to the appealing Delegates in writing, noting the status of the appeal. Once an appeal is received, all additional documentation submitted by the Delegates is reviewed and, if appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.

Failure to submit a CAP ~~Submission Requirement~~

A. Failure to submit CAPs may result in one of the following activities, depending on the nature of the audit or study and the seriousness of the deficiency:

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

~~B. IEHP may issue a CAP for a decline in performance or identified risk in any given month.~~

   ~~1. Delegated Entities are evaluated and monitored for performance on an ongoing~~

~~basis through the various sources, to include but not limited to:~~

~~a. Pre-Delegation Audits~~

~~b. Annual Audits~~

~~c. Focused Audits~~

~~d. Clinical Audits~~

~~e. Delegate Reporting~~

~~2. If IEHP identifies an opportunity of improvement based on a decline in performance or identifies a compliance risk, IEHP will issue the Delegated entity a CAP that includes their findings, where the Delegated Entity is required to respond to within thirty (30) calendar days receipt of the CAP.~~

~~3.~~8. Upon receipt of the Corrective Action Plan, IEHPs will review for compliance and:

a. May elect to keep the CAP open while the Delegates performance is monitored for sustained improvements; or

b. Complete a validation audit following the implementation of the audit (as needed).

Failure to Implement Corrective Action Plan

A. Failure to demonstrate CAP implementation and sustained improvement as outlined in the Corrective Action Plan may result in further action including:

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

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   4. Corrective Action Plan Requirements

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2001
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

1. Credentialing Policies

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for Medi-Cal Providers~~lines of business~~.

POLICY:

A. IEHP and Delegates adhere to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing and recredentialing process, including the confidentiality of Practitioner information obtained during the credentialing process. Department of Health Care Services (DHCS) can modify these requirements at any time and is required to notify the Centers for Medicare & Medicaid Services (CMS) within ninety (90) days prior of any such changes.

~~A.~~B. Delegates must have a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to its Members.[1]

~~B. Delegates' policies and procedures describe a process for notifying Practitioners about their right to review information submitted to support their credentialing application.~~

C. Delegates' policies and procedures describe how primary source information is received, dated and stored; how modified information is tracked and dated from its initial verification; the staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate; the security controls in place to protect the information from unauthorized modification; and how the organization audits the processes and procedures.

~~At least annually, IEHP demonstrates that it monitors compliance with its CR controls.~~

~~D. Delegates' recredentialing policies and procedures require information from quality improvement activities and Member complaints in the recredentialing decision making process.~~

~~E. Delegates' policies and procedures must ensure that they only contract with Providers who have not opted out.~~

~~F. Delegates 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 Office of Inspector General (OIG) Report).~~

~~G.~~D. ~~Delegates must have policies and procedures that state they do not contract with Practitioners who are precluded from receiving payment for Medicare Advantage (MA) items~~

[1] Title 42 Code of Federal Regulations (CFR), Part 455, Subpart E

~~and services Part D drugs furnished or prescribed to Medicare beneficiaries.~~

PURPOSE:

A. IEHP promulgates credentialing and recredentialing decision guidelines for Practitioners directly contracted with IEHP, as well as Practitioners credentialed and contracted by IEHP's Delegates, who perform these activities. IPAs are expected to use these guidelines when educating and training PCPs and Specialists, outlining patient age ranges for Practitioners, making hospital arrangements, and reviewing potential issues of malpractice or other adverse history when making credentialing and recredentialing decisions.

~~B.~~A. ~~IEHP and Delegates adhere to all procedural and reporting requirements under state and federal laws and regulations regarding the credentialing and recredentialing process, including the confidentiality of Practitioner information obtained during the credentialing process.~~

~~C.~~B. ~~IEHP will use procedures consistent with Department of Health Care Services (DHCS) for all of Medi-Cal. DHCS can modify these rules at any time and is required to notify Centers for Medicare & Medicaid Services within ninety (90) days prior of any such change.~~

C. IEHP delegates all credentialing and recredentialing functions to Delegates that meet IEHP's requirements for delegation of credentialing. The Delegate must demonstrate a rigorous process to select and evaluate Practitioners.

——Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. Breeze, National Practitioner Data Bank (NPDB) etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from a National Committee for Quality Assurance (NCQA) approved and appropriate state-licensing agency.

D.

DEFINITION:

A. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

B. PSV Documentation Methodology: - The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.

C. Verbal Verification - Requires a dated, signed document naming the person at the primary

source who verified the information, his/her title, the date and time of verification and include what was verified verbally.

~~A.~~D. Verification Time Limit (VTL) - NCQA counts back from the decision date to the verification date to assess timeliness of verification.

~~B.~~A. ~~Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification and include what was verified verbally.~~

~~C.~~A. ~~Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.~~

~~D.~~E. Written Verification - Requires a letter or documented review of cumulative reports. The Delegated IPA must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

~~E.~~A. ~~Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. Breeze, National Practitioner Data Bank (NPDB) etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from a National Committee for Quality Assurance (NCQA) approved and appropriate state licensing agency.~~

~~F.~~A. ~~PSV Documentation Methodology: The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.~~

~~G.~~F. Delegate~~:~~ - If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight.

    a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

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

PROCEDURES:

A. Delegates' policies and procedures must include the Practitioner Credentialing Guidelines that specify the following:[2]

1. The types of Practitioners it credentials and recredentials. Credentialing requirements apply to:[3]

   a. Practitioners who are licensed, certified, or registered by the State of California to practice independently (without direction or supervision).

   b. Practitioners who have an independent relationship with the organization.

      1) An independent relationship exists when the organization directs its members to see a specific Practitioner or group of Practitioners, including all Practitioners whom Members can select as Primary Care Provider~~s~~ (PCP).

   c. Practitioners who provide care to Members under the organization's medical benefits.

   d. The criteria listed above apply to Practitioners in the following settings:

      1) Individual or group practices

      2) Facilities

      3) Telemedicine

   e. Delegates are required to contract with and credential all their Practitioners defined as PCPs, Specialists, Non-Physician Practitioners, and Physician Admitters, including employed ~~physicians~~ Physicians participating on the Provider panel and published in external directories who provide care to Members. At minimum, the Credentialing policies and procedures include the following types of Practitioners and describes which Providers the Delegate credentials:

      1) Doctor of Medicine (M.D.)

      2) Doctor of Osteopathic Medicine (D.O.)

      3) Doctor of Podiatric Medicine (D.P.M.)

      4) Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), who provide medical services only

[2] 42 CFR § 422.204
[3] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 1, Element A, Factor 1

5) Occupational Therapists (O.T.)
6) Physical Therapy (P.T.)
7) Physician Assistants (P.A.) or Physician Assistants Certified (P.A.-C)
8) Certified Nurse Midwives (C.N.M.)[4]
9) Nurse Practitioners (N.P.)
10) Speech Pathologists (S.P.)
11) Audiologists (Au.)
12) Registered Dieticians (R.D.) and Nutritionists
13) Psychiatrists (M.D.)
14) Licensed Marriage and Family Therapists (L.M.F.T.)
15) Licensed Clinical Social Workers (L.C.S.W.)
16) Psychologists (Ph.D., Psy.D.)
17) Doctor of Chiropractic (D.C.)
18) Licensed Midwife (L.M.)[5]

f. Practitioners who do not need to be Credentialed:

1) Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the ~~hospital~~ Hospital or another inpatient setting.
2) Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility.
3) Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) Functions.
4) Covering ~~practitioners~~ Practitioners (e.g., locum tenens).
    - Locum tenens who do not have an independent relationship with the organization are outside NCQA's scope of credentialing.
5) Practitioners who do not provide care for members in a treatment setting (e.g. board certified consultants).

[4] Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022 supersedes APL 16-017 and APL 15-017, "Provision of Certified Midwife and Alternative Birth Center Facility Services
[5] Ibid.

6) Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

7) IEHP does not require Delegated IPAs to credential Practitioners that are ~~hospital~~ Hospital based and do not see Members on a referral basis.

g. IEHP does not require Delegated IPAs to contract with the following Provider types, where services rendered by these Practitioners are covered by IEHP, however, must utilize the network contracted by IEHP. Therefore, credentialing and recredentialing of these Providers will be completed by IEHP.

1) Doctor of Chiropractic (D.C.)

2) Licensed Acupuncturists (LAc.)

3) Optometrists (O.D.)

4) Other Behavioral Healthcare Practitioners:

- Addiction Medicine Specialists
- Master Level Clinical Nurses
- Licensed Clinical Social Workers
- Marriage Family Therapists
- Licensed Professional Clinical Counselors (L.P.C.C.) ~~who have met the couples and families requirement only~~ [6,~~7~~]

2. Delegates' credentialing policies and procedures describe the sources the organization uses to verify credentialing information. Listed below are the sources used and accepted by IEHP to verify credentialing information of each of the following criteria listed below. All verification sources must be included in policy to ensure compliance with IEHP.[8]

a. State license to Practice (Verification Time Limit (VTL): one hundred-eighty (180) calendar days prior to Credentialing decision date). Must be unencumbered, valid, and current, at the time of committee and remain valid and current throughout the Practitioner's participation with IEHP. Failure to maintain a valid and current license at all times, will result in an administrative termination of the Practitioner.

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

[6] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3
[7] ~~National Committee for Quality Assurance (NCQA), 2022~~21 Health Plan Standards and Guidelines, CR 1, Element A, Factor 1
[8] NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 2

directly with the licensing board via phone or mail:

1) Medical Board of California (M.D.)
2) Osteopathic Medical Board of California (D.O.)
3) Board of Podiatric Medicine (D.P.M.)
4) Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C., L.P.C.C.)
5) Board of Psychology (Ph.D., Psy.D.)
6) Dental Board of California (D.D.S., D.M.D.)
7) California Board of Occupational Therapy (O.T.)
8) California State Board of Optometry (O.D.)
9) Physical Therapy Board of California (P.T.)
10) Physician Assistant Committee (P.A., P.A.-C)
11) California Board of Registered Nursing (C.N.M., N.P.)
12) California Board of Chiropractic Examiners (D.C.)
13) Speech-Language Pathology & Audiology Board (S.P., Au)
14) Acupuncture Board (L.Ac.)

b. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate verified through one (1) of the following sources:

1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision.
2) IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA number and NPI number will be documented in the Practitioner's file.
3) If a Practitioner does not have a DEA or CDS certificate, the Delegate must have a documented process requiring an explanation of why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner's patients who need prescriptions requiring DEA certification.

c. Education and Training (VTL: Prior to the Credentialing Decision) IEHP may use any of the following to verify education and training:

1) The primary source from the Medical School.

2) The state licensing agency or specialty board or registry, if the state agency and specialty board, respectively, perform primary source verification. IEHP:

- Obtains written confirmation of primary source verification from the primary source, at least annually~~,~~; or
- Provides a printed, dated screenshot of the state licensing agency or specialty board or registry website displaying the statement that it performs primary source verification of Practitioner education and training information~~,~~; or
- Provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution~~.~~; or
- National Student Clearinghouse may be considered an agent of the medical or professional school if the school has a contract with the Clearinghouse to provide verification services.
    - IEHP must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.

3) Sealed transcripts if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program.

4) Below are acceptable sources for ~~physicians~~ Physicians (M.D., D.O.) to verify graduation from Medical School:

- AMA Physician Master File.
- American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

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

- Primary source from the institution where the postgraduate medical training was completed.
- AMA Physician Master File.

- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
- FCVS for closed residency programs.
  - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

~~5) Below are the acceptable sources for Licensed Professional Clinical Counselors (L.P.C.C.'s) to verify training in Couples and Families.~~

- ~~The status must be recognized and verified through the BreEZe Online services website or directly with the licensing board via phone or mail.~~

~~6)~~5) Below is the acceptable source for Nurse Practitioners with a Behavioral Health (BH) designation, to verify training in Psych/Mental Health.

- The status must be recognized and verified through the BreEZe Online services website or directly with the licensing board via phone or mail.

~~7) Below is the acceptable source for Physician Assistants with a Behavioral Health (BH) designation:~~

- ~~Primary source verification from the Physician Assistant School, University of California, Irvine (UC Irvine) to confirms a completed Fellowship in Primary Care Psychiatry.~~

d. Board Certification (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). Below are the acceptable sources to verify board certification:

1) For all Practitioner types

- The primary source (appropriate specialty board).
- The state licensing agency if the primary source verifies board certification.

2) For Physicians (M.D., D.O.)

- ABMS or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
  - The ABMS "Is your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
- AMA Physician Master File.

- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
- Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards perform~~s~~ primary source verification of completion of education and training.

3) For other health care professionals

- Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.

4) For Podiatrists (D.P.M.)

- American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
- The American Board of Podiatric Medicine.
- American Board of Multiple Specialties in Podiatry.

5) For Nurse Practitioners (N.P.)

- American Association of Nurse Practitioners (AANP).
- American Nurses Credentialing Center (ANCC).
- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
- Pediatric Nursing Certification Board (PNCB).
- American Association of Critical-Care Nurses (AACN).

6) For Physician Assistants (P.A.-C).

- National Commission of Certification of P.A.'s (NCCPA).

7) For Certified Nurse Midwives (C.N.M.).

- American Midwifery Certification Board (AMCB).

8) For Psychologists (Ph.D., Psy.D.).

- American Board of Professional Psychology (ABPP).

e. Work history (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date) IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.

f. Malpractice Claim History. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the Practitioner. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). IEHP will obtain confirmation of the past seven (7) years of malpractice settlements through one (1) of the following sources:

1) Malpractice Insurance Carrier;

2) National Practitioner Data Bank Query; or

3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.

g. Current Malpractice Insurance Coverage: IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) or written verification from the insurance carrier directly, be obtained in conjunction of collecting information on the application. (VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner's participation with IEHP).

1) For Practitioners with federal tort coverage, (e.g. Health Resources & Services Administration (HRSA)), the Practitioner must submit:

- A copy of the face sheet or a federal tort letter as an addendum to the application. The face sheet or the federal tort letter must include the:
    - Insurance effective and expiration dates (future effective dates are acceptable)
- A practitioner roster that lists the practitioners covered under the federal tort coverage.

h. Hospital Admitting Privileges: IEHP must verify that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating ~~hospital~~Hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be confirmed with the Hospital, in writing, via approved website or verbally.

1) If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in "good standing."

2) If the Practitioner does not have clinical privileges, the IEHP must have a written statement delineating the inpatient coverage arrangement documented in the Provider's file. (See Policy ~~5D~~5B, "Hospital Privileges").

3) Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have ~~hospital~~ Hospital privileges and documentation in the file is not required for these types of Practitioners.

4) Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Nurse Midwives (NM)) may not have ~~hospital~~ Hospital privileges. However, if they provide the IEHP their ~~hospital~~ Hospital privileges, IEHP will be responsible for verifying if those privileges are active and ensure they are in good standing.

5) Specialists (MDs, DOs and DPMs) may not have ~~hospital~~ Hospital privileges. Documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).

i. State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).

1) Verification sources for sanctions or limitations on licensure include:

- Chiropractors: State Board of Chiropractic Examiners CIN-BAD, NPDB.
- Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
- Physicians: Appropriate state board agencies, FSMB, NPDB.
- Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.
- Non-~~physician~~ Physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.
- For delegates using the Continuous Query (formerly Proactive Disclosure Service (PDS))
    - Evidence of current enrollment must be provided.
    - Report must be reviewed within one hundred eighty (180) calendar days of the initial credentialing decision.
    - Evidence of review must be documented in the file or on checklist.

j. Medicare/Medicaid Sanctions. Verification Sources for Medicare/Medicaid Sanctions:

1) OIG must be the one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS.[9]

- ~~Date of query and staff initials must be evident on a checklist or the OIG page must be in the file.~~

2) The Medi-Cal Suspended and Ineligible list must be one (1) of the verification source for Medicaid sanctions, to ensure compliance with DHCS.[10]

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

3) NPDB

4) FSMB

5) FEHB Program Department Record, published by the Office of Personnel Management, OIG.

6) List of Excluded Individuals and Entities (maintained by OIG).

7) Medicare Exclusions Database.

8) State Medicaid Agency or intermediary and the Medicare intermediary.

9) For delegate's using the Continuous Query (formerly Proactive Disclosure Service (PDS))

k. NPI Number: Practitioners must hold and maintain a valid and active individual National Provider Identification Number (NPI) that can be verified through the National Plan & Provider Enumeration System (NPPES) website.

1) Group NPI Numbers may be requested by IEHP, in addition to the mandatory individual NPI number.~~[11],~~[12]

l. Medi-Cal Enrollment. IEHP uses the California Health & Human Services Agency's portal to confirm the Providers enrollment status with the Medi-Cal Program through DHCS, prior to the Provider being submitted to IEHP for participation in the IEHP network.[13]

3. Delegates' policies require credentialing of Practitioners before they provide care to Members. IEHP does not allow provisional credentialing. Policies must define the criteria

[9] DHCS APL ~~17-019~~19-004
[10] Ibid.
~~[11] NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 2~~
[12] ~~DHCS APL 19-004~~Ibid.
[13] Ibid.

required to reach a credentialing decision and must be designed to assess the Practitioner's ability to deliver care. Practitioners who do not meet the criteria set forth in this policy are subject for review by the Credentialing Subcommittee and/or Peer Review Subcommittee. This criteria is used to determine which Practitioners may participate in its network, which may include, but are not limited to:[14]

a. Verification of Credentials

1) A current and valid, unencumbered license to practice medicine in California, at the time of Credentialing decision.

2) Current and valid DEA registered in California, applies to Practitioners who are required to write prescriptions.

- If the ~~practitioner~~ Practitioner designates another ~~practitioner~~ Practitioner to write all prescriptions on their behalf, while their DEA is still pending, the Practitioner must provide the following information for the designated ~~physician~~ Physician to ensure compliance with NCQA:
  - Practitioner Name
  - NPI (IEHP requirement)
    - Used as a unique identifier for the prescribing practitioner
  - DEA Number (IEHP requirement)
    - Used to validate that the DEA is current, active and registered in California.

3) Education and Training. Medical Doctors (M.D.) and Doctor of Osteopathic (D.O.) must meet the education and training requirements set forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) and additional criterion set by IEHP and noted below, if applicable. All IEHP specific specialty requirements are subject for review by the IEHP Medical Director or Chief Medical Officer (CMO). Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

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

- If the Practitioner is not board certified in the subspecialty in which he/she is applying, there must be evidence of verification of residency and training in the subspecialty (e.g. Fellowship in Cardiology, Rheumatology, Pediatric

[14] NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 3

Endocrinology, etc.), as relevant to the credentialed specialty, and meet the training requirements as set forth by ABMS or AOA.

- Practitioners who do not meet graduate medical training requirements as set forth by ABMS or AOA for the Provider's requested subspecialty, will be subject to review by the IEHP Credentialing Subcommittee for review. Further review may be completed by the IEHP Peer Review Subcommittee.

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

AttestationIEHP Bariatric Surgery Attestation" in Section 5) to indicate volume of the following:

- 1) Volume of applicant's proctored cases; and
- 2) Volume of cases where applicant was the primary surgeon.
  - ❖ IEHP requires a minimum of fifteen (15) cases where applicant was the primary surgeon.[15]

- Current or past "Regular or Senior Member" of American Society for Metabolic and Bariatric Surgery (ASMBS). Verification of membership will be obtained by the Credentialing Department.
- IEHP recommends applicant actively participates with the MBSAQIP (Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program) or an equivalent regional or national quality improvement program.
  - Supportive documentation of participation with program is to be submitted with Credentialing application and/or request.

- **Family Practice 1: Family Practice Providers with Obstetrics (OB) services**, must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:
  - Provide a copy of a signed agreement that states Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
    - The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted hospital linked with that IPA network.
- **Family Practice 2: Family Practice that includes full OB services and delivery)** must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:
  - Have and maintain full delivery privileges at an IEHP contracted hospital.

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

- Provide a written agreement for an available OB back up Provider is required.
  - The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP hospital linked with the Family Practice Provider; and
  - Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

- **Internal Medicine Providers may practice outside of scope (with expanding age ranges to all ages)** will be processed with a secondary specialty of General Practice, for review and approval by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the IEHP Peer Review Subcommittee who will either approve or deny. The following documents are required for consideration:
  - Detailed explanation specifically outlining the material basis for the request to expand practice parameters for Member age range. At minimum, the written request must include:
    - Documentation of any relevant training (e.g., Continuing Medical Education, postgraduate/residency training, etc.); and
    - Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.).
  - PCPs that have Member assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program
    - Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients~~.~~; (See Attachment, "IEHP Addendum E" in Section 5)~~;~~
    - Provide evidence of twenty-five (25) CME units in Pediatric Primary Care completed within the last three (3) years; and
    - Applicants must provide two (2) letters of recommendation from a ~~physician~~ Physician coworker (i.e., ~~Primary Care Providers~~PCPs with work experience associated with the applicant in the preceding twenty-four (24) months). The

~~physician~~ Physician coworkers must hold an active board certification in Pediatrics or Family Practice.

- **Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Provider on**ly, will provide outpatient well woman services only with no hospital or surgical privileges, must provide the following information for consideration:
  - Documentation of primary care practice in the United States;
  - Twenty-five (25) Continuing Medical Education (CME) units for most recent three (3) year period, of which must be in primary care related areas;
  - Applicants must provide two (2) letters of recommendation from a ~~physician~~ Physician coworker (i.e. ~~Primary Care Providers~~PCPs with work experience associated with the applicant in the preceding twenty-four (24) months); and
    - The ~~physician~~ Physician coworkers must hold an active board certification in a Primary Care Specialty (i.e. board certified in Internal Medicine, Family Practice or Pediatrics).
  - In lieu of having full ~~hospital~~ Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery. (See Attachment, "Patient Transfer Agreement" in Section 5).
    - The Agreement must include back-up ~~physician's~~ Physician's full delivery privileges at IEHP network hospital, in the same network as the non-admitting OB Provider.
    - The OB Provider must be credentialed and contracted within the same network.

    These OB/GYNs provide outpatient well woman services only with no hospital or surgical privileges. This exception must be reviewed and approved by IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.
- **Pediatric Providers may practice outside of scope (with expanding age ranges to all ages)** will be processed with a secondary specialty of

General Practice, for review and approval by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the IEHP Peer Review Subcommittee who will either approve or deny. The following documents are required for consideration:

- PCPs that have Member assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.
- Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, "IEHP Addendum E" in Section 5)~~;~~
- Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years; and
- Applicants must provide two (2) letters of recommendation from a ~~physician~~ Physician coworker (i.e., ~~Primary Care Providers~~PCPs with work experience associated with the applicant in the preceding twenty-four (24) months). The ~~physician~~ Physician coworkers must hold an active board certification in Internal Medicine or Family Practice.

~~o General Preventive Medicine PCP's must complete the following, in addition to meeting the education requirements set by ABMS or AOA:~~

- ~~Twelve (12) month internship; and~~
- ~~Nine (9) months direct patient care experience (during or after residency);~~

o **Specialties not recognized by either board (ABMS or AOA) are subject to Medical Director, Chief Medical Officer Review.** Further review may be completed by the Credentialing Subcommittee or Peer Review Subcommittee, who will either approve or deny.

o **Urgent Care Providers** must meet the education and training requirements set forth by ABMS or AOA for at least one (1) of the following Specialty boards:

- American Board of Pediatrics
- American Board of Family Practice
- American Board of Internal Medicine
- American Board of Obstetrics and Gynecology
- American Board of Emergency Medicine

- Osteopathic Board of Pediatrics
- Osteopathic Board of Family Physicians
- Osteopathic Board of Internal Medicine
- Osteopathic Board of Obstetrics and Gynecology
- Osteopathic Board of Emergency Medicine
- If the Practitioner is board certified or eligible in a specialty and/or subspecialty recognized by the American Board of Medical Specialties or American Osteopathic Association not referenced above, then those Providers are subject to Medical Director, Chief Medical Officer Review. Further review may be completed by the Peer Review Subcommittee, who will either approve or deny. For their review and consideration, the following documents must be submitted:
  - Provide evidence of twenty-five (25) CME units in Pediatric Primary Care completed within the last three (3) years if the Provider is requesting to treat Pediatric patients;
  - Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years if the Provider is requesting to treat ~~Adult~~ adult patients; and
  - Applicants must provide two (2) letters of recommendation from a ~~physician~~ Physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The ~~physician~~ Physician coworkers must hold an active board certification in Pediatrics, Family Practice or Internal Medicine

4) Board Certification. IEHP does not require board certification; however, IEHP must verify the certification status of the practitioners who state that they are board certified, to include that board eligibility requirements are met.

5) Work History. IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the practitioner's application or Curriculum Vitae (CV). If the practitioner has less than five years of work history, the time frame starts at the initial licensure date.

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

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

   - Number of claims - any claims within the prior seven (7) years.
   - Results of cases - any settlements within the prior seven (7) years.
     - Settlements with a minimum payout of $30,000 or more
     - Settlements resulting in major permanent injury or death
   - Trends in cases - Practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).

7) Hospital Admitting Privileges. Practitioners must have clinical privileges in good standing. Practitioners must indicate their current hospital affiliation(s) or admitting privileges at a participating hospital. Practitioners must have appropriate admitting privileges or arrangements with IEHP's contracted hospitals, if applicable. (See Policy 5B~~D~~, "Hospital Privileges" and ~~See~~ Attachment, "Hospital Admitting Privileges Reference by Specialty" in Section 5).

   - Providers are not required to maintain hospital admitting privileges if they are only practicing at an Urgent Care or providing Telehealth Services only.

8) NPI: Must confirm Provider has an active Individual NPI with a Primary address that must be registered to an address in California.

   - Group NPI may be submitted to IEHP in conjunction to the Individual NPI.
   - Telehealth Providers are not required to have an NPI registered with a primary address in California.

9) Grievance History

   - Lower than average grievance rate
   - Absence of grievance trend

10) All Primary Care Provider (PCP) and Urgent Care Providers must meet the Facility Site Review (FSR)/Medical Record Review (MRR) ~~Guidelines~~guidelines. See Policy MC06A, "Facility Site Review and Medical Records Review Survey Requirements and Monitoring.[16]

[16] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3

- ~~Providers at a site without an active participating PCP must still have an FSR/MRR completed and passed to be considered a No Assignment Provider in the network. No PCPs or No Assignment Providers will be able to provide services at sites without completing an FSR/MRR~~
- ~~All PCPs must pass a required initial facility review performed by IEHP prior to receiving IEHP enrollment and treating Members.~~
  - ~~IEHP has ninety (90) days from the submission of all required credentialing information to complete the facility site review.~~

- Sanction Information. IEHP must verify the following sanction information for credentialing.
  1) State Sanctions, restriction on licensure and limitation on scope of practice:
     - Any actions, restrictions or limitations on licensure or scope of practice, are presented for review and discussion to the Credentialing Subcommittee and/or Peer Review Subcommittee.
  2) Medicare and Medicaid Sanctions
     - Medi-Cal Suspended & Ineligible List Providers are deemed suspended and ineligible from Medi-Cal will be terminated or not be credentialed and contracted with for Medi-Cal line of business. IEHP does not allow Medi-Cal Suspended & Ineligible List Providers to participate in the IEHP network.
     - Providers Excluded/Sanctioned by Medicare or Medicaid (OIG). IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report). Providers identified on the OIG report, will not be credentialed or contacted, and terminated from our network if they are existing Providers.[17]
     - Medicare Opt-Out Providers who are:
       - Behavioral Health (BH) Practitioners are not allowed to participate in the IEHP network for any lines of business due to contract limitations and system design, therefore are administratively terminated for all lines of business. All Members will be assigned to new Practitioners
     - Practitioners outside of BH are not allowed to participate in the IEHP network for Medicare Lines of business. Medicare Members are reassigned to new Practitioners.~~Providers who are identified on the Medicare Opt-Out~~

[17] DHCS APL 19-004

~~will not be contracted for Medicare line of business. IEHP does not allow Medicare Opt-Out Providers to participate in the IEHP network.~~

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- Preclusions List, Providers identified on the preclusions list will be terminated or not be credentialed and contracted with.[18]

- Credentialing Application – Practitioners must submit an application or reapplication that includes the following:
  1) Attestation to:
     - Reasons for inability to perform the essential functions of the position;
     - Lack of present illegal drug use;
     - History of loss of license and felony convictions;
     - History of loss or limitation of privileges or disciplinary actions;
     - Current Malpractice Insurance coverage. Must have current and adequate malpractice insurance coverage that meets the following criteria:
       - Minimum $1 million per claim/$3 million per aggregate.
       - Coverage for the specialty the Provider is being credentialed and contracted for.
       - Coverage for all locations the Provider will be treating IEHP patients.[19]
     - Current and signed attestation confirming the correctness and completeness of the application.
  2) Release of Information used for primary source verification.
  3) Addendum A
     - Practitioner Type
     - Practice Type
     - Name(s) of any employed Advanced Practice Practitioners (e.g. Nurse Practitioners (NP), Nurse Midwives, or Physician Assistants (PA))
     - Age Limitations
     - Practitioner Office Hours

[18] Centers for Medicare & Medicaid Services, "Preclusion List Requirements", 11/02/2018
[19] NCQA, 2021~~1~~ HP Standards and Guidelines, CR1, Element C, Factor 5

- Practitioner's written plan for continuity of care if they do not have ~~hospital~~ Hospital privileges
- Languages spoken by Physician
- Languages spoken by staff

4) Addendum B, used for Professional Liability Action explanation(s).
5) Addendum C, used to confirm Practitioner's status as a:
   - Certified Workers Compensation Provider
   - Reservist
6) Addendum D, Notice to Practitioners of Credentialing Rights/Responsibilities
7) Addendum E, applicable to General Practice and Obstetrics/Gynecology providers who are PCP's.
8) Verification of Qualifications for HIV/AIDS Physician Specialist form (See Attachment, "Verification of Qualifications for HIV/AIDS Physician Specialist~~Identification of HIV/AIDS Specialists~~", in Section 5) required for Practitioners who would like to be designated as an HIV/AIDS Specialist.
9) Behavioral Health Area(s) of Expertise Form – To ensure Practitioners are listed with the types of services they offer, this form is required for all Practitioners with a Behavioral Health Affiliation/Designation, to include but are not limited to:
   - Psychiatrists
   - Psychologists
   - Addiction Medicine Specialists
   - Master Level Clinical Nurses
   - Licensed Clinical Social Workers
   - Licensed Marriage Family Therapists
   - License Professional Clinical Counselors ~~who have met "Couples and Families" requirement, only~~
   -
   - ~~Nurse Practitioners~~NPs with a Behavioral Health (BH) designation
   - ~~Physician Assistants~~PAs with a Behavioral Health (BH) designation ~~who completed a Primary Care Psychiatry Fellowship~~

10) Transgender Questionnaire (See Attachment, "Transgender Questionnaire~~Questionnaire for: Providers for Transgender Members,~~" in Section 5) is required for all Practitioners who are or would like to be designated as a Transgender Competent Provider. At minimum, the Practitioner must meet and provide evidence of the following for consideration:

- Demonstrate ten (10) Continuing Medical Education (CME) hours within the last three (3) years,
- Certification through WPATH,
- Must provide evidence of the following annual staff training on transgender care, that includes:
    - Agenda,
    - Sign in sheet,
    - Policies and Procedures.

11) Licensed Midwife Attestation: Plan for Consultation, Emergency Transfer, & Transport (See Attachment, "Licensed Midwife Attestation", in Section 5) required for all Licensed Midwife practitioners.

- IEHP requires the backup Licensed Physician, engaged in active clinical obstetrical practice and with whom the Licensed Midwife consults when there are significant deviations from the normal, in either mother or infant, is an active Obstetrics/Gynecology practitioner within the IEHP network.

12) Attachment I: Statement of Agreement by Supervising Provider. IEHP requires a completed Attachment I: Statement of Agreement by Supervising Provider, for all Advanced Practitioner and Supervising Physician arrangements, to ensure arrangements are documented appropriately, which will be collected at the time of credentialing, recredentialing and upon relationship change.

~~12)~~• If these arrangements are clearly described on the Delegation of Services Agreement, Practice Agreement, or Standardized Procedures, those documents may be used in lieu of submitting an Attachment I form.

13) Practitioner offices who employ Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) must ensure written arrangements are in place between the Advanced Practice Practitioner and the practice where they treat IEHP members. These documents must be readily available to IEHP upon request. (See Policy 6F, "Facility Site Review – Non-Physician Practitioner Requirements").

- IEHP requires all Advanced Practice Practitioners to practice at the same site as their Supervising Physician.

- ~~Physician Assistants~~PAs with a Behavioral Health Designation must be supervised by a licensed ~~p~~Physician who specializes in Psychiatry.

~~13)~~ The following written arrangements must be provided to IEHP upon request for:

- ~~Physician Assistants~~PAs must provide one (1) o~~f~~n the following:
    - Delegation of Services Agreement and Supervising Physician Form (See Attachment, "Delegation of Services Agreement and Supervising Physician Form" in Section 5).[20] This agreement must:
        - Define specific services identified in practice protocols or specifically authorized by the supervising Physician., and
        - Both the Physician and PA must attest to, date and sign the document.
        - An original or copy must be readily accessible at all practice sites in which the PA works;
    - Practice Agreement, effective January 1, 2020,[21] the writing, developed through collaboration among one or more ~~physicians~~ Physicians and ~~surgeons~~ Surgeons and one or more ~~physicians'~~ PAs~~assistants~~, that defines the medical services the ~~physician~~ PA~~assistant~~ is authorized to perform~~ pursuant to Section 3502~~[22] and that grants approval for ~~physicians~~ Physicians and ~~surgeons~~ Surgeons on the staff of an organized health care system to supervise one or more ~~physician~~ PAs~~assistants~~ in the organized health care system. Any reference to a Delegation of Services Agreement relating to ~~physician~~ PAs~~assistants~~ in any other law shall have the same meaning as a practice agreement. The Practice Agreement must include provisions that address the following:~~~~[23]
        - The types of medical services a PA~~physician assistant~~ is authorized to perform.
        - Policies and procedures to ensure adequate supervision of the ~~physician assistant~~PA, including, but not limited to, appropriate communication, availability, consultations, and referrals between

[20] Title 16 California Code of Regulations (CCR) § 1399.540(b)
[21] Senate Bill 697
[22] Business & Professions Code ~~(BPC)~~ § 3502
[23] Bus~~.iness~~ & Prof~~.essions~~ Code ~~(BPC)~~ § 3502.3

a ~~physician~~ Physician and ~~surgeon~~ Surgeon and the ~~physician assistant~~PA in the provision of medical services.

- The methods for the continuing evaluation of the competency and qualifications of the PA~~physician assistant~~.
- The furnishing or ordering of drugs or devices by a PA~~physician assistant pursuant to Section 3502.1~~.[24]
- Any additional provisions agreed to by the ~~physician assistant~~PA and ~~physician~~ Physician and ~~surgeon~~Surgeon.

- A practice agreement shall be signed by both of the following:
  - The ~~physician assistant~~PA.
  - One or more ~~physicians~~ Physicians and ~~surgeons~~ Surgeons or a ~~physician~~ Physician and ~~surgeon~~ Surgeon who is authorized to approve the practice agreement on behalf of the staff of the ~~physicians~~ Physicians and ~~surgeons~~ Surgeons on the staff of an organized health care system.
- A delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.
- A practice agreement may designate a PA as an agent of a supervising ~~physician~~ Physician and ~~surgeon~~Surgeon.
- Nothing in this section shall be construed to require approval of a practice agreement by the board.
  - Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California, a practice agreement may authorize a PA to do any of the following:
    - Order durable medical equipment, subject to any limitations[25] ~~set forth in Section 3502~~ or the practice agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.[26]
    - For individuals receiving home health services or personal care services, after consultation with a supervising ~~physician~~

[24] Bus. & Prof Code § 3502.1
[25] Bus. & Prof Code § 3502
[26] Bus. & Prof Code § 3502.3 (1)

Physician and ~~surgeon~~Surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

- After performance of a physical examination by the PA under the supervision of a ~~physician~~ Physician and ~~surgeon~~ Surgeon consistent with this chapter, certify disability ~~pursuant to Section 2708~~ of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.[27]

- ~~Nurse Practitioners~~NPs and ~~Certified Nurse Midwives~~CNMs are required to have Standardized Procedures. Standardized Procedures must be on-site site specific and:
  - To meet the requirements, r~~R~~eference textbooks and other written sources~~, to meet the requirements of Title 16, CCR § 1474 (3),~~which must include:[28]
    - Book (specify edition) or article title, page numbers and sections.
  - NP and/or CNM must be practicing at a site assigned to their supervising Physician; and
  - Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the documents must include:
    - Table of Contents of the Standardized Procedures used, between the NP and/or CNM and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
    - Evidence that the Standards of Care established by the sources were reviewed and authorized by the ~~nurse Practitioner~~NP, Physician and administrator in the practice setting (i.e., signature page that includes all parties involved).
- Standardized Procedures written using the Practice Agreement or ~~Physician Assistants~~PAs Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.[29,30,31]

d. Adverse History Guidelines: IEHP must carefully review the Delegate's oversight

[27] California Code, Unemployment Insurance Code (UIC) § 2708
[28] 16 CCR § 1474 (3)
[29] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 1, Element A, Factor 3
[30] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3
[31] ~~Title~~ 16 CCR~~, California Code of Regulations (CCR)~~ § 1474 (3)

process to ensure all Practitioners with evidence of adverse history are presented to Credentialing Committee for review and documented in the meeting minutes. Adverse history requiring review by the Credentialing Committee may include, but is not limited to, Providers who have:

1) Restrictions on licensure
2) Restrictions on DEA
3) Loss of Clinical privileges or negative privilege actions
4) Identified on any of the following Sanctions:
5) Other negative actions may include, but are not limited to:
    - Use of illegal drugs
    - Criminal history
    - Engagement in unprofessional conduct or unacceptable business practices.

e. Provider Network

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

- Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.).

4) Patient Age ranges for ~~Primary Care Provider (~~PCP~~)~~ must be specifically delineated as part of the Delegated credentialing process. The guidelines for PCP age ranges are provided below:

SPECIALTY	AGE RANGE
Pediatrics	• 0 – 18 • 0 – 21
Family Practice	• All Ages • 14 and above
Internal Medicine	• 14 and above • 18 and above • 21 and above
Public Health and General Preventive Medicine	• 18 and above • 21 and above
Obstetrics/Gynecology	• 14 and above; restricted to females
General Practice	• All Ages, if evidence of pediatric training, experience and/or CME is present • 14 and above

- PCPs that have Members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.

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

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

4. Delegates' policies must define the process used and the criteria required to reach credentialing decisions that are designed to assess the Practitioner's ability to deliver care.

At a minimum:[32]

a. The Credentialing Committee must receive and review the credentials of the Practitioners who do not meet the Delegates established criteria.

b. Delegates' policies must identify what is considered acceptable to be determined as a clean file, if the Delegate utilized a clean file process.

c. If retrospective review by IEHPs Credentialing Department reveals that a Practitioner approved by a Delegate does not meet the above requirements, IEHP can submit the Practitioner to the IEHPs Peer Review Subcommittee for review.[33]

5. Delegates may designate to their Medical Director the authority to determine and sign off on a credentialing and recredentialing file that meets the Delegate standards as complete, clean, and approved. Delegates may assign an associate medical director or other qualified medical staff member as the designated medical director if the individual has equal qualifications as the medical director and is responsible for credentialing, as applicable. The Delegate's Credentialing Committee must review the credentials of all Practitioners being credentialed or recredentialed who do not meet the Delegates established criteria, and to provide advice and expertise for credentialing decisions.[34]

a. If the Medical Director or equally qualified Practitioner signs off on clean files, the sign off date is the Committee date.

b. If the Delegate decides not to use the Medical Director or equally qualified Practitioner, the Delegate can continue to send "clean files" to the Credentialing Committee.[35,36]

6. Delegates' policies must describe the process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.[37,38]

a. Policies must explicitly state that credentialing and recredentialing decisions are not based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient in which the Practitioner specializes and describe the steps for monitoring or preventing discriminatory practices during the credentialing/recredentialing processes.

b. Delegates procedures for monitoring and preventing discriminatory credentialing decisions may include but are not limited to:

[32] NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 4
[33] NCQA, 2021 HP Standards and Guidelines, CR 1, Element A, Factor 4
[34] NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 5
[35] NCQA, 2021 HP Standards and Guidelines, CR 1, Element A, Factor 5
[36] NCQA, 2021 HP Standards and Guidelines, CR 1, Element A, Factor 6
[37] 42 CFR § 422.205
[38] NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 6

1) Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination;

2) Maintaining and heterogeneous Credentialing Committee membership and requiring those responsible for credentialing decisions to sign an affirmative statement to make decisions in a non-discriminatory manner.

3) Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes. Policy must indicate that monitoring is to be conducted at least annually. Examples of monitoring discriminatory practices:

   - Having a process for performing periodic audits of credentialing files (in-process, denied and approved files)
   - Having a process for performing annual audits of Practitioner complaints about possible discrimination. (Can be reviewed and discussed during quarterly or semi-annual review of complaints)

4) Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes. Examples for preventing discriminatory practices:

   - Maintaining a heterogeneous credentialing committee and requiring those responsible for credentialing decisions to sign a statement affirming that they do not discriminate.
   - Timeframe for prevention: None. Committee members can attest annually or at each meeting.

7. Delegates' policies and procedures must describe the process for notifying Practitioners when credentialing information obtained from other sources varies substantially from that provided. A statement that Practitioners are notified of discrepancies does not meet the requirement.[39]

8. Delegates' policies and procedures must describe the process for notifying Practitioners the credentialing and recredentialing decisions within sixty (60) calendar days of the Committee's decision.[40]

9. Delegates' policies must describe the medical director or other designated Practitioner's overall responsibility and participation in the credentialing process.[41]

10. Delegates' policies and procedures must clearly state the information obtained in the credentialing process is confidential and describe the process to ensure confidentiality of the information collected during the credentialing process. The Delegates' mechanisms

[39] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 1, Element A, Factor 7
[40] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 1, Element A, Factor 8
[41] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 1, Element A, Factor 9

in effect to ensure confidentiality of all information obtained in the credentialing process, except as otherwise provided by law, may include, but is not limited to:[42]

a. Confidentiality statements are signed by Committees and Credentialing staff;

b. Practitioner files are maintained in locked file cabinets are only accessible by authorized personnel, if applicable; and

c. Security for database systems is maintained through passwords or other means to limit access to Practitioner information to authorized staff only.[43]

11. Delegates' policies and procedures describe the Delegates' process for ensuring that information provided to IEHP for Member materials and Practitioner directories is consistent with the information obtained during the credentialing and recredentialing process. At minimum, policy should demonstrate that the information collected during the credentialing and recredentialing process and requests received in between cycles, is entered, maintained, and submitted to IEHP by the Credentialing Department to ensure consistency.[44]

B. Delegates' policies and procedures describe how the following three (3) factors are met and how the Practitioners are notified (e.g. application, contact, Provider Mmanual, other information distributed to Practitioners, website, letter to Practitioners):[45]

1. Review information submitted to support their credentialing application

a. Policies should allow for review of information obtained from outside sources (e.g. malpractice insurance carriers, state licensing boards) to support their credentialing application. Delegates are not required to make available:

1) References.

2) Recommendations.

3) Peer-Review protected information.

2. Delegate notifies Practitioners of their right to correct erroneous information (submitted by another source) and must clearly state:

a. The time frame for making corrections.

b. The format for submitting corrections.

c. Where corrections must be submitted.

Delegates are not required to reveal the source of information that was not obtained to

[42] NCQA, 2022 HP Standards and Guidelines, CR 1, Element A, Factor 10
[43] NCQA, 20221 HP Standards and Guidelines, CR 1, Element A, Factor 10
[44] NCQA, 20221 HP Standards and Guidelines, CR 1, Element A, Factor 11
[45] NCQA, 2022 HP Standards and Guidelines, CR 1, Element B, Factor 1-3

meet the verification requirements or if federal or state law prohibits disclosure.

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

3. Delegates notifies Practitioners of:
   a. Their right to be informed of the status of their application, upon request.
   b. The information it is allowed to share with Practitioners.
   c. Its process for responding to requests for application status. [46]

C. Delegates credentialing process, both paper and electronic, must describe:
1. How primary source verification information is received, dated and stored.
2. How modified information is tracked and dated from its initial verification.
   a. The policy must clearly state how it tracks:
      1) When the information was modified
      2) How the information was modified
      3) Staff who made the modification
      4) Why the information was modified
3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.
   a. The delegates policies and procedures identify the:
      1) Level of staff who are authorized to access, modify and delete information
      2) Circumstances when modification or deletion is appropriate
4. The security controls in place to protect the information from unauthorized modification.
   a. Policies and procedures describe the process for:
      1) Limiting physical access to the credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources.
      2) Preventing unauthorized access, changes to and release of credentialing information.
      3) Password-protecting electronic systems, including user requirements to:
         - Use strong passwords
         - Avoid writing down passwords

[46] NCQA, 20221 HP Standards and Guidelines, CR 1, Element B, Factors 1-3

- Use different passwords for different accounts
- Change passwords periodically
- Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security to:
  - Change passwords when appropriate
  - Disable or remove passwords of employees who leave the organization
- If the Delegate contracts with an external entity to outsource storage of credentialing information, the contract describes how the contracted entity ensures the security of the stored information.
  - Contract will require review if outsourcing

5. How the organization audits the processes and procedures in factors 1-4.
   a. The policies and procedures must describe the audit process for identifying and assessing risks and ensuring the specified policies and procedures are followed. The description includes:
      1) The audit methodology used, including sampling, the individuals involved in the audit and audit frequency.
      2) The oversight of the department responsible for the audit.[47]

D. At least annually, Delegates must demonstrate that it monitors compliance with its CR controls, by:

1. Identifying all modifications to credentialing and recredentialing information that did not meet the organizations policies and procedures for modifications.
2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications, by conducting qualitative and quantitative analysis of all modification that did not meet its policies and procedures.
3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters.

~~D.~~E. Delegates' recredentialing policies and procedures require information from quality improvement activities and Member complaints in the recredentialing decision making process.[48, 49]

~~E.~~F. Delegates' policies and procedures must ensure that it only contracts with ~~physicians~~

[47] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 1, Element C, Factors 1-5
[48] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3
[49] DHCS APL 19-004

Physicians who have not opted out.

1) Medicare Opt-Out Providers who are identified on the Medicare Opt-Out will not be contracted for Medicare line of business. IEHP does not allow Medicare Opt-Out Providers to participate in the IEHP network for Medicare lines of business.[50]

~~F.~~G. Delegates must have policies and procedures that prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report). Providers identified on the OIG report, will not be credentialed or contacted, and terminated from our network if they are existing Providers.[51]

~~G.~~H. Delegates must have policies and procedures that they do not contract with Practitioners who are precluded from receiving payment for Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries. IEHP does not allow Practitioners identified on the preclusions list to participate in the IEHP network.

[50] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.2.
[51] DHCS APL 19-004

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
10. Credentialing Quality Oversight of Delegates

APPLIES TO:

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

POLICY:

A. Delegates must obtain approval of Practitioners seeking participation in the IEHP network, from the Delegates Credentialing Committee and/or Medical Director before submitting the Practitioner to IEHP, for review and approval. Delegates must confirm the Practitioners meet IEHPs criterion as specified in Policy 25B1, "Credentialing Standards – Credentialing Policies."

B. If a Practitioner is changing from one (1) IPA to another, the new IPA must submit the Provider's documentation (as noted in Procedure A below) within sixty (60) calendar days of the effective date of the change.

C. All Delegates are responsible for recredentialing and/or employed Practitioners within the thirty-six (36) months of the last credentialing decision, as required by National Committee for Quality Assurance (NCQA). Delegates are required to report their credentialing recredentialing activities to IEHP. Delegates must report credentialing, recredentialing and terminations activities by the 15th of the following month.

D. All Practitioner terminations and changes (i.e., Address, specialty, age limits, Supervising Physicians, TIN changes etc.) must be submitted to providerupdates@iehp.org. All changes and terminations submitted through the Secure File Transfer Protocol (SFTP) server will not be processed.

E. Delegates must provide IEHP with a status report of their specialty network on a semi-annual basis during Provider Directory review. Delegates that do not require their Providers to be listed in the Provider Directory submit specialty networks quarterly.

F. IPAs are responsible for reviewing, maintaining and notifying IEHP of any changes to their Hospital admitting arrangements for each of their affiliated links.

PURPOSE:

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

credentialing standards or to IEHPs expectations.[1]

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

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.

    a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

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

PROCEDURES:

A. Delegates must obtain approval of Practitioners seeking participation in the IEHP network, from the Delegates Credentialing Committee and/or Medical Director before submitting the Practitioner to IEHP, for review and approval.

1. All credentialing file information must be submitted to IEHP via the SFTP, into the Delegates assigned 'Credentialing' Folder.

    a. Once the upload is complete, the Delegate must take a screenshot showing the files uploaded into the 'Credentialing' Folder. The Delegate will need to email Provider Delegation at CredentialingProfileSubmission@iehp.org notifying IEHP when the credentialing files are posted.

        1) IEHP will then respond to the email with a confirmation that the credentialing files were located.

[1] ~~1~~ National Committee for Quality Assurance (NCQA), 2022~~1~~ HP Standards and Guidelines, CR 8, Element A, Factor 3~~.~~

[2] NCQA, 2022 HP Standards and Guidelines, CR 8, Element A, Factor 4

- Upon receipt of credentialing files into the Delegate's SFTP 'Credentialing' folder, IEHP will begin the credentialing process. Submitted files will be forwarded to IEHP Credentialing for processing.
    - For all Primary Care Providers (PCPs), Obstetrics/Gynecology (OB/GYNs) and Urgent Cares, once all credentialing information is received, IEHP's Credentialing Department will request for a facility site review with IEHP's Quality Management (QM) Department, in accordance to Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring."
    - If a Practitioner's submission packet is incomplete and/or missing supporting documentation, the Delegate is notified via email with the reason why that the process was terminated for the Practitioner. The Delegate must resubmit all documents again, to include missing information to IEHP for review and reconsideration.
- Credentialing Files submitted through any other methods will be rejected and the Delegate will be directed to submit the files via the SFTP.

2. The Delegate must submit the following for review and consideration:
    a. Contract (1st and signature pages)
        1) To include any applicable addendums to show the Practitioners relationship or affiliation with that contract.
    b. W-9 for all Tax Identification Numbers (TINs) used by the Practitioner.
    c. Attachment I: Statement of Agreement by Supervising Provider is required for all Physician Extenders (Physician Assistants (PA), Nurse Practitioners (NP), and Certified Nurse Midwife's (CNM) to confirm the relationship between the ~~Supervising~~ supervising Physician and Physician Extender(s). (See Attachment, "Attachment I - Statement of Agreement by Supervising Provider" in Section 5)
        ~~c.~~1) If these arrangements are clearly described on the Delegation of Services Agreement, Practice Agreement, or Standardized Procedures, those documents may be used in lieu of submitting an Attachment I form.
    d. Hospital Admitting arrangements must be noted on the profile or provided as an attachment at the time of submission, to include but not limited to alternate admitting arrangements.
        ~~d.~~1) If the IPA provides an alternative arrangement, IEHP does not have on file the IPA will be required to submit those arrangements to ensure compliance with IEHP requirements. (See Policy 5B, "Hospital Privileges" ~~in Section 5~~)
    e. Practitioner ~~Profile~~ profile or spreadsheet that includes all the elements listed below,

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

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
1.	✓	✓	✓	IPA Name
2.	✓	✓	✓	Line(s) of Business • Required if Delegate is participating in more than one (1) line of business
3.	✓	✓	✓	Identifier as to whether the packet is Initial (I) or Recredentialing (R)
4.	✓	✓	✓	Identifier for Practitioner Type: • PCP • Specialist; or • Mid-Level Practitioner
5.	✓	✓	✓	Practitioner Name as it's listed on License to Practice
6.	✓	✓	✓	Other Names used (Preferred)
7.	✓	✓	✓	Practitioner Specialty
8.	✓	✓	✓	Practice/Clinic Name(s)
9.	✓	✓	✓	Practitioner Address(es)
10.	✓	✓	✓	Practitioner Phone and Fax numbers
11.	✓	✓	✓	Practitioner Office Hours
12.	✓	✓	✓	Practitioner Date of Birth (D.O.B.)
13.	✓	✓	✓	Practitioner Social Security Number (S.S.N.)
14.	✓	✓	✓	Practitioner Gender

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
15.	✓	✓	✓	Practitioner Cultural Background (optional);
16.	✓	✓	✓	Practitioner Languages spoken
17.	✓	✓	✓	Practitioner Tax Identification Number(s)
18.	✓	✓	✓	Practitioner License Number and expiration date
19.	✓	✓	✓	Initial Committee Approval Date
20.	✓	✓	✓	Recredentialing Committee Approval Date (if applicable)
21.	✓	✓	✓	Drug Enforcement Administration (DEA) Number and expiration date (if applicable)
22.	✓	✓		DEA Arrangements if the Practitioner does not have a DEA Certificate (if applicable)
23.	✓	✓		Hospital Affiliations • Hospital Name • Status • Type of Service provided - Specialty
24.	✓	✓		Hospital Admitter arrangements • Name of Hospital • Name of Admitter

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
25.	✓	✓	✓	Malpractice Insurance Coverage • Name of Insurance carrier • Policy number • Coverage per claim • Coverage per aggregate • Expiration date
26.	✓	✓	✓	Board Certification • Name of Board • Expiration date/re-verification date • Certification status
27.	✓	✓	✓	Medical School • Name of Institution • Graduation Date MM/YYYY)
28.	✓	✓		Internship • Institution Name • Specialty • Training Type • Start Date MM/DD/YYYY • End date MM/DD/YYYY
29.	✓	✓		Residency, if applicable • Institution Name • Specialty • Training Type • Start Date MM/DD/YYYY • End date MM/DD/YYYY

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
30.	✓	✓		Fellowship, if applicable • Institution Name • Specialty • Training Type • Start Date MM/DD/YY • End date MM/DD/YY
31.	✓	✓	✓	Individual National Provider Identifier (NPI) Number
32.			✓	Name of Supervising Physician
33.	✓	✓	✓	Staff Languages spoken
34.	✓	✓	✓	Medi-Cal Number
35.	✓	✓	✓	Age Limits

3. Upon receipt of the documentation, IEHPs Credentialing Department performs a quality review of each delegate's credentialed and approved Practitioner to ensure compliance with IEHPs guidelines (See Policy 5A, "Credentialing Standards – Credentialing Policies").

   a. The Practitioner review includes, but is not limited to the following:

      1) Review of credentialed Practitioner specialty and relevant education, training, practice experience.

      2) Review of requested age range

      3) Review of Hospital arrangements, if applicable

      4) Review of adverse history;

         - History of negative license action;
         - History of negative privileges action;
         - History of Medicare or Medicaid sanctions; and
         - Other adverse history (including felony convictions, etc.).

b. In cases where the IPA submitted credentialing information is consistent with IEHP guidelines, no adverse history is present, and the Practitioner has successfully passed IEHP's site review (if applicable), the PCPs, Specialists, and Mid-Levels are reviewed and signed off by Credentialing Department.

c. In cases where either the Delegate(s) submitted credentialing information is inconsistent with IEHP guidelines or data, or there is evidence of significant adverse history.

1) Delegates must provide a written plan of action for the respective practitioner that includes, but is not limited to:

- The Credentialing Date the practitioner was presented to review and discussion.
- The Credentialing Committee decision and/or outcome.
- If the Delegate will conduct additional monitoring (i.e. grievances and complaints), if so, how frequent
- If the Delegate issued a plan of action or requested any additional information for the practitioner.

2) The Practitioner is forwarded to the IEHP Peer Review Subcommittee for further review, discussion and decision. The IEHP Medical Director presents the Practitioner's credentialing file and any other necessary supporting documentation from the IPA, Practitioners, or IEHP to determine if potential quality of care issues for Members exists.

- If the IEHP Peer Review Subcommittee determines that no potential quality of care concern exists, no further action or review is undertaken.
- If the IEHP Peer Review Subcommittee determines there is a potential quality of care concern or adverse event that exists. The Peer Review Subcommittee may make recommendations to improve the performance of a Practitioner, that includes but is not limited to:
    - Request for additional information from the Delegate, with review at next meeting.
    - Individual counseling by the Delegate or IEHP Medical Director.
    - Focused audits of Practitioner's practice by IEHP Quality Management staff.
    - Continuing medical education or training.
    - Restriction of privileges, including age range restrictions or other limitations.

- Termination of the Practitioner from the IEHP network; and
- Any other action appropriate for the circumstances

3) Actions by the IEHP Peer Review Subcommittee that differ from the IPA Credentialing Committee decisions, including changes in privileges and termination are tracked by IEHP.

- The IEHP Medical Director reviews the tracking report, the credentialing files and any other supporting information as necessary.
- After review, IEHP takes any of the following action(s) against the delegate:
  - No action.
  - Verbal or written request for additional information from the Delegate's Medical Director.
  - Request an interim focused credentialing audit of the Delegate by IEHP staff; or
  - Any other action as appropriate, including revocation of delegated credentialing responsibilities. [3]

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

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

C. All Delegates are responsible for recredentialing Practitioners within the thirty-six (36) months of the last credentialing decision, as required by NCQA as a Must-Pass Element.[4]

1. By the 5th of every month, IEHP will post the Delegates outstanding recredentialing report to the SFTP Server.
2. Delegates are required to review these reports and ensure that the Providers identified on the report are submitted to IEHP with their new recredentialing dates, by the due dates as specified on the IPA Reporting Requirements Schedule (See Attachment, "IPA Reporting Requirements Schedule – Medi-Cal" in Section 25).
   a. These dates are used to conduct file selections for the Delegates Delegation Oversight Audit for Credentialing; and

[3] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 5, Element A, Factor 5
[4] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 4, Element A, Factor 1

b. Track the Delegates Recredentialing timeliness (Recredentialing Cycle Length)

3. The Delegates failure to submit timely reports or failure to recredential practitioners within the thirty-six (36) month timeframe will be deemed non-compliant and will result in a corrective action plan.

4. Delegates are required to report their credentialing and recredentialing activities, and termination via excel format. (See Attachment, "Credentialing and Recredentialing Report", in Section 25). For MDLive, American Specialty Healthplan (ASH) and Kaiser (See Attachment, "Credentialing and Recredentialing Report for Delegated Networks", in Section 25, applicable to only). Delegates must submit their report based on the IPA Reporting Requirements Schedule (See Attachment, "IPA Reporting Requirements Schedule – Medi-Cal" in Section 25).[5]

a. Credentialing Tab: IEHP will review and analyze the Practitioner list and their credentialing dates to ensure they are consistent with IEHPs data.

1) The Credentialing Dates are used to capture the Delegation Oversight Audit file selection, based on the look-back period, to select files for the annual audit.

b. Recredentialing Tab: IEHP will review and analyze the Practitioner list and their credentialing and recredentialing dates to ensure they are consistent with IEHPs data.

1) The recredentialing dates are used to capture the Delegation Oversight Audit file selection, based on the look-back period, to select files for the annual audit.

c. Termination Tab: IEHP will review and analyze the Practitioner list to ensure the practitioners identified are not active in the IEHP network.

1) The Provider Network Department will be notified of all practitioners who are not terminated from IEHP.

- Upon request, Delegates are required to submit supporting documentation regarding terminations, that includes but is not limited to:

  - Reason for termination
  - Termination effective Date
  - Reassignment of Advanced Practice Practitioners
  - ~~4.~~ Member reassignment designations

D. All Practitioner terminations and changes (i.e. Address, specialty, age limits, Supervising Physicians, Taxpayer Identification Number (TIN) changes etc.) must be submitted to providerupdates@iehp.org. All changes and terminations submitted through the SFTP server will not be processed. (See Policy Section 18, "Provider Network").

[5] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element A, Factor 3

1. PCP relocations must pass a California Department of Health Care Services (DHCS) required FSR Survey and close CAPs prior to receiving assignment of members, within thirty (30) days upon relocation or the date IEHP discovers that the PCP site moved, and a minimum every three (3) years thereafter, unless it was determined that they be placed on annual review. (See Policy 6A, "Facility Site Review and Medical Record Survey Requirements and Monitoring").[6]
2. Changes in Specialty and age limits are considered practice parameter expansions and reductions and submit the required documentation in Policy 25B1, "Credentialing Standards - Credentialing Policies").
3. Advanced Practice Practitioners (PAs, NMs, and NPs) relocating or changing supervising Physicians, Delegates must provide a current copy of the following documents to ensure compliance with IEHP guidelines (See Policy 6F, "~~Non-Physician~~ Advance Practice Practitioner Requirements").
   a. ~~Physician Assistants~~PAs must provide one (1) on the following:
      1) Delegation of Services Agreement and Supervising Physician Form (See Attachment, "Delegation of Services Agreement and Supervising Physician Form" in Section 5).[7] This agreement must:
         - Define specific services identified in practice protocols or specifically authorized by the supervising Physician., and
         - Both the Physician and PA must attest to, date and sign the document.
         - An original or copy must be readily accessible at all practice sites in which the PA works;
      2) Practice Agreement, effective January 1, 2020,[8] the writing, developed through collaboration among one or more ~~physicians~~ Physicians and surgeons and one or more physicians' assistants, that defines the medical services the ~~physician assistant~~PA is authorized to perform pursuant to Section 3502[9] and that grants approval for ~~physicians~~ Physicians and ~~surgeons~~ Surgeons on the staff of an organized health care system to supervise one or more ~~physician assistants~~PAs in the organized health care system. Any reference to a Delegation of Services Agreement relating to ~~physician assistants~~PAs in any other law shall have the same meaning as a practice agreement. The ~~Practice~~ practice ~~Agreement~~ agreement must include provisions that address the following:

[6] Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006 Supersedes Policy Letters 14-004 and 03-002 and All Plan Letter 03-007, "Site Reviews: Facility Site Review and Medical Record Review"
[7] Title 16 California Code of Regulations (CCR) § 1399.540(b)
[8] Senate Bill 697
[9] Business ~~&~~ and Professions Code ~~(BPC)~~ § 3502

- A practice agreement shall include provisions that address the following:[10]
  - The types of medical services a ~~physician~~ PA~~assistant~~ is authorized to perform.
  - Policies and procedures to ensure adequate supervision of the ~~physician assistant~~PA, including, but not limited to, appropriate communication, availability, consultations, and referrals between a ~~physician~~ Physician and ~~surgeon~~ Surgeon and the ~~physician assistant~~PA in the provision of medical services.
  - The methods for the continuing evaluation of the competency and qualifications of the ~~physician assistant~~PA.
  - The furnishing or ordering of drugs or devices by a ~~physician~~ Physician ~~assistant~~ Assistant.[11] ~~pursuant to Section 3502.1~~.
  - Any additional provisions agreed to by the ~~physician assistant~~PA and ~~physician~~ Physician and ~~surgeon~~Surgeon.
- A practice agreement shall be signed by both of the following:
  - The ~~physician assistant~~PA.
  - One or more ~~physicians~~ Physicians and ~~surgeons~~ Surgeons or a ~~physician~~ Physician and ~~surgeon~~ Surgeon who is authorized to approve the practice agreement on behalf of the staff of the ~~physicians~~ Physicians and ~~surgeons~~ Surgeons on the staff of an organized health care system.
- A delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.
- A practice agreement may designate a PA as an agent of a supervising physician and surgeon.
- Nothing in this section shall be construed to require approval of a practice agreement by the board.
  - Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California, a practice agreement may authorize a PA to do any of the following:
    - Order durable medical equipment, subject to any limitations set forth in Section 3502 or the practice agreement. Notwithstanding

[10] Bus.~~iness~~ ~~&~~ and Prof.~~essions Code~~ Code ~~(BPC)~~ § 3502.3
[11] Bus. & Prof. Code § 3502.1

that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

- For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.
- After performance of a physical examination by the PA under the supervision of a physician and surgeon consistent with this chapter, certify disability pursuant to Section 2708 of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.

b. ~~Nurse Practitioners (~~NPs~~)~~ and ~~Nurse Midwives (~~CNMs~~)~~ may perform the following procedures if a standardized procedure is in place:

1) To diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissue of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions.

2) Standardized ~~Procedures~~ procedures must be on-site site specific and[12]

- Reference textbooks and other written sources to meet the requirements of Title 16, CCR § 1474 (3), must include:
  - Book (specify edition) or article title, page numbers and sections.
- NP and/or NM must be practicing at a site assigned to their supervising physician; and
- Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the Delegate must collect and submit to IEHP:
  - Table of Contents of the Standardized Procedures used, between the NP and/or ~~Certified Nurse Midwife (~~CNM~~)~~ and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
  - Evidence that the Standards of Care established by the sources were reviewed and authorized by the ~~nurse practitioner~~NP, Physician and administrator in the practice setting (i.e. signature page that includes all

[12] Title 22 California Code of Regulations (CCR) § 1474 (3)

parties involved).[13]

- Standardized Procedures written using the PAhysician Assistants Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.

4. Practitioner Terminations. Delegates must provide IEHP sixty (60) calendar days advance notice of any significant change in their network, including the termination of a Practitioner.[14]

   a. All Delegates are required to notify IEHP of any adverse actions against any of their contracted Practitioners.

E. Delegates must provide IEHP with a status report of their specialty network on a semi-annual basis during Provider Directory review. Delegates that do not require their Providers to be listed in the Provider Directory submit specialty networks quarterly (e.g., MDLive, ASH, and Kaiser).[15]

1. On a semi-annual basis, IEHP provides Delegates with the Specialty and Extender Roster information via online verification reports on the Secure Provider Portal including admitter and ancillary Providers previously submitted by the Delegate to IEHP that identifies the Delegate's current Provider Network that includes:

   a. Provider name

   b. Address (Address, City, and ZIP)

   c. Phone/Fax number

   d. Specialty

2. Delegates must indicate for each specialist listed, as applicable, the following:

   a. "New Hospital Privileges" – provided to indicate the Practitioner is adding new privileges with an IEHP network Hospital. Indicate Name of Hospital and privileges (active, courtesy, etc.).

   b. "New Hospital Link" – provided to indicate which network Hospital will be added to Practitioner.

   c. "Information is correct" – provided to specify information is correct and no changes are required.

   d. "Provider Term Date" – provided to indicate the Practitioner is no longer part of the IPA's specialty network. Provide effective date of termination.

[13] 16 CCR § 1474
[14] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Supersedes APL 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"
[15] NCQA, 20221 HP Standards and Guidelines, CR 8, Element A, Factor 3

e. "Term This Site Only" – provided to indicate the Practitioner is no longer at this location only. Provide effective date of location closure. Provide IEHP additional details on a separate sheet, if further review is required (i.e. provider is relocating, this site is the providers only existing location with IEHP and needs to add a different location."

f. "Updated information" – provided to specify new addresses, a typo, or any other changes to the information provided on the secure Provider Portal.

3. IEHP makes the indicated changes that will be reflected on the IPA's roster.

a. Delegates are required to update all information online and advise of completion to their Provider Service Representative within thirty (30) days of receipt. The online verification reports are made available in IEHP's secure portal.

F. IPAs are responsible for reviewing, maintaining and notifying IEHP of any changes to their Hospital admitting arrangements for each of their affiliated links, through the following process:

1. The Delegation Oversight Analyst emails all Delegates on the 15th of each month for verification of all Admitter arrangements to ensure accurate information is obtained.

2. IPAs are responsible for the following:

a. Ensuring all providers listed with the correct Admitting Provider.

a. If there are changes, the IPAs are responsible for notifying the Provider of the changes and of their current admitter arrangements for each respective hospital.

b. For the Admitting Providers, the IPA confirms admitting privileges to the Hospitals they are admitting to, are in place and in good standing.

1) The IPA is responsible for providing a replacement. If not, the Provider will be terminated from the IPA's network for not having Hospital admitting arrangements.

c. The IPA is responsible for reviewing the Specialist Providers and reconfirming their Hospital arrangements, to ensure that the Admitting Provider is:

1) Within the same specialty;

2) Cover the same age range;

3) Within the same practice; and

4) Active within the same IPA network as the referring Physician.

d. Ensuring all Providers on the report are still active with the IPA.

e. Any changes from the IPAs must be submitted by the 25th of every month, via Secure File Transfer Protocol (SFTP) server.

1) The IPAs failure to respond by the 25th of each respective month will result in non-compliance and may result in a corrective action plan on monthly delegation reporting.

3. On the last day of the month all network Hospitals are emailed the final Admitter list for that month. It includes Admitter's name, phone number and fax number for each Provider who utilizes a Hospital Admitter.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
2. Credentialing Committee

APPLIES TO:

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

POLICY:

A. Delegates Credentialing Committee must use participating Practitioners to provide expert advice and expertise for credentialing decisions.

B. In accordance with National Committee for Quality Assurance (NCQA) guidelines, Delegates Credentialing Committee must review credentials for Practitioners who do not meet established thresholds.~~.~~

1. Assessment of Timeliness - ~~In accordance to National Committee for Quality Assurance (NCQA) guidelines,~~ IEHP uses the Credentialing Committee or medical director decision date to assess timeliness in the file review elements, even if a review board or governing body reviews decisions made by the Credentialing Committee or Medical Director.

2. Providing care to Members - IEHP does not permit Practitioners to provide care to its Members before they are credentialed.

~~B.~~3.

C. Delegates Credentialing Committee ensures files that meet established criteria are submitted to the Credentialing Committee for review or has a process for medical director review and approval clean of files.

PURPOSE:

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

B. ~~Delegate obtains meaningful advice and expertise from participating Practitioners when it makes credentialing decisions.~~

~~C.~~A. ~~Assessment of Timeliness - In accordance to National Committee for Quality Assurance (NCQA) guidelines, IEHP uses the Credentialing Committee or medical director decision date to assess timeliness in the file review elements, even if a review board or governing body reviews decisions made by the Credentialing Committee or Medical Director.~~

~~D.~~A. ~~Providing care to Members - IEHP does not permit Practitioners to provide care to its Members before they are credentialed.~~

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to

perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, Managed Service Organization (MSO) etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.

   a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

   b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

B. Clean files: Credentialing files that meet the organization's criteria for participation and are not required to be sent to the credentialing committee for review.[1]

C. Credentials Committee Minutes: A document from a peer review committee which includes thorough discussion of credentialing files, decisions/recommendations, and follow-up of issues.

D. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g. evaluation of a physician's credentials and practice by another physician).[2]

E. Timeliness: A term used when auditing file elements to confirm they are within one-hundred eighty (180) calendar days of the credentials committee decision.

~~b.~~

PROCEDURES:

A. ~~Delegates Credentialing Committee must use participating Practitioners to provide expert advice and expertise for credentialing decisions.~~ Participating ~~practitioners~~ Practitioners are external to the organization and are part of the organization's network, as noted by NCQA.[3]

1. The Credentialing Committee is a peer-review body with members from the types of Practitioners participating in the organizations network that makes recommendations regarding credentialing decisions.

   Delegates may have separate review bodies for each ~~practitioner~~ Practitioner type (e.g., ~~physician~~Physician, ~~oral~~ Oral ~~surgeon~~Surgeon, ~~psychologist~~Psychologist), specialty or

[1] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, Glossary
[2] NCQA, 2022 HP Standards and Guidelines, Glossary
[3] ~~National Committee for Quality Assurance (~~NCQA~~)~~, 202~~1~~2 H~~ealth~~ P~~lan~~ Standards and Guidelines, CR 2, Element A, Factor 1

multidisciplinary committee, with representation from various specialties.

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

At a minimum, the policy and procedures must include:

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

1) Representation includes a range of participating Practitioners in the Delegates network;

2) If the Credentialing Committee is comprised of Primary Care ~~Physicians'~~ Providers' (PCP) only, the policy must state that Specialists are consulted, when necessary and appropriate. Evidence may include, but is not limited to:

- There is evidence through their Committee minutes that a Specialist was consulted, when applicable; and
- There is a listing that indicates what Specialists were used (if applicable).

3) Quorum requirements of Committee (minimum of three (3));

- Meetings should include a quorum of Practitioners for each meeting.

4) Identity of voting Members;

5) Identity of who has authority to make final credentialing decisions and the relationship to the Governing Board (if applicable);

6) Frequency of Committee meeting (at minimum, quarterly);

7) Process to document, review and approve delegate credentialing policies and procedures by the Committee on an annual basis;[4]

8) Committee's opportunity to review documentation, criteria and credentials of all Practitioners being credentialed or recredentialed prior to rendering a recommendation; and

9) All primary source information obtained and reviewed in the credentialing or recredentialing process must be no more than one hundred eighty (180) days old at the time of the Committee decision.

B. Delegates Credentialing Committee policies must describe how the Credentialing Committee receives and reviews the credentials of Practitioners who do not meet the Delegates criteria

[4] NCQA, ~~2021~~ 2022 HP Standards and Guidelines, CR 2, Element A, Factor 3

for participation in the network. The Credentialing Committee must give thoughtful consideration of the credentialing information. IEHP will review Credentialing Committee meeting minutes from three (3) different meetings within the look-back period. If the required meeting minutes are not available for review, IEHP will review the meeting minutes that are available within the look-back period. Delegates must provide evidence of the following:[5]

1. The Credentialing Committee reviewed credentials for Practitioners who do not meet the Delegate's criteria for participation in the network.
2. The Credentialing Committee's discussion must be documented within its meeting minutes; and
3. Credentialing Committee meetings and decision-making take place in the form of real-time virtual meetings (e.g. through video conferencing or WebEx conferment with audio).
    a. All meetings, including ad hoc, may not be conducted only through email.
    b. Meetings should include a quorum of ~~practitioners~~ Practitioners for each meeting, as established in the Delegates policy.
    c. Minutes should be signed by the Credentialing Committee Chairperson and dated within one (1) month or by the date of the next meeting.
    d. Ad hoc Credentialing Committee meeting minutes must be documented at the time of the ad hoc meeting and must be presented at the next formal meeting.

C. For files that meet the Delegates credentialing criteria, the delegate must:[6]

1. Submit all ~~practitioner~~ Practitioner files to the Credentialing Committee for review; or
2. Has a process for medical director or quality physician review and approve clean files.
    a. Evidence of review is a handwritten signature, handwritten initials, or unique electronic identifier, if the organization has appropriate controls for ensuring that only the designated medical director or qualified physician can enter the electronic signature.
    b. An individual signature is not required in each ~~practitioner~~ Practitioner file if there is one report with a signature that lists all required credentials for all ~~practitioners~~ Practitioners with clean files.
3. If the Delegate presents all files (including clean files) to the Credentialing Committee, this factor is met.

[5] NCQA, 2022 HP Standards and Guidelines, CR 2, Element A, Factor 2
[6] NCQA, 2022 HP Standards and Guidelines, CR 2, Element A, Factor 3

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

3. Credentialing Verifications

APPLIES TO:

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

POLICY:

A. Delegate verifies that the following are within the prescribed time limits: License to Practice, Drug Enforcement Administration (DEA), education and training, board certification, work history and malpractice history.

B. Delegate verifies state sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions.

C. Delegate ensures applications for credentialing and recredentialing include reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitation of privileges or disciplinary actions, current malpractice insurance coverage, and a current and signed attestation confirm the correctness and completeness of the application.

D. Delegate verifies that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating Hospital.

E. Delegate monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out.

F. Delegate includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process.

G. Delegate confirms all Practitioners maintain an active individual National Provider Identifier (NPI) number registered through the Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) and must be registered to an address in the State of California.

H. Delegate ensures all Primary Care Provider's (PCP) and Urgent Care's (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring").

I. Delegates must provide IEHP with Social Security Numbers for all new and existing practitioners participating providers, to ensure all Practitioners are included in IEHP's screening of the Death Master File.

J. Delegates must ensure all Practitioners submitted to IEHP for participation, for the Medi-Cal line of business, are enrolled in the Medi-Cal Program.

K. Delegates monitors its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List.

L. Delegates must ensure all Practitioners are within the appropriate age range guidelines, as appropriate.

M. Delegates must submit appropriate documentation to expand or limit their practice parameters for IEHP review and approval.

N. Delegates must ensure and obtain the appropriate documentation for all Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Nurse Midwives (NMs) between the Advanced Practice Practitioner and Supervising Physician, provide them to IEHP, and ensure these documents are readily available upon request. (See Policy 6F, "Non-Physician Practitioner Requirements").

PURPOSE:

A. IEHP must ensure Delegates conducts timely verification of information to ensure that Practitioners have the legal authority and relevant training and experience to provide quality care.

B. Pencils are not an acceptable writing instrument for credentialing documentation.

C. Each file contains evidence of verification, defined by NCQA as "Appropriate documentation." IEHP documents verification in the credentialing files using any of the following methods or a combination:

1. Credentialing documents signed (or initialed) and dated by the verifier.
2. A checklist that includes for each verification:
    a. The source used.
    b. The date of verification.
    c. The signature or initials of the person who verified the information.
    d. The report date, if applicable.
3. A checklist with a single signature and a date for all the verifications that has a statement confirming that the signatory verified all of the credentials on that date and that includes for each verification.
    a. The source used.
    b. The report date, if applicable.
    c. If the checklist does not include checklist requirements listed above appropriate credentialing information must be included.

D. Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. BreEZe, National Practitioner Data Bank (NPDB), etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there

is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from an NCQA approved and appropriate state-licensing agency.

E. PSV Documentation Methodology. The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.

~~B.~~F. Delegates may use web crawlers to verify credentialing information from approved sources. A "web crawler" is software that retrieves information directly from a website; in this case, the state licensing or certification agency (i.e. the primary source). Delegates must provide documentation that the web crawler collects information from approved sources, and documents that staff reviewed the credentialing information.

DEFINITION:

A. Verification Time Limit (VTL): National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification.

1. For web queries, the data source data – e.g. release date or as of date is used to assess timeliness of verification.

~~B.A. Each file contains evidence of verification, defined by NCQA as "Appropriate documentation." IEHP documents verification in the credentialing files using any of the following methods or a combination:~~

~~1. Credentialing documents signed (or initialed) and dated by the verifier.~~

~~2.~~1. ~~A checklist that includes for each verification:~~

~~a. The source used.~~

~~b.~~a. ~~The date of verification.~~

~~c.~~a. ~~The signature or initials of the person who verified the information.~~

~~d.~~a. ~~The report date, if applicable.~~

~~3.~~1. ~~A checklist with a single signature and a date for all the verifications that has a statement confirming that the signatory verified all of the credentials on that date and that includes for each verification.~~

~~a. The source used.~~

~~b.~~a. ~~The report date, if applicable.~~

~~c.~~a. ~~If the checklist does not include checklist requirements listed above appropriate credentialing information must be included.~~

~~C.~~B. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification, and include what was verified verbally.

~~D.~~C. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

~~E.~~D. Written Verification - Requires a letter or documented review of cumulative reports. The Independent Practice Association (IPA) must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

~~F.~~A. ~~Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. BreEZe, National Practitioner Data Bank (NPDB), etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from an NCQA approved and appropriate state licensing agency.~~

~~G.~~A. ~~PSV Documentation Methodology. The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.~~

~~H.~~E. NPPES – CMS National Plan and Provider Enumeration System.

~~I.~~F. CMS Preclusions List – List of prescribers and individuals or entities who fall within any of the following categories:

1. Currently revoked from Medicare;
2. Under an active re-enrollment bar; or
3. CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.

~~J.~~G. Death Master File (DMF) contains information about persons who had Social Security numbers and whose deaths were reported to the Social Security Administration from 1962 to the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.

~~K.~~H. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The

Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub delegation oversight.
    a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.
    b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

~~L.~~I. Types of Signatures:

1. Wet signature - created when a person physically marks a document.
2. Faxed signature – the "copy" or "duplication" of your signature (no matter the method, system or medium you choose) is referred to as a facsimile signature.
3. Digital signature - type of electronic signature that encrypts documents with digital codes that particularly difficult to duplicate. It includes a certificate of authority, such as a Windows certificate, to ensure the validity of the signatory (the signature's author and owner).
4. Electronic signature - symbols or other data in digital form attached to an electronically transmitted document as verification of the sender's intent to sign the document.
5. Scanned signature - a written signature that's been scanned into an electronic format, like a PDF.
6. Photocopied signature - a signature reproduced provided that the copy must be of an original document containing an original handwritten signature.
7. Signature stamp - is an implement personalized with an individual's name for a quick and easy authorization of documents. These stamps can come customized with just a signature or can include both a signature and printed name.

PROCEDURES:

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

1. A current and valid license to practice in California (Verification Time Limit (VTL): one hundred-eighty (180) calendar days prior to Credentialing decision date).
    a. Must be valid, current, and unencumbered at the time of committee and remain valid and current throughout the Practitioner's participation with IEHP.
        1) All Practitioners must be licensed by the State of California by the appropriate state licensing agency. Delegates must verify licensure directly from the state

licensing or certification agency (or its website). The following licensures may be verified through BreEZe Online services online or directly with the licensing board via phone or mail:

- Medical Board of California (M.D.)
- Osteopathic Medical Board of California (D.O.)
- Board of Podiatric Medicine (D.P.M.)
- Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
- Board of Psychology (Ph.D., Psy.D.)
- Dental Board of California (D.D.S., D.M.D.)
- California Board of Occupational Therapy (O.T.)
- California State Board of Optometry (O.D.)
- Physical Therapy Board of California (P.T.)
- Physician Assistant Committee (P.A., P.A.-C)
- California Board of Registered Nursing (C.N.M., N.P.)
- California Board of Chiropractic Examiners (D.C.)
- Speech-Language Pathology & Audiology Board (S.P., Au)
- Acupuncture Board (L.Ac.)

2) Failure to maintain a valid and current license at all times, will result in an administrative termination of the Practitioner.[1]

2. A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate. Delegates must verify that the practitioner's DEA or CDS certificate is valid and current in each state where the practitioner providers care to members. The DEA or CDS Certificate:

   a. Must be valid and current at the time of committee and remain valid and current throughout the Practitioner's participation with IEHP registered with an address in the State of California.

   b. Verification may be in the form of:

[1] National Committee for Quality Assurance (NCQA), 202~~1~~2 Health Plan Standards and Guidelines, CR 3, Element A, Factor 1

1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision; or

c. Any Practitioner with a DEA with an "EXEMPT" Fee or status, the DEA is only valid at the exempting institution and any affiliate Hospital or Clinic rotations within the scope of training.

1) Delegate must confirm the Practitioner's practice and exempting institutions relationship and document their findings in the Provider file, if the address on the DEA does not match the Providers practice location.

~~c.~~• If a Practitioner is practicing outside of the exempting institution and/or its affiliates, the Practitioner must obtain a "Paid" status DEA.

~~d.~~2) Delegates may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, if the delegate has a documented process for allowing a Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA number and NPI number will be documented in the Practitioner's file.

~~e.~~d. If a Practitioner does not have a DEA or CDS certificate, Delegates must have a documented process to require an explanation why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner's patients who need prescriptions requiring DEA certification.

1) For credentialing files where verification of DEA or CDS is before June 1, 2020, and a practitioner who is DEA- or CDS- eligible does not have a DEA or CDS certificate, NCQA accepts either the verification process required in the 2020 standards or the applicable prior year's standards, which state "If a qualified practitioner does not have a valid DEA or CDS certificate, the organization notes this in the credentialing file and arranges for another practitioner to fill prescriptions."

- Practitioner's statement. I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management, example provided by NCQA.

~~f.~~e. Failure to maintain an active DEA, may result in an administrative termination of the Practitioner.[2]

3. Education and training (VTL: Prior to the Credentialing Decision) All Practitioners must have completed appropriate education and training for practice in the U.S. or a residency program recognized by NCQA, in the designated specialty or subspecialty they request

[2] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 3, Element A, Factor 2

to be credentialed and contracted. The delegate verifies the highest of the following three (3) levels of education and training obtained by the Practitioner, as appropriate. i.e., Board Certification, Residency or Graduation from medical or professional school. An expired board certification may be used for verification of education/training.

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

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

a. The primary source from the Medical School.

~~a.~~

b. The state licensing agency or specialty board or registry if the state agency and specialty board, respectively, perform primary source verification. The Delegate:

1) Obtains written confirmation of primary source verification from the primary source, at least annually, or

2) Provides a printed, dated screenshot of the state licensing agency's or specialty board or registry website displaying the statement that it performs primary source verification of Practitioner education and training information, or

3) Provides evidence of a state statute requiring the licensing agency, specialty or registry to obtain verification of education and training directly from the institution.

4) National Student Clearinghouse may be considered an agent of the medical or professional school if the school has a contract with the Clearinghouse to provide verification services.

~~3)~~• Delegates must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.

c. Sealed transcripts if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program.

d. Below are acceptable sources for physicians (M.D., D.O.) to verify graduation from Medical School:

1) American Medical Association (AMA) Physician Master File.

2) American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.

3) Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

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

1) Primary source from the institution where the postgraduate medical training was completed.
2) AMA Physician Master File.
3) AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
4) Federation Credentials Verification Service (FCVS) for closed residency programs.
    - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.[3]

4. Board certification status, if applicable (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date).
    a. The delegate verifies current certification status of Practitioners who state that they are board certified.
        1) The delegate must document the expiration date of the board certification within the credential file.
            - If a Practitioner has a "lifetime" certification status and there is no expiration date for certification, the Delegate verifies that the board certification is current and documents the date of verification.
        2) If board certification has expired, it may be used as verification of education and training.
        3) Verification must be performed through a letter directly from the board or an online query of the appropriate board as long as the board states that they verify education and training with primary sources, is an acceptable source by NCQA, and indicate that this information is correct. Below are the acceptable sources to verify board certification:
            - For all Practitioner types

[3] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 3, Element A, Factor 3

- The primary source (appropriate specialty board).
- The state licensing agency if the primary source verifies board certification.

- For Physicians (M.D., D.O.)
  - American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
    - The ABMS "Is your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
  - AMA Physician Master File.
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.
- For other health care professionals
  - Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.
- For Podiatrists (D.P.M.)
  - American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
  - The American Board of Podiatric Medicine.
  - American Board of Multiple Specialties in Podiatry.
- For Nurse Practitioners (N.P.)
  - American Association of Nurse Practitioners (AANP).
  - American Nurses Credentialing Center (ANCC).
  - National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
  - Pediatric Nursing Certification Board (PNCB).

- American Association of Critical-Care Nurses (AACN).

- For Physician Assistants (P.A.-C).
  - National Commission of Certification of P.A.'s (NCCPA).
- For Certified Nurse Midwives (C.N.M.).
  - American Midwifery Certification Board (AMCB).
- For Psychologists (Ph.D., Psy.D.).
  - American Board of Professional Psychology (ABPP).

5. Work history (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision date) The delegate must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.
   a. The Delegate must document review of work history on the application, CV, or checklist that includes the signature or initials of staff who reviewed work history and the date of review. Documentation of work history must meet the following:
      1) Must include the beginning and ending month and year for each work experience.
      2) The month and year do not need to be provided if the Practitioner has had continuous employment at the same site for five (5) years or more. The year to year documentation at that site meets the intent.
      3) If the Practitioner completed education and went to straight into practice, this will be counted as continuous work history.
      4) If the Practitioner has practiced fewer than five (5) years from the date of credentialing. The work history starts at the time of initial licensure.
      5) The Delegate must review for any gaps in work history. If a work history gap of six (6) months to one (1) year is identified, the Delegate must obtain an explanation from the Practitioner. Verification may be obtained verbally or in writing or in writing for gaps of six (6) months to one (1) year.
      6) Any gap in work history that exceeds one (1) year must be clarified in writing from the Practitioner. The explanation of the gap needs to be sufficient to ascertain that the gap did not occur as a result of adverse and/or reportable situations, occurrences or activities.[4]
6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner. (VTL: one hundred-eighty (180) calendar days prior to

[4] NCQA, 2021~~2~~2 HP Standards and Guidelines, CR 3, Element A, Factor 5

Credentialing decision date)

a. The delegate must obtain confirmation of the past seven (7) years of malpractice settlements through one of the following sources:

1) Malpractice Insurance Carrier

2) National Practitioner Data Bank Query

3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.

b. A minimum the seven (7) years claim history must be reviewed for initial credentialing and all claim history activities after the previous credentialing decision date, will be reviewed for recredentialing.

c. The seven (7) year period may include residency and fellowship years. The delegate is not required to obtain confirmation from the carrier for Practitioners who had a hospital insurance policy during a residency and fellowship.[5]

B. Delegate must verify the following sanction information for credentialing:

1. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).

a. Verification sources for sanctions or limitations on licensure include:

1) Chiropractors: State Board of Chiropractic Examiners, Chiropractic Information Network/Board Action Databank (CIN-BAD), or NPDB.

2) Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.

3) Physicians: Appropriate state board agencies, Federation of State Medical Boards (FSMB), NPDB.

4) Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.

5) Non-physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.

6) For delegate's using the Continuous Query (formerly Proactive Disclosure Service (PDS))

- Evidence of current enrollment must be provided.

[5] NCQA, 2021~~2~~ HP Standards and Guidelines, CR 3, Element A, Factor 6.

- Report must be reviewed within one hundred eighty (180) calendar days of the initial credentialing decision.
- Evidence of review must be documented in the file or on checklist.

2. Medicare and Medicaid sanctions. (VTL: one hundred-eighty (180) calendar days prior to Credentialing decision).
   a. Verification Sources for Medicare/Medicaid Sanctions:
      1) State Medicaid Agency or intermediary and the Medicare intermediary.
      2) Medicare intermediary.
      3) List of Excluded Individuals and Entities (maintained by OIG).
         - OIG must be one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS.
           - Date of query and staff initials must be evident on a checklist or the OIG page must be in the file.
      4) Medicare Exclusions Database.
      5) The Federal Employees Health Benefits (FEHB) Program Department Record, published by the Office of Personnel Management, Office of the Inspector General (OIG).
      6) AMA Physician Master File
      7) NPDB
         - For delegate's using the Continuous Query (formerly Proactive Disclosure Service (PDS)). Continuous Query must be reviewed within one hundred-eighty (180) calendar days of the credentialing decision and show evidence the practitioner was enrolled in the alert services at the time of the cited report. Evidence must be documented in the file or on checklist.
      8) FSMB
      9) The Medi-Cal Suspended and Ineligible list must be one (1) of the verification source for Medicaid sanctions, to ensure compliance with Department of Health Care Services (DHCS).[6]
         - Date of query and staff initials must be evidence on a checklist, or the report page must be in the file.

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

[6] ~~Coordinated Care Initiative (CCI) Three-Way Contract, January 2018, Section 2.10~~

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

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

   a. All Practitioners must have current and adequate malpractice insurance coverage that is current and:
      1) Meets IEHP's standard of $1 million/$3 million, as well as the IPAs standards. Professional Liability Insurance coverage and amounts of coverage must be verified with the insurance carrier or through the Practitioner via a copy of the policy and the signed attestation completed by the Practitioner. The copy of the Practitioner's certificate must be initialed, and date stamped to show receipt prior to the credentialing decision and to show it was effective at the time of the credentialing decision.
      2) Must include coverage for the specialty the Practitioner is being credentialed for and for all locations the Practitioner will be treating IEHP patients.

[7] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 3, Element C, Factor 1
[8] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 3, Element C, Factor 2
[9] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 3, Element C, Factor 3
[10] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 3, Element C, Factor 4

- If the specialty coverage and/or the locations are not identified on the malpractice insurance certificate, the coverage must be verified with the insurance carrier and documented in the Practitioner's file.

3) For Practitioners with federal tort coverage, (e.g. Health Resources & Services Administration (HRSA)), the Practitioner must submit:

- A copy of the face sheet or federal tort letter as an addendum to the application. The face sheet or federal tort letter must include the:
  - Insurance effective and expiration dates (future effective dates are acceptable)
- A roster that lists all practitioner covered under the federal tort coverage.

4) There must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee approval date.

- Failure to maintain current malpractice coverage for the specialty the Provider is being credentialed for and for all locations the Practitioner will be treating IEHP patients, will result in an administrative termination of the Practitioner.[11]

6. Current and signed attestation confirm the correctness and completeness of the application. Attestation must be:

a. Signed and dated within the timeframe and must include all elements to be compliant.

1) The one hundred-eighty (180) calendar-day time frame is based on the date the Practitioner signed the application.

- If the signature or attestation exceeds one hundred-eighty (180) calendar days the Practitioner must only attest that the information on the application remains correct and complete, be re-signing and re-dating the attestation. Practitioner does not need to complete another application.

b. Signed with a full signature, if the attestation needs to be re-signed by the Practitioner; dating and initialing is not acceptable.

1) Faxed, digital, electronic, scanned or photocopies signatures are accepted. Signature stamps are not acceptable. (See Definitions, "Types of Signatures")

c. If the attestation is not signed and/or dated, within the appropriate time frame, all application elements are non-compliant (except current malpractice coverage since IEHP requires a face sheet is obtained).

1) If a question is answered incorrectly, Delegate is responsible for notifying the

[11] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 3, Element C, Factor 5

Practitioner to have them review the question.

- If the Provider chooses to change their response, the Provider may initial and date next to the change.
- If the Provider chooses not to change their response, the Delegate will document their attempt to have the Practitioner review their response and that the provider chose not to change their response.

d. When reviewing the Council for Affordable Quality Healthcare (CAQH) application, NCQA accepts the last attestation date generated by this system as the date when the practitioner signed and dated the application to attest to its completeness and correctness.[12]

D. Delegate must verify that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current Hospital affiliation or admitting privileges at a participating Hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be:

1. Confirmed with the Hospital, in writing, via approved website or verbally, and must include:
   a. The date of appointment;
   b. Scope of privileges, restrictions (if any i.e. restricted, unrestricted) and recommendations.
   c. Confirmation Provider has admitting privileges in the specialty the Provider is credentialed and contracted for.
   d. If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in "good standing."
   e. Practitioner must meet the requirements for Hospital Privileges as required by IEHP. (See Policy 5B, "Hospital Privileges"), i.e. if an admitter or hospitalist arrangement is used, a written agreement that meets IEHP admitter requirements, confirming coverage for all inpatient work covering the entire age range of the Practitioner must be included in the Practitioner's credentialing file.
      1) These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider profile, admitter report or attachment.

[12] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 3, Element C, Factor 6

2) If the Provider utilizes an admitter or hospitalist arrangement, the Delegate must document these arrangements in the Provider file, to include when the Provider was notified. Documentation must include:

- The date the Practitioner was notified
- Name(s) of the admitter and/or hospitalist, admitting on behalf of the Provider
- Name(s) of the Hospital, affiliated with the inpatient coverage arrangements

2. If the Practitioner does not have clinical privileges, the Delegate must have a written statement delineating the inpatient coverage arrangement. (See Policy 5B, "Hospital Privileges"). For Specialties that are required to have clinical privileges or admitting privileges at a Participating hospital, See Attachment, "Hospital Admitting Privileges Reference by Specialty".
3. Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have Hospital privileges and documentation in the file is not required for these types of Practitioners. (See Attachment, "Hospital Admitting Privileges Reference by Specialty" in Section 5)
4. Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Nurse Midwives (NM)) may not have Hospital privileges. However, if they provide the Delegate their Hospital privileges, Delegate will be responsible for verifying if those privileges are active and ensure they are in good standing.
5. Specialists (MDs, DOs and DPMs) may not have Hospital privileges, documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).
    a. These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider profile, admitter report or attachment.
        1) These arrangements are subject to IEHP review and approval.
        2) IEHP may request for inpatient coverage arrangements for the Practitioner, if IEHP identified that specialty as a specialty that requires Hospital admitting arrangements.
6. Certified Nurse Midwives (CNMs) may provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services only after they are fully credentialed and approved by the IPA or IEHP directly. CNM Providers must meet the following criteria:
    a. In lieu of having full hospital delivery privileges, provide a written agreement with an Obstetrician (OB) Provider, that includes a protocol for identifying and

transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed.

1) The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the CNM Provider.

2) The OB Provider must be credentialed and contracted within the same practice and network.

7. Family Practice including outpatient Obstetrics (OB) services (FP-1) must provide a copy of a signed agreement that states:

   a. Member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk members with a contracted and credentialed OB.

      1) The OB must be contracted and credentialed by the same network as the Family Practice Provider and must hold admitting privileges to the IEHP Hospital linked with that IPA network.

8. Family Practice including full Obstetrics services and delivery (FP-2). Providers that fulfill these requirements may be referred to and see Obstetrician/Gynecologist (OB/GYN) Members within the same IPA as the referring Physician, and must have:

   a. Full delivery privileges at an IEHP network Hospital; and

      1) Provide a written agreement for an available OB back up Provider is required. The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and

      2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

9. Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Provider only, will provide outpatient well woman services only with no Hospital or surgical privileges, must provide the following information for consideration:

   a. In lieu of obtaining or maintaining full Hospital delivery privileges, the Practitioners must provide a written agreement with OB that includes:

      1) A protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.).

      2) Must be available for consultations, as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery.

      3) The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.

- The OB Provider must be credentialed and contracted within the same network.

10. Licensed Midwife (LM) practitioners are required to have a backup Licensed Physician, engaged in active clinical obstetrical practice and with whom the Licensed Midwife consults when there are significant deviations from the normal, in either mother or infant. Therefore, LMs must complete a Licensed Midwife Attestation: Plan for Consultation, Emergency Transfer, & Transport (See Attachment, "Licensed Midwife Attestation", in Section 5) required for all Licensed Midwife Practitioners.
    a. IEHP requires the backup Licensed Physician is an active Obstetrics/Gynecology Practitioner within the IEHP network.
11. Urgent Care Providers are not required to maintain Hospital privileges if they are exclusively practicing at an Urgent Care.[13,14,15]

E. Delegate must monitor its credentialing files to ensure that it only contracts with Practitioners who have not opted out. Delegate is responsible for:

1. Reviewing and obtaining the information via hard copies or electronic from https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z.
    a. Certain healthcare Provider categories cannot opt-out of Medicare. These include Chiropractors, physical therapists and occupational therapists in independent practice.[16]
2. If Delegate employs their Practitioners, the initial credentialing and recredentialing review of employed Practitioners must include a review of the Medicare Opt-Out Report in all files credentialed.
3. The following are acceptable ways to verify review of the Opt-Out report:
    a. Checklist/Verification: Must have the following to be compliant:
        1) Staff initials/signature;
        2) Run date from CMS.gov Opt-Out Reports; and
        3) Indicate whether or not the Practitioner is listed on the report.
    b. Pages of the CMS.gov listing report showing where the providers name would have been listed in alpha order. Must have the following to be compliant:
        1) Staff initials/signature;

[13] Medicare Managed Care Manual, Relationships with Providers", Section 60.3
[14] Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, "Provider Credentialing/Recredentialing and Screening/Enrollment
[15] California Code of Regulations (CCR) § 1300.51(d)(H)(iii)
[16] Medicare Managed Care Manual, Relationships with Providers", Section 60.2

2) Run date from CMS.gov Opt-Out Reports; and

3) Indicate whether or not the practitioner is listed on the report.

F. Delegate must include information from the quality improvement activities and Member complaints in the recredentialing decision-making process. (Verification Time Limit: Last recredentialing cycle to present).

1. Quality activities include, but are not limited to:
   a. Adverse events
   b. Medical record review
   c. Data from Quality Improvement Activities
   d. Performance Information, may include but is not limited to:
      1) Utilization Management Data
      2) Enrollee satisfaction surveys
      3) Other activities of the organization
   e. Not all quality activities need to be present
2. Grievance/complaints[17,18]

G. Delegate must ensure all Practitioners hold and maintain a valid and active National Provider Identifier (NPI) Practitioners individual NPI number, and the information provided must be:

1. Verified through the NPPES website;
2. Active while in the IEHP network;
3. Current at all times (i.e. Primary Practice Address must be registered to an address within California).
   a. Telehealth Providers are not required to have an NPI registered to an address within California.
4. Practitioners that have a group NPI number may submit that information to IEHP, in addition to the required individual NPI number.[19]

H. Delegate must ensure all Primary Care Provider's (PCP) and Urgent Care's (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring"). All PCPs and UCs must pass an IEHP facility on-site review at the time of initials credentialing and every three (3)

[17] Medicare Managed Care Manual, Relationships with Providers", Section 60.3
[18] DHCS APL 19-004
[19] DHCS APL 19-004

years thereafter, for Medi-Cal Programs.[20]

1. Delegates are not delegated to perform on-site visits on behalf of IEHP; however, their policies and procedures must ensure they notify their Practitioners of IEHPs requirements and they remain compliant while they continue participation in IEHPs network. This would apply to, but not limited to:
    a. Prior to participating in the IEHP network as a PCP or an Urgent Care provider; or
    b. When a Practitioner relocates.

I. Delegates must obtain and provide IEHP with Social Security Numbers for all new and existing Practitioners participating providers, to ensure all Practitioners are included in IEHP's screening of the Social Security Administration's Death Master File (SSADMF).

1. All Delegated IPA Provider submissions for participation in the IEHP network, the Delegate must include the Provider's full Social Security Number (SSN).
    a. Submissions without SSN will be ceased and not processed by IEHP.
2. Delegated IPAs with existing Providers without SSNs will be notified. The Delegated IPAs are required to provide all missing SSNs to IEHP.
    a. Delegated IPAs who do not provide the requested information will be placed on a Corrective Action Plan (CAP), until all missing SSNs are submitted.
3. If a Practitioner confirms that his/her SSN is correctly stated on the Social Security Administration's Death Master File (SSADMF), but is clearly not deceased, the Delegate must request for:
    a. A copy of the Social Security Card;
    b. A photo ID;
    c. A signed attestation from the Practitioner confirming they are who they say they are; and
    d. The Provider to contact the Social Security Administration's Death Master File (SSADMF) to correct the issue.
4. If a Practitioners' SSN is correctly stated but the name and Date of Birth (DOB) does not, the Delegate must request for:
    a. A copy of the Social Security Card;
    b. A photo ID;
    c. A signed attestation from the Practitioner confirming they are who they say they are; and

[20] Medicare Managed Care Manual, Relationships with Providers", Section 60.3

d. The Provider to contact the Social Security Administration's Death Master File (SSADMF) to correct the issue.[21]

J. Delegates must ensure all Practitioners submitted to IEHP for participation, for the Medi-Cal line of business, are enrolled in the Medi-Cal Program, to ensure compliance with Title 42, Code of Federal Regulations (CFR) § 438.602(b) to extend Provider screening and enrollment requirements to all Managed Care Plan's contracted Providers. The intent of this requirement is to reduce the incidence of fraud and abuse by ensuring that all Providers are individually identified and screened for licensure and certification.

1. All Delegated IPA Provider submissions for participation in the IEHP network, the Delegate must provide documentation that confirms the Provider is enrolled in the Medi-Cal program state level enrollment through DHCS, prior to their submission to IEHP.

   a. Submissions without proof of Medi-Cal enrollment will be ceased and not processed by IEHP.

   b. The Delegate must use the California Health & Human Services Agency's portal to confirm the Providers enrollment status with the Medi-Cal Program through DHCS.

      1) The portal can be accessed via:

         http://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx~~https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers~~

         - The portal is maintained by the Provider Enrollment Division (PED) and is updated monthly.[22]

K. Delegates monitors its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List (See Policy 25B5, "Ongoing Monitoring and Interventions").[23]

L. Delegates must ensure all Practitioners are within the appropriate age range guidelines, as appropriate.

1. Primary Care Providers

   a. Pediatrics

      1) PCPs that have members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.[24]

      2) 0 – 18

[21] DHCS APL 19-004
[22] DHCS APL 19-004
[23] 2019 Medicare Program Final Rule, "Preclusions List Requirements"
[24] DHCS Medi-Cal Provider Manual, "Vaccines for Children (VFC) Program"

3) 0 – 21

b. Family Practice

1) PCPs that have members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.[25]

2) All Ages

3) 14 and above

c. Internal Medicine

1) PCPs that have members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.[26]

2) 18 and above

3) 21 and above

d. Public Health and General Preventive Medicine

1) 18 and above

2) 21 and above

e. Obstetrics/Gynecology

1) 14 and above; restricted to females

f. General Practice

1) PCPs that have members assigned ages 0-19 must enroll in the Vaccines for Children (VFC) Program.[27]

2) All ages, if pediatric training, experience and/or Continuing Medical Education (CME) is present

3) 14 and above

2. Specialists Member age ranges are specific to the specialty involved, training, and education of the Physician.

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

[25] Ibid.
[26] DHCS Medi-Cal Provider Manual, "Vaccines for Children (VFC) Program"
[27] Ibid.

M. Delegates must submit appropriate documentation to expand or limit their practice parameters for IEHP review and approval. Practitioners may practice outside of scope with approval from IEHP, by undergoing the Provide Privilege Adjustment process in this policy.

1. Primary Care Providers age range expansions.

   a. For PCP's who have Adult age ranges assigned and would like to expand their age range to reflect all ages, will be processed with a secondary specialty of General Practice, must provide the following information for review and consideration:

      1) Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, "IEHP Addendum E" in Section 5);

      2) Provide evidence of twenty-five (25) CME units in Pediatric Primary Care completed within the last three (3) years;

      3) Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The Physician coworkers must hold an active board certification in Pediatrics or Family Practice;

      4) PCPs that have Members assigned ages (0-19) must enroll in the Vaccines for Children (VFC) Program;

      5) Malpractice coverage for the age range provider is requesting for that covers all locations the Provider will be treating IEHP Members; and

      6) Pass a Medical Record Chart Audit for Pediatric Members

   b. For PCP's who have Pediatric age ranges assigned and would like to expand their age range to reflect all ages, will be processed with a secondary specialty of General Practice, must provide the following information for review and consideration:

      1) Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See Attachment, "IEHP Addendum E" in Section 5);

      2) Provide evidence of twenty-five (25) CME units in Adult Primary Care completed within the last three (3) years;

      3) Applicants must provide two (2) letters of recommendation from a physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The Physician coworkers must hold an active board certification in Internal Medicine or Family Practice;

4) PCPs that have Members assigned ages (0-19) must enroll in the Vaccines for Children (VFC) Program;[28]

5) Malpractice coverage for the age range Provider is requesting for that covers all locations the Provider will be treating IEHP Members; and

6) Pass a Medical Record Chart Audit for Adult Members

[28] DHCS Medi-Cal Provider Manual, "Vaccines for Children (VFC) Program"

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Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

4. Recredentialing Cycle Length

APPLIES TO:

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

POLICY:

A. Delegates are responsible for formally recredentialing their contracted Practitioners (i.e., Primary Care Providers (PCPs), ~~non~~Non-~~physician~~ Physician Practitioners, Specialists, and ~~admitting~~ Admitting ~~physicians~~ Physicians) at least every thirty-six (36) months from their last credentialing decision date and submit specific updates to IEHP. (See Policy MC_25B10 "Credentialing Standards – Credentialing Quality Oversight of Delegates")[1,2,3]

~~B. Delegate may extend a Practitioners recredentialing cycle time frame (beyond thirty-six (36) months) based on NCQA standards.~~

~~C.~~B. ~~Delegates failure to recredential within thirty-six (36) months.~~

PURPOSE:

~~A.~~ To describe the guidelines for Delegates recredentialing and ensures recredentialing is conducted in a timely manner.~~Delegate conducts timely recredentialing.~~

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.

    a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

[1] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 4, Element A
[2] Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019, "Provider Credentialing/Recredentialing and Screening/Enrollment
[3] Title 42 Code of Federal Regulations (CFR) § 422.204(b)(2)(ii)

b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

PROCEDURES:[4]

A. The length of the recredentialing cycle is within the required thirty-six (36) month time frame and is a must-pass element for NCQA. Files that fail to meet the thirty-six (36) month time frame will be scored non-compliant "0", which will result in a Corrective Action Plan from the Delegate. All recredentialing files must contain the Credentialing Committee decision date.

1. The thirty-six (36) month recredentialing cycle begins on the date of the previous credentialing decision. The thirty-six (36) month cycle is counted to the month, not to the day.

a. If a recredentialing file selected during the Credentialing Delegation Oversight audit, has not gone through the recredentialing cycle or Committee and it is not compliant for recredentialing, it will not be included in the file review.

1) The entire Delegate roster will be reviewed for recredentialing timeliness, not just those processed within the last twelve (12) months.

- IEHP will document in comments the total number of ~~practitioners~~ Practitioners that appear on the spreadsheet that have not been recredentialed within the last thirty-six (36) months, which will result in a Corrective Action Plan from the Delegate.

b. If Delegate determines that there was a system wide problem with its initial credentialing process, and as a result implemented corrective action through early recredentialing may present evidence of such actions to the health plan during the audit.

1) If a file was recredentialing early to correct a deficiency, the file will be scored non-compliant for cycle length, with comments.

c. A recredentialing file that was placed into the initial credentialing file pull due to being out of timeframe will not be included in the initial credentialing files. The file will be included in the universe of recredentialing files.

d. A recredentialing file that is past due cannot be terminated and then reinstated before or within thirty (30) calendar days and processed as an initial file.

1) The past due file must be recredentialed as soon as possible instead of being terminated.

[4] NCQA, 2022 HP Standards and Guidelines, CR 4, Element A

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

1. Verify that the ~~practitioner~~ Practitioner has a valid license to practice before the ~~practitioner~~ Practitioner resumes seeing patients.
2. Within sixty (60) calendar days of when the ~~practitioner~~ Practitioner resumes practice, the Delegate must complete the recredentialing cycle. Delegates must document this and recredentials the Practitioner within sixty (60) calendar days of the Practitioners return to practice.
    a. If there is a termination of thirty (30) calendar days, the Delegate can initially credential the ~~practitioner~~ Practitioner before rejoining the Delegates network.

C. Delegates failure to recredential within thirty-six (36) months. The Delegate will be scored down if it missed the thirty-six (36) month timeframe for recredentialing a ~~practitioner~~ Practitioner but did not terminate the ~~practitioner~~Practitioner.

1. If the Delegate does not have the necessary information for recredentialing, the Delegate must:
    a. Inform the ~~practitioner~~ Practitioner that this information is needed at least thirty (30) calendar days before the recredentialing deadline and that without this information, the ~~practitioner~~ Practitioner will be administratively terminated.
        1) The Delegate must include this notification in the ~~practitioner's~~ Practitioner's credentialing file.
        2) If the ~~practitioner~~ Practitioner is subsequently terminated for lack of information, the termination notice must be in the ~~practitioner's~~ Practitioner's file.
2. Delegates may recredential the ~~practitioner~~ Practitioner within thirty (30) calendar days of missing the deadline.
    a. If recredentialing is not completed within thirty (30) calendar days, Delegates must initial credential the ~~practitioner~~Practitioner.
3. If the Delegates terminates a ~~practitioner~~ Practitioner for administrative reasons (e.g. the ~~practitioner~~ Practitioner failed to provide complete credentialing information) and not for quality reasons, it may reinstate the ~~practitioner~~ Practitioner within thirty (30) calendar days of termination and is not required to perform initial credentialing.
    a. Delegates must perform initial credentialing if reinstatement is more than thirty (30)

calendar days after termination. [5]

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Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
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[5] ~~National Committee for Quality Assurance (NCQA), 2022~~1 Health Plan Standards and Guidelines, CR 4, Element ~~A~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

5. Ongoing Monitoring and Interventions

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for Medi-Cal Providers.

POLICY:

A. Delegates must develop and implement policies and procedures for ongoing monitoring of Practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against Practitioners when it identifies occurrences of poor quality.[1]

B. Delegates maintain a documented process for monitoring whether network Providers have opted out of participating in the Medicare Program, may not participate in Medicare lines of business.[2,3]

C. Delegates must verify that their contracted Providers have not been terminated as Medi-Cal Providers or have not been placed on the Suspended and Ineligible Provider List. IEHP does not allow providers identified on the Medi-Cal Suspended and Ineligible list to participate in the IEHP network.[4]

D. Delegated maintains a documented process for monitoring whether its Practitioners are included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List, to ensure compliance with the ~~2019~~ Medicare Program Final Rule.[5]

E. IEHP maintains a documented process for monitoring ~~practitioners~~ Practitioners identified on the Restricted Provider Database, for ~~practitioners~~ Practitioners directly credentialed with IEHP and those credentialed through a Delegated Network.[6]

F. IEHP maintains a documented process that includes the System for Award Management (SAM) in their list of database checks, for ~~practitioners~~ Practitioners directly credentialed with IEHP and those credentialed through a Delegated Network.[7]

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[1] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 5, Element A, Factors 1-5

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

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

[4] ~~Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019 "Provider Credentialing/Recredentialing and Screening/Enrollment"~~ Ibid.

[5] Centers for Medicare & Medicaid Services (CMS), Policy CMS-4182 Final Rule~~Centers for Medicare & Medicaid Services, "Preclusion List Requirements", 11/02/2018~~

[6] DHCS APL 19-004

[7] Ibid.

G. Delegates that subscribe to a sanctions alert service must have a documented process and evidence for the screening and notification process.

H. Delegate is responsible for notifying IEHP of any findings and the actions decided by the Credentialing Committee regarding the Practitioners identified through the ongoing monitoring of sanctions, complaints, and quality issues between recredentialing cycles.

I. Delegate must have a process to verify and maintain Practitioner licensing status, DEA or CDS certificate, etc., and remedies if the license or certification expires or status changes during the Practitioner's participation with IEHP regardless of its outside the recredentialing cycle.

J. Delegates must report Social Security Numbers for all new and existing Practitioners to IEHP, to ensure all Practitioners are included in IEHP's screening of the Social Security Administration's Death Master File (SSADMF).[8]

PURPOSE:

A. Delegate identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.[9]

DEFINITION:

A. Adverse event~~—~~: An injury that occurs ~~while~~ in the course of a Member ~~is~~ receiving health care services from a Practitioner.[10]

B. Death Master File (DMF) contains information about persons who had Social Security Numbers and whose deaths were reported to the Social Security Administration from 1962 to the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.

C. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, Management Service Organization (MSO) etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The

[8] DHCS APL 19-004
[9] NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 1-5
[10] NCQA, 2022 HP~~Health Plan~~ Standards and Guidelines, Glossary

Delegate will be responsible for sub-delegation oversight.

a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.

D. NPDB Continuous Query generates individual alerts from NCQA-recognized sources reporting an action.

E. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g., evaluation of a physician's credentials and practice by another physician).[11]

~~D.~~F. Quality of care: The degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[12]

PROCEDURES:

A. Delegates include in their policy and procedures and provide evidence of ongoing monitoring and makes appropriate interventions by:

1. Delegate collects and reviews information from the following sources for Medicare and Medicaid sanctions. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance.

a. Delegates must use the List of Excluded Individuals and Entities (maintained by OIG) as the verification source for Medicare Sanctions, and review the report on a monthly basis, within thirty (30) calendar days of its release.[13,14~~15~~]

1) Delegate may develop a tracking log to include the report run date, review date, initials of person reviewing report, the list reviewed, and the web link used; or

2) Delegate can print the entire list. The report must be dated and initialed.

- Practitioners identified on the Health & Human Services (HHS)-Office of Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned

[11] NCQA, 2022 ~~Health Plan~~HP Standards and Guidelines, Glossary
[12] Ibid.
[13] NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 5
[14] NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 1-2
~~[15] Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019 "Provider Credentialing/Recredentialing and Screening/Enrollment"~~

from participation.

- Members will be reassigned to new Practitioners.
- The Provider will be presented to Peer Review Subcommittee as an administrative termination, for further review and discussion. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings to include any additional prior quality of care issues and Member complaints for the Provider.[~~16~~]

2. Delegate collects and reviews information from any of the following sources for reviewing sanctions or limitations on licensure. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance.[17]

   a. Physicians. Sanction and limitation on licensure verifications must be verified through:

      1) BreEZe Online services online or directly with the licensing board via phone or mail:

         - Medical Board of California (M.D., L.M.)
         - Osteopathic Medical Board of California (D.O.)

      2) Federation of State Medical Boards (FSMB)

      3) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:

         - Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
         - Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
            - Documentation can be kept electronically or via an electronic or paper/log checklist.

   b. Chiropractors. Sanction and limitation on licensure verifications must be verified through:

      1) BreEZe Online services online or directly with the licensing board via phone or

[~~16~~] ~~National Committee for Quality Assurance (NCQA), 2022~~21 Health Plan Standards and Guidelines, CR 5, Element A, Factor 1

[17] NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 2

mail:

- California Board of Chiropractic Examiners (D.C.)

2) Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD)

3) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:

- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
- Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
    - Documentation can be kept electronically or via an electronic or paper/log checklist.

c. Oral Surgeons. Sanction and limitation on licensure verifications must be verified through:

1) BreEZe Online services online or directly with the licensing board via phone or mail:

- Dental Board of California (D.D.S., D.M.D.)

2) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:

- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
- Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
    - Documentation can be kept electronically or via an electronic or paper/log checklist.

d. Podiatrists. Sanction and limitation on licensure verifications must be verified through:

1) BreEZe Online services online or directly with the licensing board via phone or mail:

- Board of Podiatric Medicine (D.P.M.)

2) Federation of Podiatric Medical Board (FPMB)

3) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:

- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
- Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
    - Documentation can be kept electronically or via an electronic or paper/log checklist.

e. Nonphysician healthcare Practitioners. Sanction and limitation on licensure verifications must be verified through:

1) BreEZe Online services online or directly with the licensing board via phone or mail:

- Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C., L.P.C.C.)
- Board of Psychology (Ph.D., Psy.D.)
- California Board of Occupational Therapy (O.T.)
- California State Board of Optometry (O.D.)
- Physical Therapy Board of California (P.T.)
- Physician Assistant Committee (P.A., P.A.-C)
- California Board of Registered Nursing (C.N.M., N.P.)
- Speech-Language Pathology & Audiology Board (S.P., Au)
- Acupuncture Board (L.Ac.)[18]

2) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within thirty (30) calendar days of their release. The Delegate must:

[18] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 5, Element A, Factor 2

- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within thirty (30) calendar day of its release.
- Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
    - Documentation can be kept electronically or via an electronic or paper/log checklist.

3) Direct contact with the Delegate, if necessary

- Confirmed information is forwarded to the Delegate for review and decision. Delegates are requested to inform IEHP in writing of their decision within thirty (30) days of the decision.

4) Direct contact with the Practitioner, if necessary

3. Policies for collecting and reviewing complaints must state Delegate:[19]
    a. Investigates Practitioner-specific Member complaints upon their receipt and evaluates the Practitioner's history of complaints, if applicable.
    b. Evaluates the history of complaints for all Practitioner's history of complaints at least every six (6) months.
    c. Quality or collecting and reviewing complaints are not delegated and complaints are forwarded to the Health Plans, as applicable. IEHP also provides the Delegates with copies of any Practitioner specific information such as Member complaints or studies received directly or conducted by IEHP.
    d. Policy and evidence may be found in the Quality Department.[~~20~~]
4. Policies for collecting and reviewing information from identified adverse events Delegate must state:[21]
    a. Monitoring for adverse events occurs every six (6) months.
    b. Quality/collecting and reviewing adverse events are not delegated and events are forwarded to the Health Plans, as applicable.
    c. Policy and evidence may be found in the Quality Department.[~~22~~]
5. Policies for implementing appropriate interventions when it identifies instances of poor quality related for factors 1-4 may be found in the Quality Department. Delegate must have a process to determine if there is evidence of poor quality that could affect the health

[19] NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 3
[~~20~~] ~~NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 3~~
[21] NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 4
[~~22~~] ~~Ibid.~~

and safety of its Members and implement the appropriate policy based on action/intervention.

a. At minimum, Providers identified through ongoing monitoring for licensure actions, sanctions, adverse history, grievances and/or complaints, must be fully discussed and reviewed by the Credentialing Committee. The reason for review must be considered and documented in the meeting minutes.[23]

1) Interventions can be identified in one of the following:

- Committee minutes
- Practitioner files
- Delegate file binders[24]

b. If IEHP believes that a Member's health or safety may be at risk due to adverse events or quality concerns, IEHP may take one of the following actions:

1) Refer the Practitioner to the next IEHP Peer Review Subcommittee meeting for direction;

2) Immediately suspend the Practitioner from participation with IEHP with referral to the next IEHP Peer Review Subcommittee meeting; or

3) Any other action as appropriate, given the circumstances and severity of the situation.

B. Delegates maintains a documented process for monitoring whether network physicians have opted out of participating in the Medicare Program using one of the CMS.gov Opt-Out sites. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance.

1. Delegate must review the Opt-Out Report from one of the CMS.gov sites on a quarterly basis, within thirty (30) days of its release.

a. The report must be dated and initialed

b. A checklist may be used to document the date of the electronic file download. The checklist must contain:

1) The date of the download and signature of the Delegate personnel who verified it.

2) Delegates must review quarterly Opt-Out reports even if they employ their Practitioners.

~~2. Practitioners identified on the Medicare Opt Out List may not participate in any Medicare~~

[23] NCQA, 2022 HP Standards and Guidelines, CR 5, Element A, Factor 5
[24] ~~NCQA, 20221 HP Standards and Guidelines, CR 5, Element A, Factor 5~~

~~line of business but may participate in other lines of business.~~

C. Delegates must use the Medi-Cal Suspended & Ineligible List, published monthly by the Department of Health Care Services (DHCS), as the verification source for Medicaid Sanctions. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance. Delegate must review the Suspended & Ineligible List on a monthly basis, within thirty (30) days of its release.[25]

1. Delegate may develop a tracking log to include the report run date, review date, initials of person reviewing report, the list reviewed, and the web link used;
2. Delegate may print the parts of the list that are applicable; or
3. Delegate can print the entire list.
    a. The report must be dated and initialed
        1) Providers identified on the Medi-Cal Suspended and Ineligible List will be automatically suspended from participation in all Medi-Cal lines of business, without appeal rights.
            - All Members assigned to suspended Practitioners will be reassigned to new Practitioners.
            - The ~~Suspended~~ suspended Practitioner will be presented to the Peer Review Subcommittee as an administrative termination and for further review, discussion.
                - Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings to include any additional prior quality of care issues and Member complaints for the Provider.[26,27]

D. Delegated maintains a documented process for monitoring whether its Practitioners are included in the ~~Centers for Medicare & Medicaid Services (~~CMS~~)~~ Preclusions List, to ensure compliance with the 2019 Medicare Program Final Rule. In order for Providers (including entities) to receive payment from Medicare Plan (Part C and D), they must not be included in the ~~Centers for Medicare & Medicaid Services (~~CMS~~)~~ Preclusions List. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance.[28]

1. On a monthly basis, IEHP will share updates of the Preclusions List on the Secure File Transfer Portal (SFTP), as it will be made available by CMS approximately every thirty

[25] DHCS APL 19-004
[26] ~~DHCS APL 19-004~~Ibid.
[27] ~~Coordinated Care Initiative (CCI) Three-Way Contract, January 2018, Section 2.10~~
[28] Centers for Medicare & Medicaid Services (CMS), Policy CMS-4182 Final Rule

(30) days, around the first (1st) business day of each month.

a. Delegates are required to screen their Provider network against the Preclusions List monthly, within thirty (30) days of its release.

b. Notify IEHP within two (2) business days if an exact match is found for:

1) National Practitioner Identification (NPI)

2) Employer Identification Number (EIN), specific to entities

E. IEHP maintains a documented process for monitoring practitioners identified on the Restricted Provider Database (RPD).[29] IEHPs Credentialing Analyst will obtain the Restricted Provider Database report monthly, by the 5th of each month, for practitioners directly credentialed with IEHP and those credentialed through a Delegated Network.

1. Providers identified on the RPD will be presented to Peer Review Subcommittee for review and discussion. The following actions will be required to ensure compliance with DHCS guidelines:

a. Payment Suspension: Providers are placed under a payment suspension while under investigation based upon a credible allegation of fraud.

1) IEHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services will be withheld; or

- If IEHP chooses to continue the contractual relationship with providers who are placed on payment suspensions, IEHP must allow out-of-network access to members currently assigned to the provider by approving the request.

2) IEHP may choose to terminate the contract by submitting appropriate documentation ~~as outlined in APL 21-003~~.[30]

b. Temporary Suspension: Providers placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.

1) IEHP must terminate the contract and submit appropriate documentation. ~~as outlined on APL 21-003~~.[31]

F. IEHP maintains a documented process that includes the System for Award Management (SAM) in their list of database checks. IEHP uses OIG Compliance Now as the vendor to collect data and alert services, to include but is not limited to the System for Award Management (SAM) in their scope of review.

1. The OIG LEIE includes all healthcare providers and suppliers that are excluded from participation in federal health care programs, including those health care providers and

[29] ~~DHCS APL 19-004~~Ibid.
[30] DHCS APL 21-003 Supersedes APL 16-001 "Medi-Cal Network Provider and Subcontractor Terminations"
[31] Ibid.

suppliers that might also be on the SAM (previously EPLS). In addition to health care providers (that are also included on the OIG LEIE) the EPLS includes non-health care contracts[32], which are out of scope for the practitioners undergoing the Credentialing process.

G. Delegates that subscribe to a sanctions alert service must have evidence of its subscription to the sanctions alert service during the look back period. Delegates using an outside company or sanctions alert service (i.e. OIG Compliance Now, Streamline Verify) for ongoing monitoring or data collection and alert services, must:

1. Have evidence of its subscription to the sanctions alert service during the look back period.
2. Provide a documented process and evidence that includes, but is not limited to:
   a. How the list of Providers is compiled and provided to the company for screening
   b. List of sanctions screened by outside company, (can be found in an attachment or contract with entity)
   c. How the Outside company notifies Delegate of their findings
   d. Screening is reviewed within thirty (30) calendar days of their release
   e. If no reports were received for ongoing monitoring, Delegate must document or note that no reports were received during the monthly look-back period.
   f. Documentation can be kept electronically or via electronic or paper log/checklist.
      1) A spreadsheet/tracking log may be used as documentation for compliance. Delegate must include:
         - Name of board/entity
         - Date of query
         - Date of report
         - Signature(s)/initials of Delegate personnel who reviewed it.
      2) If the reporting entity does not publish sanction information on a set schedule, the delegates:
         - Documents that the reporting entity does not release information on a set schedule.
         - Queries for this information for at least six (6) months.
      3) If the reporting entity does not release sanction information reports, the delegate

[32] Medicare Managed Care Manual, Chapter 21 "~~Compliance Program Guidelines and Prescription Drugs Benefit Manual~~OIG/GSA Exclusion", Section 50.6.8

must conduct individual queries of credentialed Practitioners every twelve (12) to eighteen (18) months after the last credentialing cycle.

H. IEHP notifies Delegates of any adverse actions it becomes aware of through sources other than the Delegate. In addition, IEHP shares with all Delegates the results of performing monitoring through quality improvement studies, Member complaints and Member satisfaction surveys, as applicable. IEHP reviews the history of each Delegate's credentialed and approved Practitioners. Delegate is responsible for notifying IEHP of:

1. Any findings and the actions decided by the Credentialing Committee within thirty (30) days of the decision, to include, but not limited to:
    a. Date(s) of the Credentialing Committee the Practitioner was reviewed;
    b. Date of the Credentialing Committee decision;
    c. Delegate's Plan of action for the Practitioner;
    d. Frequency of monitoring (if applicable); and
    e. Any follow-ups scheduled.
        1) All Practitioners identified through the ongoing monitoring will be presented to IEHP's Peer Review Subcommittee for review and decision.
            - IEHP reserves the right to approve, deny, terminate or otherwise limit Practitioner participation in the IEHP network for any reason including up to quality issues.
                - If a Provider is denied participation due to quality of care and an 805 was filed with the appropriate licensing agency and the National Practitioner Data Bank (NPDB) than the Provider is not eligible to reapply.
                    - For administrative terminations or denials, he/she may reapply after one (1) year.
                - Practitioners can appeal adverse decisions by the IEHP Peer Review Subcommittee as delineated in IEHP's Peer Review Process and Level I Review and Level II Appeal (See Attachments, "IEHP Peer Review Level I and Credentialing Appeal~~Process and Level I Review~~" and "IEHP Peer Review Process and Level II Appeal" in Section 5).
2. Any of the following occurs with one of their contracted Practitioners:
    a. The surrendering, revocation or suspension of a license;
    b. The surrendering, revocation or suspension of DEA registration;
    c. A change in hospital staff status or hospital clinical privileges, including any

restrictions or limitations;

d. A change in hospital admitting arrangements for Practitioners without IEHP affiliated hospital privileges;

e. Loss of malpractice insurance; and

f. The notification must include the IPA's proposed action and/or resolution.

3. Delegates are required to notify IEHP in writing within thirty (30) days of its knowledge, if any of the following occurs with one of their contracted Practitioners:

a. Any filing pursuant to Business and Professions Code Sections § 805, 805.01 or 809;

b. Any filing with the NPDB; and

c. The notification must include the Delegate's proposed action and/or resolution.

I. Delegate must have a process to verify and maintain Practitioner licensing status, DEA or CDS certificate, etc., and remedies if the license or certification expires or status changes during the Practitioner's participation with IEHP.

1. Delegate is responsible for notifying IEHP of any licensure and DEA changes within thirty (30) days of the change. The notification must include:

a. Date the Delegate was notified

b. Type of change

c. Effective date of the change

d. Date of Credentialing Committee review, (if applicable)

e. Delegate's Plan of Action for the Practitioner

f. Frequency of monitoring (if applicable); and

g. Any follow-ups scheduled

J. Delegates must report Social Security Numbers (SSN) for all new and existing Practitioners to IEHP, to ensure all Practitioners are included in IEHP's screening of the ~~Social Security Administration's Death Master File (~~SSADMF~~)~~.

1. All Delegates must provide the Social Security Numbers for their respective practitioners under the following:

a. Provider Profile Submission

b. Credentialing Activities Report

c. Upon request by IEHP. Applicable to all existing practitioners with missing SSN.

1) Delegates who do not provide the requested information will be placed on a Corrective Action Plan (CAP) until all missing SSNs are submitted.

2. If a Practitioner is identified on the SSADMF, and the practitioner:
   a. Confirms that his/her SSN is correctly stated on the SSADMF, but is not deceased, IEHP will request for the following information from the practitioner:
      1) A copy of the Social Security Card.
      2) A Photo ID.
      3) A signed attestation (See attachment, "Death Master File Identity Attestation" in Section 5) from the Practitioner confirming their identity; and
      4) Request for the practitioner to contact the ~~Social Security Administration's Death Master File (~~SSADMF~~)~~ to correct the issue.
   b. Confirms their SSN is correctly stated but the name and Date of Birth (DOB) does not, IEHP will request for the following:
      1) A copy of the Social Security Card.
      2) A Photo ID.
      3) A signed attestation (See attachment, "Death Master File Identity Attestation" in Section 5) from the Practitioner confirming their identity; and
      4) Request for the practitioner to contact the ~~Social Security Administration's Death Master File (~~SSADMF~~)~~ to correct the issue.
3. Upon receipt of the required documents, the Credentialing ~~Analyst~~ designee will provide the attestation and supporting documentation to our Compliance Department for review and repository.[33]

[33] DHCS APL 19-004

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION OVERSIGHT

B. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

APPLIES TO:

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

POLICY:

A. Delegates' policies and procedures must state how the organization reviews participation of Practitioners whose conduct could adversely affect Members' health or welfare, specify the range of actions that may be taken to improve Practitioner performance before termination, how the Delegate reports its actions to the appropriate authorities including state licensing agencies, the National Practitioner Data Bank (NPDB), and Inland Empire Health Plan (IEHP) [1] ~~authorities~~ and inform Practitioners of ~~makes the~~ appeal process ~~known to Practitioners~~.~~[2]~~ [3]

~~B. Delegates' policies and procedures regarding suspension or termination of a participating Physician require the Delegate to ensure that the majority of the hearing panel members are peers of the affected Physician.~~

PURPOSE:

~~A. A Delegate that has taken action against a Practitioner for quality reasons reports the action to the appropriate authorities and offers the Practitioner a formal appeal process.~~

~~B.~~A. Delegates must use objective evidence and patient-care considerations when deciding on a course of action for dealing with a Practitioner who does not meet its quality standards.[4]

~~C.~~B. ~~If a Delegate terminates or suspends a Practitioner for quality reasons, it must report to the appropriate authorities, including state licensing agencies, the National Practitioner Data Bank (NPDB), and Inland Empire Health Plan (IEHP).~~

~~D.~~C. Notification applies to Physicians and nonphysicians for suspensions and terminations for quality reasons.[5]

~~E.~~D. Delegates must provide evidence that it followed its appeal process if it altered the conditions of a Practitioner's participation based on quality of care or service reasons.[6]

[1] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 6, Element A, Factor 1
[2] ~~National Committee for Quality Assurance (NCQA), 2022~~21 Health Plan Standards and Guidelines, CR 6, Element A, Factor 1
[3] NCQA, 2022 HP Standards and Guidelines, CR 6, Element A, Factor 2
[4] NCQA, 2022 HP Standards and Guidelines, CR 6, Element A, Factor 1-2
[5] Title 42 Code of Federal Regulations (CFR) § 422.202
[6] Ibid.

~~F.~~E. Practitioners must appeal directly to their contracted IPA for adverse credentialing decisions rendered by the Delegated IPA.

~~G.~~F. Reporting to appropriate authorities is not applicable in the following circumstances:

1. If there are no instances of suspension, termination, restriction or revocation to report for quality reasons.
2. For automatic administrative terminations based on the Practitioners not meeting specific contractual obligations for participation in the network.

~~H.~~G. All credentialing records and proceeds are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.[7]

DEFINITION:[8]

A. "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates.

1. The Medical Board of California is the agency for the following Practitioner types:

a. Physicians and Surgeons (MDs)

b. Doctors of Podiatric Medicine (DPMs)

c. Licensed Midwives (LMs)

d. Physician Assistants (PAs)

B. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.

a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

b. If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT

[7] California Evidence Code § 1157~~California Code, Evidence Code (EVID), § 1157~~
[8] Business and Professions Code § 805

considered delegation.

C. "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

D. "Licentiate" means a Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, or physician's assistant. Licentiate also includes a person authorized to practice medicine. ~~pursuant to California Code, Business and Professions Code Section 2113 or 2168.~~[9]

E. "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to the patient's safety or to the delivery of patient care.

~~A.~~F. "Peer" is an appropriately trained and licensed Physician in a practice similar to that of the affected Physician.

~~B.A. "Licentiate" means a Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, or physician's assistant. Licentiate also includes a person authorized to practice medicine pursuant to California Code, Business and Professions Code Section 2113 or 2168.~~

~~C.~~A. ~~"Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates.~~

~~1. The Medical Board of California is the agency for the following Practitioner types:~~

~~a. Physicians and Surgeons (MDs)~~

~~b.~~a. ~~Doctors of Podiatric Medicine (DPMs)~~

~~c.~~a. ~~Licensed Midwives (LMs)~~

~~d.~~a. ~~Physician Assistants (PAs)~~

~~D.~~G. "Staff privileges" means any arrangements under which a licentiate can practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

[9] Business and Professions Code § 2113 and 2168

~~E.~~A. ~~"Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.~~

~~F.~~A. ~~"Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to the patient's safety or to the delivery of patient care.~~

~~G.~~A. ~~Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.~~

1. ~~Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.~~

~~a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.~~

~~b.~~a. ~~If information is gathered from a company website and the Delegate staff is pulling the queries for Office of Inspector General (OIG) or other types of queries, it is NOT considered delegation.~~

PROCEDURES:

A. Delegates has policies and procedures for:

1. The range of actions available to the Delegate, that:

   a. Specify the Delegate reviews participation of Practitioners whose conduct could adversely affect Members' health or welfare.

   b. Specify the range of actions available to the Delegate, that they may take to improve the Practitioner performance before termination[10], to include, but not limited to:

      1) Profiling

      2) Corrective actions(s)

      3) Monitoring

      4) Medical Record Audit

[10] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 6, Element A, Factor 1

c. Specify that the Delegate reports its actions to the appropriate authorities. Appropriate authorities include, but are not limited to:

1) Appropriate Licensing Board[11]

- Medical Board of California 805 and 805.01 reports or the appropriate licensing board must be filed fifteen (15) days after a recommendation or final determination. The following types of providers require 805 and 805.01 reporting:

(a) Medical Doctors (MD)

(b) Dentists (DDS)

(c) Osteopaths (DO)

(d) Podiatrists (DPM)

(e) Marriage Family Therapists (MFT)

(f) Licensed Clinical Social Workers (LCSW)

(g) Psychologists (PsyD, PhD)

(h) Physician Assistants

(i) Nurse Practitioners (NP) effective 01/01/2021 (AB 890)

2) National Practitioner Data Bank (NPDB)

2. Making the appeal process known to ~~practitioners~~Practitioners. The Delegates' policies and procedures must give the Practitioners the right to appeal and must include the following steps within the appeal process:[12]

a. Provide written notification when a professional review action has been brought against a Practitioner, including reasons for the action.

b. Allow Practitioners to request a hearing/appeal and the timing for submitting the request.

c. Policy must state that the Delegate cannot have an attorney, if the Practitioner does not have attorney representation, to ensure compliance with CA Business & Professions Code 809.3(c).[13]

3. Practitioner ~~Appeal~~ appeal ~~Process~~ process where the Delegate informs the affected Practitioner of its appeal process and includes the following information in process and

[11] Bus. and Prof. Code § 805
[12] NCQA, 2022 HP Standards and Guidelines, CR 6, Element A, Factor 2
[13] ~~California Code,~~ Bus.~~iness~~ and Prof.~~essions~~ Code ~~(BPC)~~ § 809.3(c)

notification.[14]

a. Providing written notification indicating that:

1) A professional review action has been brought against the Practitioner;

2) Reasons for the action; and

3) A summary of the appeal rights and process, which can be made known to the Practitioner through an attachment, addendum, policy, contract or manual.

b. Allowing the Practitioner to request a hearing and the specific time period for submitting the request.

c. Allowing at least thirty (30) days after the notification for the Practitioner to request a hearing.

d. Allowing the Practitioner to be represented by an attorney or another person of the Practitioner's choice.

e. Appointing a hearing officer or a panel of individuals to review the appeal.

f. Providing written notification of the appeal decision that contains specific reasons for the decision.[15]

4. Delegates must have policies and procedures that describe when and how reporting occurs, to whom incidents are reported and what specific incidents are reportable. The policy must address what is expected of the Delegates' staff and outline accountability so that staff understand their responsibilities in order to perform their functions correctly. When the Delegate decides to suspend or terminate a Practitioner's contract, there must be procedures notifying the appropriate authorities (including state agencies, as appropriate) of the action, that includes, but is not limited to:

a. 805 Reports.[16]

1) Delegate is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason.

- If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a Physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

- If the California Board of Podiatric Medicine or a licensing agency of

[14] NCQA, 2022 HP Standards and Guidelines, CR 6, Element A, Factor 2
[15] ~~NCQA, 2022~~1 HP Standards and Guidelines, CR 6, Element A, Factor 2
[16] Bus. and Prof. Code § 805

another state revokes or suspends, without a stay, the license of a doctor of podiatric medicine, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension

2) If an 805 is reported, it shall include the following information:

- The name of the licentiate involved;
- The license number of the licentiate involved;
- A description of the facts and circumstances of the medical disciplinary cause or reason; and
- Any other relevant information deemed appropriate by the reporter.

3) Delegates must file an 805 report with the relevant agency within fifteen (15) days after the effective date on which any of the following occur as a result of an action of a peer review body:

- A licentiate's application for staff privileges or membership is denied or rejected for medical disciplinary cause or reason.
- A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
- Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any twelve (12) month period, for a medical disciplinary cause or reason.

4) If a licentiate takes any action listed above, after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the chief of a staff or a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within fifteen (15) days after the licentiate takes the action.[17]

- Resigns or takes a leave of absence from membership, staff privileges or

[17] Bus. & Prof. Code § 805

employment.

- Withdraws or abandons his or her application for staff privileges or membership.
- Withdraws or abandons his or her request for renewal of staff privileges or membership.[18]

b. 805.01 Reports[19]

1) Delegate must file an 805.01 within fifteen (15) days after a peer review body makes a final decision or recommendation of termination, suspension or restriction of staff privileges, membership or employment due to an investigation, for at least one (1) of the following reasons:

- Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one (1) or more patients in such manner as to be dangerous or injurious to any person or the public.
- The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
- Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
- Sexual misconduct with one (1) or more patients during a course of treatment or an examination.[20]

c. National Practitioner Data Bank (NPDB)

1) Reports must be submitted to the NPDB within thirty (30) days of the action.[21]

d. Health Plan Reporting

1) Reports must be submitted to IEHPs Credentialing Manager, within thirty (30)

[18] California Code, Business and Professions Code § 805
[19] California Code, Business and Professions Code (BPC) § 805.01
[20] California Code, Business and Professions Code (BPC) § 805.01
[21] 45 CFR § 60Code of Federal Regulations (CFR), 45 CFR Part 60 "National Practitioner Data Bank"

days of the action.[22]

B. Delegates' policies and procedures regarding suspension or termination of a participating physician require the Delegate to ensure that the majority of the hearing panel members are peers of the affected Physician.[23][24]

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

[22] Title 45 Code of Federal Regulations (CFR) § 60
[23] Medicare Managed Care Manual, Chapter 6, "Suspension, Termination, or Nonrenewal fo Physician Contract,", Section 60.4
[24] ~~Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Section 60.4~~

25. DELEGATION OVERSIGHT

B. Credentialing Standards
6. Notification to Authorities and Practitioner Appeal Rights

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

7. Assessment of Organizational Providers

APPLIES TO:

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

POLICY:

A. Delegate has written policies and procedures for the initial and ongoing assessment of Providers who contract with the Delegate, to provide medical services to Members as designated on the IEHP Division of Financial Responsibility (DOFR) Matrix. Delegates must assess all health care delivery providers before contracting with a provider, and for at least every thirty-six (36) months thereafter. Delegates must confirm the provider is in good standing with state and federal regulatory bodies; confirms the provider has been reviewed and approved by an accrediting body; and conducts an onsite quality assessment if the provider is not accredited.[1]

B. IEHP delegates to IPAs that meet IEHP delegation requirements for credentialing, the responsibility for the initial and on-going assessment of subcontracted Providers that render services to Members and the Delegate is responsible for claims payment for those Health Care Delivery Organization Providers. IEHP retains oversight responsibilities for all subcontracted Providers. The Provider types included in the medical assessment include, but are not limited to: Hospitals[2], Home Health Agencies,[3] -Skilled Nursing Facilities,[4] Free-Standing Surgical Centers[5] and Clinical Laboratories.

C. Delegates are not responsible for the claim's payment for behavioral healthcare facilities, therefore are not required to include them in their scope. IEHP includes behavioral healthcare facilities, providing mental health or substance abuse services in an inpatient setting in their scope of providers. Residential Treatment Facilities and Ambulatory Behavioral Health Facilities are not covered by this policy as these are not a covered IEHP benefit.[6]

~~D. Delegates must assess contracted mental health providers against the requirements and within the timeframes set forth in this policy.~~

~~E. IEHP is responsible for the initial and ongoing assessment for behavioral healthcare facilities, providing mental health or substance abuse services in inpatient settings. Residential Treatment Facilities and Ambulatory Behavioral Health Facilities are not covered by this policy as these are not a covered IEHP benefit.~~

[1] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 7, Element A, Factors 1-3
[2] NCQA, 2022 HP Standards and Guidelines, CR 7, Element B, Factor 1
[3] NCQA, 2022 HP Standards and Guidelines, CR 7, Element B, Factor 2
[4] NCQA, 2022 HP Standards and Guidelines, CR 7, Element B, Factor 3
[5] NCQA, 2022 HP Standards and Guidelines, CR 7, Element B, Factor 4
[6] NCQA, 2022 HP Standards and Guidelines, CR 7, Element C, Factors 1-3

~~F. Delegate has documentation of assessment of free-standing surgical centers to ensure that if the organizational provider is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program.~~

~~G. Delegates must conduct Federal and Database checks during the provider's assessment and reassessment process, and monthly thereafter.~~

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

PURPOSE:

A. Delegate evaluates the quality of organizational Providers with which the Delegate contracts.

B. IEHP directly contracts with IPAs, and Hospitals (Providers). In turn, Providers subcontract with Health Care Delivery Organizational Providers (subcontracted Providers) to provide services to Members as designated in the Division of Financial Responsibility (DOFR) Matrix outlined in IEHP's Capitated Agreements with Hospitals and IPAs. ~~Subcontracted Providers include, but are not limited to, Hospitals, Home Health Agencies, Skilled Nursing Facilities, Free-Standing Surgical Centers, and Clinical Laboratories.~~

C. All Providers must adhere to all procedural and reporting requirements under ~~state~~ State and ~~federal~~ Federal laws and comply with the most recent NCQA~~, state and~~ regulatory guidelines for subcontracted organizational Providers, as well as IEHP requirements.

D. Delegated Providers that subcontract with Ancillary and organizational Providers are responsible for ensuring that their subcontracted Providers meet IEHP's requirements as stated herein and in Policy ~~0~~5A7, "Credentialing Standards - Assessment of Organizational Providers", IEHP audits Delegate's compliance with IEHP requirements on an annual basis, using the IEHP Delegation Oversight Audit Tool beginning with a pre-contractual assessment, in accordance with Policy 25A2, "Delegation Oversight – Delegation Oversight Audit." Delegated IPAs are subject to corrective action as defined in Policy 25A4, "Delegation Oversight - Corrective Action Plan Requirements."

E. IEHP reserves the right to perform facility site audits when quality of care issues arises and to deny contracted or subcontracted Providers participation in the IEHP network if IEHP requirements for participation are not met.

F. Contracted and/or subcontracted Provider's failure to meet IEHP's requirements may result in adverse action up to and including non-renewal or termination of the delegated entity contract or IEHP contract.

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e., Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g., Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.

   a. Ongoing monitoring or data collection and alert service are NOT seen as delegation.

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

B. Free-Standing facility: An outpatient center that is separate from a Hospital or other inpatient facility and whose primary focus is providing immediate or short-term medical services on an outpatient basis.[7]

C. Organizational Provider (OP): refers to facilities providing services to Members and where Members are directed for services rather than being directed to a specific Practitioner. This element applies to all OPs with which the organization contracts (e.g., Telemedicine Providers, Urgent Care Centers).[8]

D. Organizational Provider Credentialing: Credentialing of facilities including hospitals, home health agencies, skilled nursing facilities & rehabilitation facilities, etc.

~~b.~~

PROCEDURES:

A. Delegate has written policies and procedures for the initial and ongoing assessment of Providers who contract with the Delegate, to provide medical services to Members as designated on the IEHP Division of Financial Responsibility (DOFR) Matrix. Delegates' policies for assessing a health care delivery provider specifies that before it contracts with a Provider, and at least every thirty-six (36) months thereafter~~, it~~:[9]

[7] NCQA, 2022 HP Standards and Guidelines, Glossary
[8] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 7, Element A
[9] California Welfare and Institutions Code (Welf. & Inst. Code), § 14043.6 and 14123

1. Must specify sources used to confirm that Providers are in good standing with state and federal requirements, that include, but are not limited to:[10]

   a. State (Department of Health Care Services) regulatory body. Licensure must be maintained throughout the duration of the subcontractors' participation in the IEHP network.

      1) Copies of Credentials (e.g., A copy of the license and expiration date) from the provider. The Health Care Delivery Organization Provider is responsible for providing IEHP with copies of its renewed license and accreditation within sixty (60) days following the expiration of the license and accreditation.~~[11]~~

         - Accreditation and licensure must be maintained throughout the duration of the subcontractors' participation in the IEHP network. A current and unencumbered license; must also be appropriately licensed and no other negative license actions that may impact participation

            - Physician-owned clinics are not required to be licensed by DHCS, but they must be accredited by an agency approved by the Medical Board. (If the physician-owned clinic is appropriately accredited, they would be compliant with the Knox-Keene Act of Title 28);[12]

      2) If a state license is not issued by the Department of Health Care Services, the facility should have a business license or certificate of occupancy.

      3) Successful enrollment in the Medi-Cal Program via the Department of Health Care Services (DHCS) Provider Enrollment Division (PED) or through a Managed Care Plan's enrollment process;

         - All Health Care Delivery Organization Providers must periodically revalidate their enrollment information with the Medi-Cal Program through DHCS. All Providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process.,[13] ~~in accordance with the DHCS All Plan Letter (APL) 17-019.~~ DHCS's PED is responsible for the timely enrollment of Providers into the Medi-Cal Program. The PED has two (2) options for enrollment:

            - Online
              The PED now offers an improved web-based alternative to the current paper application enrollment process via the Provider Application and

[10] NCQA, 2022 HP Plan Standards and Guidelines, CR 7, Element A, Factor 1
~~[11] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 7, Element A, Factor 1~~
[12] Knox-Keene Health Care Service Plan Act of Title 28
[13] DHCS APL 19-004 Supersedes All Plan 17-019, "Provider Credentialing/Recredentialing and Screening/Enrollment"

Validation for Enrollment (PAVE) Provider Portal. The PAVE portal can be accessed using the following link, http://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx.

- Paper Application
  Application forms, instructions, and tips can be found on the DHCS website at http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.aspx.~~http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp~~. The webpage has information that can assist you in completing and submitting a complete application package.

Providers that are successfully enrolled can verify their enrollment utilizing the California Health & Human Services Agency's portal. The portal will allow Providers to see if they are already enrolled in the Medi-Cal program through DHCS. The portal can be accessed via https://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider~~https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017~~. The portal is maintained by the PED and is updated monthly.[14]

b. Federal Regulatory Bodies. Delegates must review and ensure Providers have no sanctions that may impact participation. Delegates must ensure review of the:

1) Department of Health & Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities List (LEIE). Review of OIG or Medicare/Medicaid Sanctions must be completed and documented on the spreadsheet or the file. The monthly review of the OIG report as part of the "Ongoing Monitoring" qualifies as compliant for this section if the facilities are included on the OIG Report.[15]~~,16~~

- IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners or entities found on OIG Reports).[17,18]

  - CMS' Medicare Exclusion Database (MED) is the source that is used

[14] DHCS APL 19-004 Supersedes All Plan 17-019 "Provider Credentialing/Recredentialing and Screening/Enrollment"
[15] Medicare Managed Care Manual, Chapter 6 "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks~~Relationships with Providers,~~", ~~Chapter 6~~ § 60.2
~~[16] Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019 "Provider Credentialing/Recredentialing and Screening/Enrollment"~~
[17] DHCS APL19-004
[18] DHCS APL 21-003

to populate the LEIE list. IEHP will use the LEIE to verify if practitioners are identified on the MED.[19]

2) ~~Centers for Medicare and Medicaid Services (~~CMS~~)~~ signed participating agreement letter, if applicable.[20]

3) An attestation from a Provider to the organization regarding the Providers' regulatory status is not acceptable.

c. The Organizational Providers must always maintain accreditation and license status in good standing and/or current during their participation in the IEHP network.[21]

2. Delegates may accept an accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the Provider, as evidence that the Provider has been reviewed and approved by an accrediting body. Accreditation and licensure must be maintained throughout the duration of the subcontractors' participation in the IEHP network.

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

a. Hospitals

1) The Joint Commission (TJC)

2) Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)

3) Det Norske Veritas National Integrated Accreditation of Healthcare Organization (DNVNIAHO)

4) Center for Improvement in Healthcare Quality (CIHQ)

b. Home Health Agencies

1) The Joint Commission (TJC)

2) Community Health Accreditation Program (CHAP)

3) Accreditation Commission for Health Care Inc (ACHC)

c. Skilled Nursing Facilities

1) The Joint Commission (TJC)

[19] Ibid.
[20] Medicare Managed Care Manual, Chapter 6 "Institutional Provider and Supplier Certification", Section 70
[21] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 7, Element A, Factor 1

2) Commission on Accreditation or Rehabilitation Facilities (CARF)

3) Continuing Care Accreditation Commission (CCAC)

d. Free-Standing Surgical Centers

1) The Joint Commission (TJC)

2) American Association for Accreditation for Ambulatory Surgical Facilities (AAAASF)

3) Accreditation Association for Ambulatory Health Care (AAAHC)

4) Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)

5) The Institute for Medical Quality's (IMQ's) (CMS approved accrediting body verified by IEHP)[22]

e. Behavioral Health Providers (Intensive Programs and Inpatient Treatment Programs)

1) The Joint Commission (TJC)

2) Commission on Accreditation or Rehabilitation Facilities (CARF)

3) Healthcare Facilities Accreditation Program (HFAP)

4) Council on Accreditation (COA)

f. Clinical Laboratories

1) The Joint Commission (TJC)

2) Clinical Laboratory Association Improvement (CLIA) Certificate or CLIA Waiver

3) Commission on Office Laboratory Accreditation (COLA)

4) College of American Pathology (CAP)

3. An onsite quality assessment must be conducted if the Provider is not accredited. Delegate policy must specify the onsite quality assessment criteria for each type of non-accredited provider includes, but is not limited to:

a. Onsite quality assessment criteria for each type of Provider.

b. A process ensuring that the Providers credential their Practitioners.

c. Delegates policy may specify it only contracts with accredited Providers to meet this

[22] NCQA, 2022 HP Standards and Guidelines, CR 7, Element A, Factor 2

requirement.

d. A CMS or state quality review in lieu or a site visit under the following circumstances (if the Delegate chooses to substitute the site visit with a with a CMS or state quality review), if it meets the following requirements:

1) The CMS or state review is no more than three (3) years old.

- If the CMS or state review is older than three (3) years, the organization conducts its own onsite quality review.

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

- The report meets the Delegates quality assessment criteria or standards.

3) The Delegate is not required to conduct a site visit if the state or CMS has not conducted a site review of the Provider and the Provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html).[23,24]

B. Delegates' policies and procedures must state which organizational Providers types are contracted and the Delegate is responsible for the initial and ongoing assessment of medical providers, which includes, but is not limited to:

1. Hospitals[25]
2. Home Health Agencies[26]
3. Skilled Nursing Facilities[27]
4. Free-Standing Surgical Centers[28]
5. Clinical Laboratories in its assessment
6. If Delegate policies and procedures address all Provider types, the Delegate will not need to specify which types they do not contract with.

C. IEHP's delegation arrangements with Delegates, "carves out" behavioral healthcare services, therefore, Delegates are not responsible for the initial and ongoing assessment for behavioral healthcare facilities providing mental health or substance abuse services in an inpatient setting. Residential Treatment Facilities and Ambulatory Behavioral Health Facilities are not

[23] Ibid.
[24] Medicare Managed Care Manual, Chapter 6, "Institutional Provider and Supplier Certification", Section 70
[25] NCQA, 2022 HP Standards and Guidelines, CR 7, Element B, Factor 1
[26] NCQA, 2022 HP Standards and Guidelines, CR 7, Element B, Factor 2
[27] NCQA, 2022 HP Standards and Guidelines, CR 7, Element B, Factor 3
[28] NCQA, 2022 HP Standards and Guidelines, CR 7, Element B, Factor 4

covered in this policy, as these are not a covered IEHP benefit.[29,30]

D. Delegates must assess contracted medical health care providers, organizational providers, against the requirements and within the time frame. Delegates may:[31]

1. Use a comprehensive spreadsheet or log showing credentialing of Medical organizational Providers, to calculate compliance and completion of the File Review.

2. Delegates must have a tracking mechanism for ensuring that licenses and certificates are current and reviews are compliant with the thirty-six (36) month timeframe.

E. Delegates are not responsible for the assessment of Behavioral Healthcare Facilities. IEHP is responsible for the initial and ongoing assessment of Behavioral Health Facilities providing mental health or substance abuse services in an inpatient setting.[32]

1. Behavioral Health Facilitates providing mental health or substances abuse services in Residential and Ambulatory settings are not covered as an IEHP benefit, therefore IEHP is not responsible for the initial and ongoing assessment.

F. IEHP has documentation of assessment of free-standing surgical centers to ensure that if the organizational provider is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program~~, in compliance with California Health and Safety Code § 1248.1~~. The following sources are included in the assessment of non-accredited free-standing surgical centers:[33,34]

1. Certification letter from Medicare stating the facility is certified.

a. If certification letter is not present, attestation in file or Medicare certification number will be noted on the spreadsheet; and

b. A CMS Survey, which include the certification number, is also present in the file.

2. If a surgical center is associated with a TJC (The Joint Commission) American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), accreditation Association for Ambulatory Healthcare (AAAHC) accredited hospital or Healthcare Facilities Accreditation Program (HFAP), accrediting program approved by the American Osteopathic Association (AOA), then the assessment of the free-standing surgical center does not apply.[35]

G. Delegates must conduct Federal and Database checks during the provider's initial assessment and reassessment process, and monthly thereafter. Each provider must maintain good standing

[29] NCQA, 2022 HP Standards and Guidelines, CR 7, Element C, Factor 1
[30] Medicare Managed Care Manual, Chapter 11, "Delegation requirements," Section 110.2
[31] NCQA, 2022 HP Standards and Guidelines, CR 7, Element D
[32] NCQA, 2021 HP Standards and Guidelines, CR 7, Element E
[33] Health and Safety Code § 1248.1
[34] NCQA, 2022 HP Standards and Guidelines, CR 7, Element B, Factor 4
[35] ~~California Health and Safety Code § 1248.1~~

in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the IEHP network.

1. Federal and State Database checks for the following databases are conducted by:
   a. IEHP
      1) Social Security Administration's Death Master File (SSADMF) applies to screening Practitioners against the (SSADMF); however Organizational Providers are not reviewed for individual practitioners, therefore the does not apply to the provider types referenced in this policy.
      2) Restricted Provider Database. Contracting will obtain the Restricted Provider Database report monthly, by the 5th of each month. Providers identified on the RPD will be presented to Compliance for review and discussion. The following actions will be required to ensure compliance with DHCS guidelines:
         - Payment Suspension: Providers are placed under a payment suspension while under investigation based upon a credible allegation of fraud.
            - IEHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services will be withheld; or
            - If IEHP chooses to continue the contractual relationship with providers who are placed on payment suspensions, IEHP must allow out-of-network access to members currently assigned to the provider by approving the request.
               - IEHP may choose to terminate the contract by submitting appropriate documentation ~~as outlined in APL 21-003~~.[36]
         - Temporary Suspension: Providers placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.
            - IEHP must terminate the contract and submit appropriate documentation ~~as outlined on APL 21-003~~.[37]
   b. Delegate
      1) National Plan and Provider Enumeration System (NPPES). IEHP ensures the provider has an active and current Organization NPI.
      2) List of Excluded Individuals/Entities (LEIE).
         - Practitioners identified on the HHS-Office of Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of

[36] DHCS APL 21-003 ~~Supersedes APL 16-001 "Medi-Cal Network Provider and Subcontractor Terminations".~~
[37] Ibid.

contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.[38,39]

- Members will be reassigned to new Practitioners.

3) System for Award Management (SAM).

- The OIG LEIE includes all healthcare providers and suppliers that are excluded from participation in federal health care programs, including those health care providers and suppliers that might also be on the SAM (previously EPLS). In addition to health care providers (that are also included on the OIG LEIE) the EPLS includes non-health care contracts.[40]

4) CMS' Medicare Exclusion Database (MED). The MED database is the source that is used to populate the LEIE list. Therefore, IEHP will use the LEIE to conduct their assessment of the MED database.

5) DHCS' Suspended and Ineligible Provider List.

- Providers identified on the Medi-Cal Suspended and Ineligible List will be automatically terminated for all lines of business, without appeal rights.
  - All Members assigned to the suspended Provider will be reassigned to new Practitioners. .[41,42]

H. Delegate has a documented process for informing IEHP's Compliance Department of any providers identified with a disciplinary action or on a exclusionary list. If during the contract period, the Delegate becomes aware of a change in the accreditation and/or CMS Site Survey, license, certification status, sanctions, fraudulent activity or other legal or remedial actions have been taken against any Provider, the Delegate must:[43]

1. Notify IEHP's Compliance Department by emailing compliance@iehp.org or fax (909) 477-8536 or via Compliance Hotline (866) 355-9038 within five (5) business days of discovering any of our Providers have been added to disciplinary or exclusionary lists.
   a. IEHP may report the termination of the contract to regulatory agencies as per contractual requirements and any services provided after the date of exclusion shall not be reimbursable or may be subject to recoupment.

[38] Medicare Managed Care Manual, Chapter 6 "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks~~Relationships with Providers~~", ~~Chapter 6~~ § 60.2
[39] DHCS APL 19-004
[40] Medicare Managed Care Manual, Chapter 21, "OIG/GSA Exclusion~~Compliance Program Guidelines and Prescription Drugs Benefit Manual~~", Section 50.6.8.
[41] DHCS APL 19-004
[42] ~~Coordinated Care Initiative (CCI) Three-Way Contract, January 2018, Section 2.10~~
[43] California Welfare and Institutions Code (Welf. & Inst. Code), 14043.6 and 14123

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
7. Assessment of Organizational Providers

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

8. Delegation of Credentialing

APPLIES TO:

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

POLICY:

A. Delegates must ensure there is a delegation agreement in place for all sub-delegation arrangements in place.[1]

B. For new delegation agreements initiated, Delegates must evaluate the sub-delegates capacity to meet National Committee for Quality Assurance (NCQA), ~~s~~State, and Federal regulatory requirements before delegation began.[2]

C. For delegation arrangements in effect for twelve (12) months or longer, Delegates must conduct oversight reviews of the Delegate's ~~C~~credentialing ~~A~~activities~~.~~ [3]

D. If there are any opportunities for improvement identified during the review of delegated credentialing activities, Delegates will identify, notify and follow-up with the sub-delegate to ensure the opportunities have been addressed.[4]

~~A. IEHP remains responsible for credentialing and recredentialing its Practitioners, even if it delegates all or part of these activities. IEHP Delegates authority for performing the functions within the National Committee for Quality Assurance (NCQA)/Centers for Medicare and Medicaid Services (CMS) standards to another entity; however, the Delegate must maintain responsibility for ensuring that the function is being performed according to organization expectations and to NCQA standards.~~

~~B. If the Delegate sub-delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities.~~

PURPOSE:

A. IEHP remains responsible for credentialing and recredentialing its Practitioners, even if it delegates all or part of these activities. Delegates are required to monitor the credentialing and recredentialing status and performance of their contracted Practitioners on a continuous basis in compliance with IEHP requirements and current NCQA, ~~state~~ State, and ~~federal~~ Federal regulatory guidelines.[5]

B. Delegates must verify that sub-delegates perform the functions discussed in Section 25, of the

[1] National Committee for Quality Assurance (NCQA), 2022 Health Plan Standards and Guidelines, CR 8, Element A, Factors 1-6
[2] NCQA, 2022 HP Standards and Guidelines, CR 8, Element B
[3] NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factors 1-6
[4] NCQA, 2022 HP Standards and Guidelines, CR 8, Element D
[5] Ibid.

Provider Manual and ~~what is outlined~~ in the Delegation Agreement between the Delegate and the sub-delegate.[6]

C. IEHP and any regulatory oversight agency~~,~~ ~~has~~ have the right, within two (2) working days advance notice to the Delegate, to examine the Delegate's credentialing~~/~~ and recredentialing files or sites as needed to perform oversight of all Practitioners or to respond to a complaint or grievance.

D. If a Management Services Organization (MSO) and an IPA are owned or under the same ownership, this is not considered delegation.

E. If an IPA changes MSOs during the annual audit period, only the current agreement will be reviewed and scored.

F. If a Delegate terminates a delegation arrangement during the annual audit period, only the termination date will be reviewed.

G. Delegates who ~~Delegate~~ delegate to an NCQA ~~Accredited~~ accredited entity, the Delegate must audit for Medi-Cal and DMHC requirements. Acceptance of accreditation only will not meet compliance for the additional regulatory requirements.

H. If the Delegate utilizes their sub-delegate for their specialty panel for HIV/AIDS ~~practitioners~~Practitioners, the Delegate must include the Identification of HIV/AIDS Specialists in their annual oversight review.

I. If the Delegate gives another organization the authority to perform certain functions on its behalf, this is considered delegation, e.g., Primary Source Verification of License, collection of the application, verification of Board Certification.

   1. Ongoing monitoring or data collection and alert services are NOT seen as delegation. IF the Delegate uses another organization for collecting data for ongoing monitoring or sanctions monitoring, and the Delegate then handles the review of information and intervention, it is not considered delegation.

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

J. Delegates must provide IEHP all sub-delegation agreements and effective dates.

DEFINITION:

A. Annual: A twelve (12) month period, within a two (2) month grace period, defined by NCQA.

B. Audit Date: The date of the file review.

C. Auto-Credit: Credit given to elements that have been audited by previous accrediting authority

[6] Medicare Managed Care Manual, Chapter 11, "Delegation requirements," Section 110.2

and meets industry compliance. Those elements will not be subjected to oversight.

D. Credentials Verification Organization (CVO): An organization that conducts primary-source verification of ~~p~~Practitioner credentials for other organizations. AN organization may obtain the following certification under NCQA CVO status:

1. Licensure
2. DEA or CDS verification
3. Education and Training
4. Work History
5. Malpractice History
6. Medical Board Sanctions
7. Medicare/Medicaid sanctions
8. Processing application and Attestation content; and
9. Ongoing Monitoring of Sanctions (licensure and Medicare/Medicaid)

E. Delegation: An organization gives and entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate the responsibility of ensuring that the function is performed appropriately.

F. Exit Interview: Auditor discussion of audit results with ~~d~~Delegate via phone, email or in person.

G. Factor: A scored item in an element.

H. Implementation Date: NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

I. Look-back period: Is the date range used for pulling files for a review.

J. Management Services Organization (MSO): an entity that, under contract provides services such as a facility, equipment, staffing, contract negotiation, administration, and marketing.

K. NCQA CR Accreditation: A provider organization that has achieved an NCQA accreditation in credentialing would receive auto-credit for certain standards of credentialing.

L. NCQA CVO Certification: An organization that has been certified by NCQA to collect primary source verifications. AN organization that has obtained this certification will still need to have a full file/policy review but does not need to evaluate~~d~~ on actual verification documentation but on the current and timely verification.

M. NCQA Health Plan Accreditation: A health plan organization that has achieved NCQA accreditation and would receive auto-credit for credentialing. An organization that has obtained this accreditation will still need to have a file/policy review for CMS, or state

requirements.

N. Pre-Assessment: Evaluation of a potential delegate's credentialing program prior to executing a delegated agreement.

~~A. Sub-delegation: Occurs when a group has delegated certain activities to in turn uses another entity to complete some of its delegated activities.~~

~~1. Using a vendor for ongoing monitoring of sanctions is not considered delegation by NCQA.~~

~~1. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered delegation.~~

~~1. Ongoing monitoring or data collection and alert services are NOT seen as delegation. If the organization uses another organization for collecting data for ongoing monitoring or sanction monitoring and the organization then handles the review of information and intervention, it is not considered delegation.~~

O. Timeliness: A term used when auditing file elements to confirm they are within one-hundred eighty (180) calendar days of the credentials committee decision.

~~A.~~P. Delegate: If IEHP gives another organization (i.e., Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Sub-delegation: Occurs when a group has delegated certain activities to in turn uses another entity to complete some of its delegated activities.

    a. Using a vendor for ongoing monitoring of sanctions is not considered delegation by NCQA.

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

    c. Ongoing monitoring or data collection and alert services are NOT seen as delegation. If the organization uses another organization for collecting data for ongoing monitoring or sanction monitoring and the organization then handles the review of information and intervention, it is not considered delegation.

~~1. Sub-delegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub delegation, and the organization would be considered a Sub-delegate. The Delegate will be responsible for sub-delegation oversight.~~

~~a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.~~

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

~~B. NCQA defines "annual" for this section as "a twelve (12) month period, with a two (2) month grace period."~~

PROCEDURES:

A. For all Credentialing delegation arrangements, Delegates must have a delegation agreement that describes all delegated Credentialing (CR), that includes:

1. A mutual agreement that documents delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the ~~organization~~ Organization and the Delegated entity. Dated and signed agreement between both parties must be evident.[7]
    a. Effective date may be at the front of the delegation agreement.
    b. If date is not in the front, the latest signatory date from both parties will be used as the effective date.[8]
    c. Other acceptable evidence of the mutually agreed-upon effective date may include, but is not limited to:
        1) A letter
        2) Meeting minutes
        3) Other form of communication between the organization and the Delegate that references the parties' agreement on the effective date of the activities.
            - Delegate must submit evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the ~~delegate's~~ Delegate's performance of delegated activities.
2. The delegation agreement or addendum thereto or other binding communication between the organization and the delegate specifies the CR activities:
    a. Performed by the delegate in detailed language.
    b. Not delegated but retained by the organization.
        1) The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other CR functions not

[7] NCQA, 2022 HP Standards and Guidelines, CR 8, Element A, Factor 1
[8] ~~National Committee for Quality Assurance (NCQA), 2022~~1 ~~Health Plan Standards and Guidelines, CR 8, Element A, Factor 1~~

specified in this agreement as the ~~delegate's~~ Delegate's responsibility).

c. If the Delegate sub-delegates an activity, the delegation agreement must specify which organization is responsible for oversight of the sub-delegate.[9]

~~c.~~d. The delegation agreement(s) must have language that the Delegate will adhere to State and Federal regulations.

1) This language is not required for Credentialing Verification Organization (CVO) Agreements.[~~10~~]

3. Delegate must determine the method of reporting and the content of the reports, but the agreement specifies:

~~a.~~d. The reporting is at least quarterly for Medi-Cal line of business, to ensure compliance with California Department of Health Care Services (DHCS). Reporting examples include:[11,12]

1) Lists of credentialed and recredentialed Practitioners~~Providers~~.

2) Committee meeting minutes.

3) Facilities credentialed.

~~b.~~e. What information is reported by the Delegate about delegated activities.

~~c.~~f. How, and to whom, information is reported (i.e. joint meetings or to appropriate committees or individuals in the organization).

~~d.~~g. Delegate must receive regular reports from all sub-delegates, even NCQA-~~Accredited~~ accredited or NCQA Certified Delegates.[~~13~~]

4. Delegates' Delegation Agreement states the process for monitoring and evaluating the Delegate's performance.[14]

5. Delegate retains the right to approve, suspend and terminate Providers, who participate in the Delegates' network.[15]

~~a.~~d. This does not apply if the sub-delegate does not have decision making authority.

~~b.~~e. If the delegation agreement does not specify the right to approve language, the Delegate may provide alternate documentation through another communication

[9] NCQA, 2022 HP Standards and Guidelines, CR 8, Element A, Factor 2
[~~10~~] ~~NCQA, 2022~~1 ~~HP Standards and Guidelines, CR 8, Element A, Factor 2~~
[11] NCQA, 2022 HP Standards and Guidelines, CR 8, Element A, Factor 3
[12] Medi-Cal Exhibit A, Attachment 4 of Plan Contract – QI Activities)
[~~13~~] ~~NCQA, 2022~~1 ~~HP Standards and Guidelines, CR 8, Element A, Factor 3~~
[14] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element A, Factor 4
[15] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element A, Factor 5

between the Delegate and sub-delegate, for review for compliance.

6. If the sub-delegate fails to meet the terms of the agreement and, at a minimum, circumstances that result in revocation of the agreement.[16]

B. For new delegation arrangements, the Delegate must evaluate the sub-delegates capacity to meet NCQA, ~~state~~ State, and ~~federal~~ Federal regulatory requirements before delegation began.[17]

1. Delegates may use an accredited Health Plan audit as the pre-delegation evaluation.
   a. If Delegate uses a health plan audit, there must be evidence that the health plan audit was reviewed, e.g., Committee minutes, email approval or other methods indicating acceptance of review.
   b. If Delegate changes Management Services Organizations (MSOs), the Delegate must evaluate the new MSO prior to contracting.[~~18~~]
2. For any amendments or newly delegated activities within the last twelve (12) months, the Delegate must have documentation, dated before the delegation began showing that it evaluated the sub-delegate before implementing delegation.[19]
3. If the pre-delegation evaluation was performed more than twelve (12) months prior to implementing delegation, the Delegate must conduct another pre-delegation evaluation.
4. The Delegate must have a systematic method for conducting this evaluation, especially if more than one (1) delegation agreement is in effect. The following list are examples:[20]
   a. Site Visit.
   b. Written review of the sub-delegate's understanding of the standards and the delegated tasks.
   c. Staffing capabilities.
   d. Performance records (e.g. Audit).
   e. Exchange of documents and review.
   f. Pre-delegation/Committee meetings.
   g. Telephone consultation.
   h. Virtual review.[~~21~~]

[16] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element A, Factor 6
[17] NCQA, 2022 HP Standards and Guidelines, CR 8, Element B, Factor 1
[~~18~~] ~~NCQA, 2022 HP Standards and Guidelines, CR 8, Element B, Factor 1~~
[19] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element B, Factor 2
[20] NCQA, 2022 HP Standards and Guidelines, CR 8, Element B, Factor 4
[~~21~~] ~~NCQA, 2022 HP Standards and Guidelines, CR 8, Element B, Factor 4~~

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

1. Annually review its Delegate's credentialing policy and procedures.
    a. Review for evidence that the Delegate's staff or committee annually reviewed their sub-delegate's credentialing policies and procedures, e.g., audit tool, audit correspondence, audit summary documentation, committee minutes, and email approval, noted in their database or other methods.
    b. A Delegate may use an accredited health plan audit as the annual evaluation.
        1) If Delegate uses a health plan audit, there must be evidence that the health plan audit was reviewed, e.g. Committee minutes, email approval or other methods indicating acceptance of review.
        2) For NCQA-Certified or Accredited Delegates, including certified CVOs:
            - Review evidence of annual review of policy and procedures for delegated functions, as applicable.[22]
2. Annually audits credentialing and recredentialing files against NCQA, ~~state~~ State, and ~~federal~~ Federal regulatory standards for each year that delegation has been in effect.[23]
    a. Review for evidence that the Delegate's staff or committee annually reviewed their sub-delegate's credentialing policies and procedures, e.g., audit tool, audit correspondence, audit summary documentation, committee minutes, and email approval, noted in their database or other methods.
    b. A Delegate may use an accredited health plan audit as the annual evaluation.
        1) If Delegate uses an accredited health plan audit, there must be evidence that the health plan audit was reviewed, e.g., Committee minutes, email approval or other methods indicating acceptance of review.
        2) If Delegate does not use an accredited health plan audit, the Delegate must audit per IEHP standards (See Attachment, "Credentialing DOA Audit Tool" in Section 25).~~[24]~~
3. Annually evaluates delegate performance against NCQA, state and federal regulatory standards for delegated activities.[25]
    a. The audit must include all pieces of the credentialing process (e.g., policies and procedures, ongoing monitoring, file audit, etc.).~~[26]~~

[22] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element C, Factor 1
[23] NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 2
~~[24] NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 2~~
[25] NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 3
~~[26] NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 3~~

4. Quarterly evaluates regular reports, as specified in element A. Acceptable methods of review include:[27]
   a. Assess the Quality or Credentialing Committee Minutes.
   b. It is acceptable to only receive lists of credentialed and recredentialed Practitioners from NCQA-accredited or NCQA-certified Delegates.
   c. Delegates that are not NCQA-accredited or NCQA-certified need to demonstrate that it collects credentialing data from the Delegate, evaluates the data, and takes corrective action if needed and follow-up on deficiencies.
   d. If no performance issues are identified, reporting could be limited to lists of credentialed and recredentialed Practitioners.
   e. For MSOs, reviewing reporting numbers which can usually be found in the Quality Improvement Meeting Minutes.[28]

5. Annually monitors the ~~d~~Delegate's system security controls to ensure that the ~~d~~Delegate monitors its compliance with the delegation agreement or with the ~~d~~Delegate's policies and procedures at least annually.[29]
   a. Delegates process for monitoring system security controls covers sub-delegates that store, create, modify, or use CR data on its behalf. If the organization contracts with such delegates, it:
      1) Has a process for annually monitoring the delegate's CR system security controls in place to protect data from unauthorized modification.?
      2) Ensures that the ~~d~~Delegate annually monitors that it follows the delegation agreement or its own policies and procedures.
   b. Delegate reviews all modifications made in all ~~d~~Delegates' CR systems during the look-back period that did not meet the modification criteria allowed by the delegation agreement or by the delegates' policies and procedures.
      1) If the Delegate's CR system does not allow modifications, the Delegate:
         - Describes the functionality of the system that ensures compliance with the established policy.
         - Provides documentation or evidence of advanced system control capabilities that automatically record dates and prevent modifications that do not meet modification criteria.

[27] NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 4
[28] ~~NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 4~~
[29] NCQA, 2022 HP Standards and Guidelines, CR 1, Element C, Factors 1-5

c. Auditing is allowed only if the Delegate or the sub-delegate does not use a CR system that can identify all noncompliant modifications.[30]

1) Documentation includes the staff roles or department involved in the audit.

2) Delegate or the sub-delegate identifies all CR system modifications, but may use sampling to identify potential noncompliant changes for the audit.

3) The Delegate uses one of the following methods to audit files:

- Five (5) percent or fifty (50) of its files, whichever is less, to ensure that information is verified appropriately.
  - At a minimum, the sample includes at least ten (10) credentialing files and ten (10) recredentialing files. If fewer than ten (10) ~~p~~Practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than the sample. ~~31~~

6. Delegate acts on all findings from ~~f~~Factor 5 for each delegate and implements a quarterly monitoring process until each sub-delegate demonstrates improvement for one finding over three (3) consecutive quarters.

a. Delegate identifies and documents all actions it has taken, or plans to take, to address all modifications that did not meet the delegation agreement or the ~~d~~Delegate's policies and procedures, if applicable. One action may be used to address more than one finding for each ~~d~~Delegate or across multiple delegates, if appropriate.

1) Delegate implements a quarterly monitoring process for each ~~d~~Delegate to assess the effectiveness of its actions on all findings.

- Delegate must continue to monitor each ~~d~~Delegate until the sub-delegate demonstrates improvement of at least one (1) finding over three (3) consecutive quarters.
- If a sub-delegate did not demonstrate improvement of at least one (1) finding during the look-back period, it submits all quarterly monitoring reports demonstrating ongoing monitoring.

~~c.~~• If the Delegate identified findings less than three (3) quarters before the survey submission date, it submits all monitoring information it has available.

D. For delegation arrangements that have been in effect for more than twelve (12) months, at least in the past year, the organization identified and followed up on opportunities for

[30] NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 5
~~[31] NCQA, 2022 HP Standards and Guidelines, CR 8, Element C, Factor 5~~

improvement, if applicable.[32]

1. Findings from the Delegates pre-delegation evaluation, annual evaluation, file audits or ongoing reports can be sources for identifying areas of improvement for which it takes actions.
2. The Delegate can use an accredited health plan audit to look for opportunities for improvement. If the Delegate sees that the health plan found opportunities for improvement, the Delegate reviews the corrective action plan (CAP) from the Delegated entity and reviews to see if the audit and CAP were reviewed and approved, i.e., committee minutes, email approval or other method indicating acceptance of review of the CAP.[33]

[32] NCQA, 2022 HP Standards and Guidelines, CR 8, Element D, Factor 1
[33] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element D, Factor 1

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
8. Delegation of Credentialing

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

9. Identification of HIV/AIDS Specialists

APPLIES TO:

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

POLICY:

A. Delegate has written policy and procedure describing the process that the Delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS specialist, according to California State Regulations on an annual basis.

B. On an annual basis, the Delegate identifies ~~or~~ and reconfirms the appropriately qualified Physician who meet the definition of an HIV/AIDS, Specialist according to California State regulations.

C. The list of identified qualifying Physicians is provided to the department responsible for authorizing standing referrals.

PURPOSE:

A. Delegates must have a written and documented process to identify and reconfirm the appropriately qualified physicians within IEHP who meet the definition and requirements of an HIV/AIDS Specialist on an annual basis.

DEFINITION:

A. Delegate – If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight.

    a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

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

B. AIDS – Acquired Immunodeficiency Syndrome.

C. Category 1 continuing medical education:

1. For Physicians, continuing medical education as qualifying for category 1 credit by the Medical Board of California;

2. For Nurse Practitioners, continuing medical education contact hours recognized by the

California Board of Registered Nursing;

3. For Physician Assistants, continuing medical education units approved by the American Association of Physician Assistants.

D. HIV – Human Immunodeficiency Virus.

PROCEDURES:

A. Delegate has a written policy and procedure describing the process that the Delegate identifies and reconfirms the appropriately qualified physicians, who meet the definition of an HIV/AIDS Specialist, according to California State Regulations on an annual basis. Written policy and procedure regarding the identification of HIV/AIDS specialists.

~~A.~~ An HIV/AIDS Specialist is a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the State of California, who meets any one of the four (4) criterions below:[1]

1. Is credentialed as an HIV specialist by the American Academy of HIV Medicine (AAHIVM);
2. Is board certified, or has earned Certificate of Added Qualifications, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualifications, in the field of HIV medicine; or
3. Is board certified in the field of Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:
    a. In the immediately preceding twelve (12) months has clinical managed medical care to a minimum of twenty-five (25) patients who are infected with HIV; and
    b. In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of category 1 continuous medical education (CME) in the prevention of HIV infection, combined with diagnosis, treatment, or both, of the HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year.
4. Meets the following qualifications:
    a. In the immediately preceding twenty-four (24) months has clinically managed medical care to a minimum of twenty (20) patients who are infected with HIV; and
    b. Has completed any of the following:
        1) In the immediately preceding twelve (12) months has obtained board certification or recertification in the field of infectious disease from a member

[1] Health and Safety Code § 1300.74.16

board of the American Board of Medical Specialties; or

2) In the immediately preceding twelve (12) months has successfully completed a minimum of thirty (30) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment of both, of HIV-infected patients.

3) In the immediately preceding twelve (12) months has successfully completed a minimum of fifteen (15) hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competence Examination administered by the American Academy of HIV Medicine.

B. Delegate identifies ~~or~~ a reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS Specialist on an annual basis. Delegate must provide:

1. Evidence that the Delegate identifies HIV/AIDS Specialists on an annual basis, which may include, but not limited to the following:

a. Review current and previous year's survey/spreadsheet/credentialing attestation/logs.

1) This does not require screening of all the Delegate's practitioners, only those who potentially may qualify and wish to be listed as HIV/AIDS Specialists.

b. The department responsible for standing referrals may conduct the annual survey, instead of the Credentialing Department; this would meet the intent of this requirement.

c. Annual screening must be completed within twelve (12) months of the prior year's annual screening.

d. If the Delegate changes MSO's and does not have this evidence, they should identify/reconfirm HIV/AIDS specialist within sixty (60) days of the MSO change.

C. The list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.[2,3,4]

1. Once the Delegate has determined which, if any, of its physicians qualify was HIV/AIDS Specialists under the above regulations, this list of qualifying practitioners is sent (e.g. e-mail, letter) or made available to the department responsible for authorizing standing referrals.

a. Distribution of findings must be communicated within thirty (30) days from the

[2] ~~California Health and Safety Code (~~Health & Saf. Code~~),~~ § 1300.74.16
[3] DHCS MMCD All Plan Letter 02001, Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program
[4] ~~California Code of Regulations (CCR), § 1300.74.16(e)~~

completion of the screening/survey assessment (e.g. The date of the last survey collected/signed is used to begin your calculation).

1) A verbal statement that the list was provided to the appropriate department is not acceptable evidence of compliance.

2) If the list is available to the appropriate department electronically, it is not required to send the list. No evidence is required.

b. If the survey revealed that there are no qualified contracted HIV/AIDS Specialists within the Delegate, communication regarding HIV/AIDS Specialists availability to the appropriate department (e.g. Utilization Management or Case Management) is all that is necessary.

c. If the Delegate does not have any contracted HIV/AIDS Specialists, the Delegate will be scored compliant during the Credentialing Audit.

d. If the annual screening was not conducted and a list was distributed with old information, the Delegate will be scored non-compliant during the Credentialing Audit.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

10. Credentialing Quality Oversight of Delegates

APPLIES TO:

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

POLICY:

A. Delegates must obtain approval of Practitioners seeking participation in the IEHP network, from the Delegates Credentialing Committee and/or Medical Director before submitting the Practitioner to IEHP, for review and approval. Delegates must confirm the Practitioners meet IEHPs criterion as specified in Policy 25B1, "Credentialing Standards – Credentialing Policies."

B. If a Practitioner is changing from one (1) IPA to another, the new IPA must submit the Provider's documentation (as noted in Procedure A below) within sixty (60) calendar days of the effective date of the change.

C. All Delegates are responsible for recredentialing and/or employed Practitioners within the thirty-six (36) months of the last credentialing decision, as required by National Committee for Quality Assurance (NCQA). Delegates are required to report their credentialing recredentialing activities to IEHP. Delegates must report credentialing, recredentialing and terminations activities by the 15th of the following month.

D. All Practitioner terminations and changes (i.e., Address, specialty, age limits, Supervising Physicians, TIN changes etc.) must be submitted to providerupdates@iehp.org. All changes and terminations submitted through the Secure File Transfer Protocol (SFTP) server will not be processed.

E. Delegates must provide IEHP with a status report of their specialty network on a semi-annual basis during Provider Directory review. Delegates that do not require their Providers to be listed in the Provider Directory submit specialty networks quarterly.

F. IPAs are responsible for reviewing, maintaining and notifying IEHP of any changes to their Hospital admitting arrangements for each of their affiliated links.

PURPOSE:

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

credentialing standards or to IEHPs expectations.[1]

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

DEFINITION:

A. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a Subdelegate. The Delegate will be responsible for sub-delegation oversight.

a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

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

PROCEDURES:

A. Delegates must obtain approval of Practitioners seeking participation in the IEHP network, from the Delegates Credentialing Committee and/or Medical Director before submitting the Practitioner to IEHP, for review and approval.

1. All credentialing file information must be submitted to IEHP via the SFTP, into the Delegates assigned 'Credentialing' Folder.

a. Once the upload is complete, the Delegate must take a screenshot showing the files uploaded into the 'Credentialing' Folder. The Delegate will need to email Provider Delegation at CredentialingProfileSubmission@iehp.org notifying IEHP when the credentialing files are posted.

1) IEHP will then respond to the email with a confirmation that the credentialing files were located.

[1] ~~4~~ National Committee for Quality Assurance (NCQA), 2022~~1~~ HP Standards and Guidelines, CR 8, Element A, Factor 3~~.~~
[2] NCQA, 2022 HP Standards and Guidelines, CR 8, Element A, Factor 4

- Upon receipt of credentialing files into the Delegate's SFTP 'Credentialing' folder, IEHP will begin the credentialing process. Submitted files will be forwarded to IEHP Credentialing for processing.
  - For all Primary Care Providers (PCPs), Obstetrics/Gynecology (OB/GYNs) and Urgent Cares, once all credentialing information is received, IEHP's Credentialing Department will request for a facility site review with IEHP's Quality Management (QM) Department, in accordance to Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring."
  - If a Practitioner's submission packet is incomplete and/or missing supporting documentation, the Delegate is notified via email with the reason why that the process was terminated for the Practitioner. The Delegate must resubmit all documents again, to include missing information to IEHP for review and reconsideration.
- Credentialing Files submitted through any other methods will be rejected and the Delegate will be directed to submit the files via the SFTP.

2. The Delegate must submit the following for review and consideration:
   a. Contract (1st and signature pages)
      1) To include any applicable addendums to show the Practitioners relationship or affiliation with that contract.
   b. W-9 for all Tax Identification Numbers (TINs) used by the Practitioner.
   c. Attachment I: Statement of Agreement by Supervising Provider is required for all Physician Extenders (Physician Assistants (PA), Nurse Practitioners (NP), and Certified Nurse Midwife's (CNM) to confirm the relationship between the ~~Supervising~~ supervising Physician and Physician Extender(s). (See Attachment, "Attachment I - Statement of Agreement by Supervising Provider" in Section 5)
      ~~c.~~1) If these arrangements are clearly described on the Delegation of Services Agreement, Practice Agreement, or Standardized Procedures, those documents may be used in lieu of submitting an Attachment I form.
   d. Hospital Admitting arrangements must be noted on the profile or provided as an attachment at the time of submission, to include but not limited to alternate admitting arrangements.
      ~~d.~~1) If the IPA provides an alternative arrangement, IEHP does not have on file the IPA will be required to submit those arrangements to ensure compliance with IEHP requirements. (See Policy 5B, "Hospital Privileges" ~~in Section 5~~)
   e. Practitioner ~~Profile~~ profile or spreadsheet that includes all the elements listed below,

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

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
1.	✓	✓	✓	IPA Name
2.	✓	✓	✓	Line(s) of Business • Required if Delegate is participating in more than one (1) line of business
3.	✓	✓	✓	Identifier as to whether the packet is Initial (I) or Recredentialing (R)
4.	✓	✓	✓	Identifier for Practitioner Type: • PCP • Specialist; or • Mid-Level Practitioner
5.	✓	✓	✓	Practitioner Name as it's listed on License to Practice
6.	✓	✓	✓	Other Names used (Preferred)
7.	✓	✓	✓	Practitioner Specialty
8.	✓	✓	✓	Practice/Clinic Name(s)
9.	✓	✓	✓	Practitioner Address(es)
10.	✓	✓	✓	Practitioner Phone and Fax numbers
11.	✓	✓	✓	Practitioner Office Hours
12.	✓	✓	✓	Practitioner Date of Birth (D.O.B.)
13.	✓	✓	✓	Practitioner Social Security Number (S.S.N.)
14.	✓	✓	✓	Practitioner Gender

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
15.	✓	✓	✓	Practitioner Cultural Background (optional);
16.	✓	✓	✓	Practitioner Languages spoken
17.	✓	✓	✓	Practitioner Tax Identification Number(s)
18.	✓	✓	✓	Practitioner License Number and expiration date
19.	✓	✓	✓	Initial Committee Approval Date
20.	✓	✓	✓	Recredentialing Committee Approval Date (if applicable)
21.	✓	✓	✓	Drug Enforcement Administration (DEA) Number and expiration date (if applicable)
22.	✓	✓		DEA Arrangements if the Practitioner does not have a DEA Certificate (if applicable)
23.	✓	✓		Hospital Affiliations • Hospital Name • Status • Type of Service provided - Specialty
24.	✓	✓		Hospital Admitter arrangements • Name of Hospital • Name of Admitter

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
25.	✓	✓	✓	Malpractice Insurance Coverage • Name of Insurance carrier • Policy number • Coverage per claim • Coverage per aggregate • Expiration date
26.	✓	✓	✓	Board Certification • Name of Board • Expiration date/re-verification date • Certification status
27.	✓	✓	✓	Medical School • Name of Institution • Graduation Date MM/YYYY)
28.	✓	✓		Internship • Institution Name • Specialty • Training Type • Start Date MM/DD/YYYY • End date MM/DD/YYYY
29.	✓	✓		Residency, if applicable • Institution Name • Specialty • Training Type • Start Date MM/DD/YYYY • End date MM/DD/YYYY

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
30.	✓	✓		Fellowship, if applicable • Institution Name • Specialty • Training Type • Start Date MM/DD/YY • End date MM/DD/YY
31.	✓	✓	✓	Individual National Provider Identifier (NPI) Number
32.			✓	Name of Supervising Physician
33.	✓	✓	✓	Staff Languages spoken
34.	✓	✓	✓	Medi-Cal Number
35.	✓	✓	✓	Age Limits

3. Upon receipt of the documentation, IEHPs Credentialing Department performs a quality review of each delegate's credentialed and approved Practitioner to ensure compliance with IEHPs guidelines (See Policy 5A, "Credentialing Standards – Credentialing Policies").
   a. The Practitioner review includes, but is not limited to the following:
      1) Review of credentialed Practitioner specialty and relevant education, training, practice experience.
      2) Review of requested age range
      3) Review of Hospital arrangements, if applicable
      4) Review of adverse history;
         - History of negative license action;
         - History of negative privileges action;
         - History of Medicare or Medicaid sanctions; and
         - Other adverse history (including felony convictions, etc.).

b. In cases where the IPA submitted credentialing information is consistent with IEHP guidelines, no adverse history is present, and the Practitioner has successfully passed IEHP's site review (if applicable), the PCPs, Specialists, and Mid-Levels are reviewed and signed off by Credentialing Department.

c. In cases where either the Delegate(s) submitted credentialing information is inconsistent with IEHP guidelines or data, or there is evidence of significant adverse history.

1) Delegates must provide a written plan of action for the respective practitioner that includes, but is not limited to:

- The Credentialing Date the practitioner was presented to review and discussion.
- The Credentialing Committee decision and/or outcome.
- If the Delegate will conduct additional monitoring (i.e. grievances and complaints), if so, how frequent
- If the Delegate issued a plan of action or requested any additional information for the practitioner.

2) The Practitioner is forwarded to the IEHP Peer Review Subcommittee for further review, discussion and decision. The IEHP Medical Director presents the Practitioner's credentialing file and any other necessary supporting documentation from the IPA, Practitioners, or IEHP to determine if potential quality of care issues for Members exists.

- If the IEHP Peer Review Subcommittee determines that no potential quality of care concern exists, no further action or review is undertaken.
- If the IEHP Peer Review Subcommittee determines there is a potential quality of care concern or adverse event that exists. The Peer Review Subcommittee may make recommendations to improve the performance of a Practitioner, that includes but is not limited to:
    - Request for additional information from the Delegate, with review at next meeting.
    - Individual counseling by the Delegate or IEHP Medical Director.
    - Focused audits of Practitioner's practice by IEHP Quality Management staff.
    - Continuing medical education or training.
    - Restriction of privileges, including age range restrictions or other limitations.

- Termination of the Practitioner from the IEHP network; and
- Any other action appropriate for the circumstances

3) Actions by the IEHP Peer Review Subcommittee that differ from the IPA Credentialing Committee decisions, including changes in privileges and termination are tracked by IEHP.

- The IEHP Medical Director reviews the tracking report, the credentialing files and any other supporting information as necessary.
- After review, IEHP takes any of the following action(s) against the delegate:
  - No action.
  - Verbal or written request for additional information from the Delegate's Medical Director.
  - Request an interim focused credentialing audit of the Delegate by IEHP staff; or
  - Any other action as appropriate, including revocation of delegated credentialing responsibilities. [3]

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

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

C. All Delegates are responsible for recredentialing Practitioners within the thirty-six (36) months of the last credentialing decision, as required by NCQA as a Must-Pass Element.[4]

1. By the 5th of every month, IEHP will post the Delegates outstanding recredentialing report to the SFTP Server.
2. Delegates are required to review these reports and ensure that the Providers identified on the report are submitted to IEHP with their new recredentialing dates, by the due dates as specified on the IPA Reporting Requirements Schedule (See Attachment, "IPA Reporting Requirements Schedule – Medi-Cal" in Section 25).
   a. These dates are used to conduct file selections for the Delegates Delegation Oversight Audit for Credentialing; and

[3] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 5, Element A, Factor 5
[4] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 4, Element A, Factor 1

b. Track the Delegates Recredentialing timeliness (Recredentialing Cycle Length)

3. The Delegates failure to submit timely reports or failure to recredential practitioners within the thirty-six (36) month timeframe will be deemed non-compliant and will result in a corrective action plan.

4. Delegates are required to report their credentialing and recredentialing activities, and termination via excel format. (See Attachment, "Credentialing and Recredentialing Report", in Section 25). For MDLive, American Specialty Healthplan (ASH) and Kaiser (See Attachment, "Credentialing and Recredentialing Report for Delegated Networks", in Section 25, applicable to only). Delegates must submit their report based on the IPA Reporting Requirements Schedule (See Attachment, "IPA Reporting Requirements Schedule – Medi-Cal" in Section 25).[5]

a. Credentialing Tab: IEHP will review and analyze the Practitioner list and their credentialing dates to ensure they are consistent with IEHPs data.

1) The Credentialing Dates are used to capture the Delegation Oversight Audit file selection, based on the look-back period, to select files for the annual audit.

b. Recredentialing Tab: IEHP will review and analyze the Practitioner list and their credentialing and recredentialing dates to ensure they are consistent with IEHPs data.

1) The recredentialing dates are used to capture the Delegation Oversight Audit file selection, based on the look-back period, to select files for the annual audit.

c. Termination Tab: IEHP will review and analyze the Practitioner list to ensure the practitioners identified are not active in the IEHP network.

1) The Provider Network Department will be notified of all practitioners who are not terminated from IEHP.

- Upon request, Delegates are required to submit supporting documentation regarding terminations, that includes but is not limited to:
  - Reason for termination
  - Termination effective Date
  - Reassignment of Advanced Practice Practitioners
  - ~~4.~~ Member reassignment designations

D. All Practitioner terminations and changes (i.e. Address, specialty, age limits, Supervising Physicians, Taxpayer Identification Number (TIN) changes etc.) must be submitted to providerupdates@iehp.org. All changes and terminations submitted through the SFTP server will not be processed. (See Policy Section 18, "Provider Network").

[5] NCQA, 2022~~1~~ HP Standards and Guidelines, CR 8, Element A, Factor 3

1. PCP relocations must pass a California Department of Health Care Services (DHCS) required FSR Survey and close CAPs prior to receiving assignment of members, within thirty (30) days upon relocation or the date IEHP discovers that the PCP site moved, and a minimum every three (3) years thereafter, unless it was determined that they be placed on annual review. (See Policy 6A, "Facility Site Review and Medical Record Survey Requirements and Monitoring").[6]
2. Changes in Specialty and age limits are considered practice parameter expansions and reductions and submit the required documentation in Policy 25B1, "Credentialing Standards - Credentialing Policies").
3. Advanced Practice Practitioners (PAs, NMs, and NPs) relocating or changing supervising Physicians, Delegates must provide a current copy of the following documents to ensure compliance with IEHP guidelines (See Policy 6F, "~~Non-Physician~~ Advance Practice Practitioner Requirements").
   a. ~~Physician Assistants~~PAs must provide one (1) on the following:
      1) Delegation of Services Agreement and Supervising Physician Form (See Attachment, "Delegation of Services Agreement and Supervising Physician Form" in Section 5).[7] This agreement must:
         - Define specific services identified in practice protocols or specifically authorized by the supervising Physician., and
         - Both the Physician and PA must attest to, date and sign the document.
         - An original or copy must be readily accessible at all practice sites in which the PA works;
      2) Practice Agreement, effective January 1, 2020,[8] the writing, developed through collaboration among one or more ~~physicians~~ Physicians and surgeons and one or more physicians' assistants, that defines the medical services the ~~physician assistant~~PA is authorized to perform pursuant to Section 3502[9] and that grants approval for ~~physicians~~ Physicians and ~~surgeons~~ Surgeons on the staff of an organized health care system to supervise one or more ~~physician assistants~~PAs in the organized health care system. Any reference to a Delegation of Services Agreement relating to ~~physician assistants~~PAs in any other law shall have the same meaning as a practice agreement. The ~~Practice~~ practice ~~Agreement~~ agreement must include provisions that address the following:

[6] Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006 Supersedes Policy Letters 14-004 and 03-002 and All Plan Letter 03-007, "Site Reviews: Facility Site Review and Medical Record Review"
[7] Title 16 California Code of Regulations (CCR) § 1399.540(b)
[8] Senate Bill 697
[9] Business ~~&~~ and Professions Code ~~(BPC)~~ § 3502

- A practice agreement shall include provisions that address the following:[10]
  - The types of medical services a ~~physician~~ PA~~assistant~~ is authorized to perform.
  - Policies and procedures to ensure adequate supervision of the ~~physician assistant~~PA, including, but not limited to, appropriate communication, availability, consultations, and referrals between a ~~physician~~ Physician and ~~surgeon~~ Surgeon and the ~~physician assistant~~PA in the provision of medical services.
  - The methods for the continuing evaluation of the competency and qualifications of the ~~physician assistant~~PA.
  - The furnishing or ordering of drugs or devices by a ~~physician~~ Physician ~~assistant~~ Assistant.[11] ~~pursuant to Section 3502.1~~.
  - Any additional provisions agreed to by the ~~physician assistant~~PA and ~~physician~~ Physician and ~~surgeon~~Surgeon.
- A practice agreement shall be signed by both of the following:
  - The ~~physician assistant~~PA.
  - One or more ~~physicians~~ Physicians and ~~surgeons~~ Surgeons or a ~~physician~~ Physician and ~~surgeon~~ Surgeon who is authorized to approve the practice agreement on behalf of the staff of the ~~physicians~~ Physicians and ~~surgeons~~ Surgeons on the staff of an organized health care system.
- A delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.
- A practice agreement may designate a PA as an agent of a supervising physician and surgeon.
- Nothing in this section shall be construed to require approval of a practice agreement by the board.
  - Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California, a practice agreement may authorize a PA to do any of the following:
    - Order durable medical equipment, subject to any limitations set forth in Section 3502 or the practice agreement. Notwithstanding

[10] Bus.~~iness~~ ~~&~~ and Prof.~~essions Code~~ Code ~~(BPC)~~ § 3502.3
[11] Bus. & Prof. Code § 3502.1

that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

- For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.
- After performance of a physical examination by the PA under the supervision of a physician and surgeon consistent with this chapter, certify disability pursuant to Section 2708 of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.

b. ~~Nurse Practitioners (~~NPs~~)~~ and ~~Nurse Midwives (~~CNMs~~)~~ may perform the following procedures if a standardized procedure is in place:

1) To diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissue of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions.

2) Standardized ~~Procedures~~ procedures must be on-site site specific and[12]

- Reference textbooks and other written sources to meet the requirements of Title 16, CCR § 1474 (3), must include:
  - Book (specify edition) or article title, page numbers and sections.
- NP and/or NM must be practicing at a site assigned to their supervising physician; and
- Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the Delegate must collect and submit to IEHP:
  - Table of Contents of the Standardized Procedures used, between the NP and/or ~~Certified Nurse Midwife (~~CNM~~)~~ and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
  - Evidence that the Standards of Care established by the sources were reviewed and authorized by the ~~nurse practitioner~~NP, Physician and administrator in the practice setting (i.e. signature page that includes all

[12] Title 22 California Code of Regulations (CCR) § 1474 (3)

parties involved).[13]

- Standardized Procedures written using the PAhysician Assistants Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.

4. Practitioner Terminations. Delegates must provide IEHP sixty (60) calendar days advance notice of any significant change in their network, including the termination of a Practitioner.[14]

   a. All Delegates are required to notify IEHP of any adverse actions against any of their contracted Practitioners.

E. Delegates must provide IEHP with a status report of their specialty network on a semi-annual basis during Provider Directory review. Delegates that do not require their Providers to be listed in the Provider Directory submit specialty networks quarterly (e.g., MDLive, ASH, and Kaiser).[15]

1. On a semi-annual basis, IEHP provides Delegates with the Specialty and Extender Roster information via online verification reports on the Secure Provider Portal including admitter and ancillary Providers previously submitted by the Delegate to IEHP that identifies the Delegate's current Provider Network that includes:

   a. Provider name

   b. Address (Address, City, and ZIP)

   c. Phone/Fax number

   d. Specialty

2. Delegates must indicate for each specialist listed, as applicable, the following:

   a. "New Hospital Privileges" – provided to indicate the Practitioner is adding new privileges with an IEHP network Hospital. Indicate Name of Hospital and privileges (active, courtesy, etc.).

   b. "New Hospital Link" – provided to indicate which network Hospital will be added to Practitioner.

   c. "Information is correct" – provided to specify information is correct and no changes are required.

   d. "Provider Term Date" – provided to indicate the Practitioner is no longer part of the IPA's specialty network. Provide effective date of termination.

[13] 16 CCR § 1474
[14] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Supersedes APL 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"
[15] NCQA, 2021 HP Standards and Guidelines, CR 8, Element A, Factor 3

e. "Term This Site Only" – provided to indicate the Practitioner is no longer at this location only. Provide effective date of location closure. Provide IEHP additional details on a separate sheet, if further review is required (i.e. provider is relocating, this site is the providers only existing location with IEHP and needs to add a different location."

f. "Updated information" – provided to specify new addresses, a typo, or any other changes to the information provided on the secure Provider Portal.

3. IEHP makes the indicated changes that will be reflected on the IPA's roster.

a. Delegates are required to update all information online and advise of completion to their Provider Service Representative within thirty (30) days of receipt. The online verification reports are made available in IEHP's secure portal.

F. IPAs are responsible for reviewing, maintaining and notifying IEHP of any changes to their Hospital admitting arrangements for each of their affiliated links, through the following process:

1. The Delegation Oversight Analyst emails all Delegates on the 15th of each month for verification of all Admitter arrangements to ensure accurate information is obtained.

2. IPAs are responsible for the following:

a. Ensuring all providers listed with the correct Admitting Provider.

a. If there are changes, the IPAs are responsible for notifying the Provider of the changes and of their current admitter arrangements for each respective hospital.

b. For the Admitting Providers, the IPA confirms admitting privileges to the Hospitals they are admitting to, are in place and in good standing.

1) The IPA is responsible for providing a replacement. If not, the Provider will be terminated from the IPA's network for not having Hospital admitting arrangements.

c. The IPA is responsible for reviewing the Specialist Providers and reconfirming their Hospital arrangements, to ensure that the Admitting Provider is:

1) Within the same specialty;

2) Cover the same age range;

3) Within the same practice; and

4) Active within the same IPA network as the referring Physician.

d. Ensuring all Providers on the report are still active with the IPA.

e. Any changes from the IPAs must be submitted by the 25th of every month, via Secure File Transfer Protocol (SFTP) server.

1) The IPAs failure to respond by the 25th of each respective month will result in non-compliance and may result in a corrective action plan on monthly delegation reporting.

3. On the last day of the month all network Hospitals are emailed the final Admitter list for that month. It includes Admitter's name, phone number and fax number for each Provider who utilizes a Hospital Admitter.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020
Chief Title: Chief Operating Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
1. Delegation and Monitoring

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP delegates to its IPAs and their Provider network the responsibility of providing comprehensive case management services to their assigned Members. This includes but is not limited to ensuring the coordination of medically necessary health care services delivered within and outside their network, provision of preventive services in accordance with established standards and periodicity schedules, continuity of care, health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.[1,2]

B. IEHP maintains the responsibility of ensuring that IPAs continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.[3]

C. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated care management activities.[4,5] Oversight includes monitoring the IPAs' care management activities monthly, quarterly, annually, and as frequently as necessary.

~~***DEFINITIONS:***~~

~~A. Interdisciplinary Care Team (ICT) – A team of individuals who are involved in the Member's health care. The team is person-centered and will collaborate with the Member and each other to assist in the development of an individualized care plan and assist in the coordination of the Member's health care needs.[6]~~

PROCEDURES:

Delegated Responsibilities

Care Management Program

A. IPAs will develop a care management program that includes:

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services
[3] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, "Subcontractual Relationships and Delegation"
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[5] Title 28, California Code of Regulations (CCR) § 1300.70
~~[6] DHCS APL 17-012 Supersedes APL 14-010, "Care Coordination Requirements for Managed Long-Term Services and Supports"~~

1. Evidence used to develop the program;
2. Criteria for identifying Members who are eligible for the program;
3. Stratification levels for the care management program;
4. Frequency of care management contact for each care management stratification level; and
5. Defined program goals.

B. IPA CM staff must include non-restricted California licensed medical personnel including, but not limited to, Registered Nurses, Licensed Vocational Nurses, Licensed Clinical Social Workers or master's level Social Workers.

C. IPAs will establish the frequency of their care management interventions based on the IPA's written policies, care management program description and the Member's identified goals, issues, barriers, and risks. IPA Care Manager interventions include:

1. Ensuring continuity of care as appropriate.~~;~~
2. Following up on Member referrals.~~;~~
3. Identifying the needs for Long-Term Services and Supports (LTSS) services, appropriate community-based resources such as housing/utilities, meals etc.~~;~~
4. Identifying the need for behavioral health services.~~;~~
5. Assisting with the coordination of care across all settings.~~;~~
6. Determining timeframes for re-contact or reassessment as stated in the IPA's program description and policies as well as determined by the health status of the Member; and
7. Ensuring the PCP and other Members of the care team are updated on the Member's health status.

D. IPAs are expected to resolve Member needs that range from referral assistance, access issues, and additional medical or non-medical needs in the realm of care coordination.

E. IPAs are responsible for coordinating care with LTSS programs, which includes Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), as well as with California Children's Services (CCS) and Inland Regional Center (IRC).[7] See Section 12, "Coordination of Care" for more information on these programs.

F. Please see Section 12, "Coordination of Care" for more information on delegated case management and care coordination responsibilities.

~~E.~~

[7] DHCS APL 17-012

Member Identification

A. IPAs are responsible for identifying Members that may benefit from care management through the following activities:

1. At least monthly, IPAs analyze internal data such as claims, encounters, utilization, pharmacy, Member, Provider and health plan referrals against the identification criteria described in their care management program description.

2. IPAs analyze data that is made available to them by IEHP through the IEHP Provider portal and Secure File Transfer Protocol (SFTP) server. This data includes but is not limited to:

   a. Health Risk Assessment (HRA) for Seniors and Persons with Disabilities (SPD) Members;

   b. Health Information Form for newly enrolled Medi-Cal Members;

   c. MSSP care plans and health assessment summaries (if available and applicable);

   d. Individual Plan of Care from CBAS centers, CBAS Eligibility Determination Tool, and Discharge Summary (if available and applicable);

   e. IHSS service hours and county social worker's contact information (if available and applicable);

   f. Monthly reports that identify new CCS Members;

   g. Monthly reports that identify Members who are turning 21 years of age that will be transitioning out of CCS; and

   h. Monthly roster of children who are currently receiving services through IRC's Early Start Program

Seniors and Persons with Disabilities (SPD)

Please see Policy 12A1, "Care Management Requirements- PCP Role" for more information on this process and delegated responsibilities.

A. IEHP performs the HRA on SPD Members, which includes basic assessment questions needed to identify and determine what level of care management would be most appropriate for the Member.[8]

1. The IPA will review all SPD HRAs on the secure IEHP Provider portal and/or the SFTP daily.

[8] DHCS APL 17-013 Supersedes Policy Letter (PL) 14-005, "Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities"

2. The SPD HRA data that is made available to the IPA will identify the post-HRA risk level as High or Low. An HRA risk level of High indicates that the Member should be immediately reviewed by the IPA for care management needs.

3. The IPA must have a process to enroll Members into a care management program appropriate for their risk level.

4. The IPA's own risk assessment of the Member should include, at a minimum, the post-HRA risk score, utilization patterns, pharmacy data, medical history, behavioral health diagnosis, social determinants, enrollment into an LTSS program such as IHSS, CBAS or MSSP, and care management assessment data.

B. If the IPA is unable to contact the Member to review the HRA or to complete an assessment, the IPA must make, at minimum, three (3) separate contact attempts to locate the Member.

1. Contact attempts must be made within thirty (30) calendar days of IEHP providing the HRA data to the IPA.

2. Attempts may be telephonic, by mail, by email, etc.

3. All contact attempts of the same type on the same day are considered one (1) attempt.

4. All contact attempts must be documented (see Attachment, "Monthly Care Management Log" in Section 25).

C. The IPA must offer an Interdisciplinary Care Team (ICT) to all identified high risk SPD Members when a need is demonstrated and in accordance with the Member's functional status, assessed need, and in the ICP. An ICT must also be available to these SPD Members upon their request.[9]

1. The ICT consists of, at a minimum, the Member and/or Member's authorized representative, the Member's caregiver, the Care Manager, the IHSS Social Worker (if the Member is receiving IHSS benefits), and the PCP or Specialist (if the Specialist is serving as the Member's PCP). Additional members may include social workers, Specialists, Medical Directors, IEHP staff, and other individuals that are actively involved in the Member's care.

2. The IPAs hold case conferences periodically, or at the Member's discretion. In addition, IEHP also recommends IPAs to consider a case conference after conducting the Member's annual assessment.

3. IEHP holds case conferences on a regular basis and can support the IPA if assistance is needed. The IPA may contact IEHP Provider Relations Team at (909) 890-2054 for assistance with coordinating an ICT case conference.

[9] DHCS APL 17-012

D. The IPA must develop an Individual Care Plan (ICP) for high-risk SPD Members and other Members that demonstrate a need for an ICP, or when requested by the Member, Provider, IEHP, or as described in the IPA's care management program description, policies and procedures.[10]

1. The IPA must develop the Member's ICP within thirty (30) business days of the HRA completion date. The Member's HRA completion date is found in the HRA data file sent to the IPA via SFTP and on the secure IEHP Provider portal.

2. The ICP must be developed based on the specific health care needs of the Member, and consider input from the Member, data obtained from the HRA, and input from the ICT if appropriate.

E. The ICP must include, but not be limited to, the following elements, as appropriate:

1. Prioritized goals that are agreed upon by the Member;

2. Identified barriers to meeting the goals;

3. Development of a schedule for follow-up that adheres to the risk stratification and program description/policies of the IPA; and

4. Assessment of the Member's progress towards the goals and the ICP is adjusted as needed.

F. ICPs must be reviewed as determined by the Member's individualized needs, including but not limited to:

1. A change in the Member's health condition, including but not limited to a change in the level of care;

2. A new problem has been identified with the Member;

3. A goal has changed priority, has been met or is no longer applicable; and

4. ICP is closed or completed.

G. IEHP and its IPAs are required to offer and provide, upon request, a copy of the initial ICP and any of its amendments by mail to the Member at least annually.[11] Updates are telephonically provided during each follow up.[12] IEHP and its IPAs must offer to send a copy of the updated ICP to the Member in these scenarios, at minimum:

1. The ICP is completed or closed;

2. A change in the Member's condition (e.g., a change in the level of care); and

[10] DHCS APL 17-012
[11] Ibid.
[12] Ibid.

3. A new problem is identified with the Member and added to the ICP, as discussed with the Care Manager.

H. The ICP will be made available in alternative formats and in the Member's preferred written or spoken language upon request.[13]

I. The ICP must be shared with the Member and Provider and be made available to other members of the ICT.

Complex Case Management

A. IEHP does not delegate Complex Case Management (CCM). Members that may benefit from these services are referred to IEHP Behavioral Health and Care Management (BH & CM) Department. The IPA must notify the IEHP BH & CM team with Member information when a review for CCM is requested (see Attachment, "IEHP Care Management Referral Form – Medi-Cal" in Section 25). Members needing CCM typically have (a) health condition(s) status that is severe in nature and without intensive assistance the Member would likely decline or use acute services more frequently. Members needing CCM level of assistance often require numerous or extensive resource coordination to improve their health or circumstances. Please see Policy policy 12R12I, "Complex Case Management" for more information on this process and delegated responsibilities.

B. IEHP will communicate to IPAs via email and/or phone regarding Members that may require referral to a higher level of case management. IPAs are responsible to evaluate and determine if a referral to CCM is appropriate. If a CCM referral is warranted, then the IPA will complete the CM Referral Form and submit to IEHP for further Member outreach. (see Attachment, "IEHP Care Management Referral Form – Medi-Cal" in Section 25).

C. On a monthly basis, IEHP will provide IPAs through the SFTP, a CCM report that identifies the following:

1. Members assigned to the IPA that are in active CCM with IEHP as of report run date;

2. Members assigned to the IPA that were closed from CCM with IEHP in the previous month with the reason for CCM closure included; and

3. Members assigned to the IPA that were referred to IEHP for CCM but where not opened to CCM as of report run date, because the Member did not meet criteria.

D. IPAs are responsible for reviewing cases and evaluating Members who did not meet CCM criteria. IPAs must outreach to these Members and assess for care coordination and case management needs.

California Children's Services

[13] DHCS APL 17-012

~~A. IEHP provides the IPA, through the SFTP, monthly CM CCS reports of Members who are newly enrolled into CCS and those who will be turning 21 years of age within six (6) months.~~

~~1. The IPA must ensure the coordination of care and services for newly enrolled CCS Members. This includes notifying the PCP that CCS services are starting and coordinating between PCP and Specialist on an as needed basis. The IPA must also notify parents of newly eligible CCS Members to advise of CCS services, provide education of service coverage and assess for any care coordination needs.~~

~~2. The IPA must ensure the coordination of care and services when a Member transitions from a pediatric PCP to an adult PCP. This includes notifying the PCP of CCS services ending due to the Member turning 21 years of age, communicating with the Member to ensure care is established with an adult PCP and collaborating with the County CCS program, as needed. The IPA is responsible to assess for care coordination needs and assist with the transition from CCS Providers to in-network or out-of-network Providers as needed.~~

~~B. IPAs may identify potential CCS cases during care management activities or through requests for assistance from PCPs or Specialists. Upon identification of a Member with a potential CCS eligible diagnosis, the IPA is to refer the Member to CCS for determination of medical eligibility. This includes providing medical documentation that supports the CCS condition along with the potential CCS referral.[14] IPA will continually provide any care coordination needs while the Member is pending CCS eligibility. Please see Policy policy 12B, "California Children's Services," for more information on this process and delegated responsibilities.~~

~~*Early and Periodic Screening, Diagnostic and Treatment (EPSDT)*~~

~~A. IPAs must provide all necessary care management services for Members receiving EPSDT services, as outlined in Policy policy 12D, "Early and Periodic Screening, Diagnosis and Treatment," for EPSDT requirements.~~

~~*Early Start Services*~~

~~A. IEHP provides the IPAs a monthly list of Members who will be aging out of the Early Start Program within the next three (3) months. The IPA must notify the PCP and Member's parents when Early Start services are ending. The IPA must assist with the transition of services such as Local Education Agency (LEA), supplemental therapy, and other necessary treatments. This includes coordinating between the Member and their PCP to obtain referrals. Please see Policy policy 12C, "Early Start Services and Referrals," for more information on this process and delegated responsibilities.~~

~~*Waiver Programs*~~

~~[14] DHCS IEHP Two-Way Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 9, California Children's Services (CCS)~~

~~A. IPAs must have procedures in place to identify Members who may benefit from Home and Community-Based Services (HCBS) Waiver programs and referring them to the agency administering the waiver program. These waiver programs include, but are not limited to, the Home and Community-Based Alternatives Waiver Program (formerly known as the Nursing Facility/Acute Hospital Waiver Program) and all other HCBS waivers. Please see~~See Policy ~~policy~~ 12P, "Home and Community-Based Alternatives Waiver Program" for more information ~~on this process and delegated responsibilities.~~

~~B. IPAs must assist in coordinating care for Members who are identified by their PCP or Specialist as a potential candidate for the Acquired Immune Deficiency Syndrome (AIDS) Waiver Program. See Policy~~ policy 12Q, "AIDS Medi-Cal Waiver Program" for more information ~~on this process and delegated responsibilities.~~

Monitoring and Oversight

A. IEHP performs monitoring and oversight of the IPAs' care management activities through live and/or desktop file reviews. Audit elements include, but are not limited to the following:

1. Care Management/Care Coordination/Population Health Management (PHM)

   a. IEHP will select and review, at a minimum, five (5) targeted cases each month for monitoring and oversight.~~:~~ The Medi-Cal Care Coordination Review Tool outlines the audit elements and methodology for review (see Attachment, "Medi-Cal Care Coordination Review Tool" in Section 25).

2. CCS, Early Start and EPSDT Cases

   a. IEHP performs monthly retrospective audit of CCS files submitted by the IPA. IEHP will select and review, at a minimum, five (5) targeted CCS, Early Start and EPSDT cases each month for monitoring and oversight (see Attachments, "IPA Reporting Requirements Schedule - Medi-Cal" and "Care Management California Children's Services Review Tool" in Section 25).

3. SPD Cases

   a. IEHP will select and review, at minimum, five (5) targeted cases each month for monitoring and oversight~~:~~. The Medi-Cal SPD Review Tool outlines the audit elements and methodology for review (see Attachment, "Medi-Cal SPD Review Tool" in Section 25"

C. Utilizing the Medi-Cal Care Coordination Review Tools (See Attachment, "Medi-Cal Care Coordination Review Tool" in Section 25), IEHP may select files each month to review from the following sources to ensure that IPAs provide care management services, including discharge planning in conjunction with IEHP staff, through the following activities:

1. IPA pre-contractual audits.~~:~~

2. IEHP and IPA Joint Operations Meetings (JOM).;
3. Delegation Oversight Audit per Policy 25A2, "Delegation Oversight – Audit.;"
4. Appeal and grievance review.;
5. Follow-up on care management cases handed off to the IPA to ensure the cases were received, evaluated and assessed for care management and coordination of care needs.;
6. Monthly care management log submission and CM file review (See Attachment, "Monthly Care Management Log" in Section 25).;
7. Follow-up on care management needs for Members who were recently discharged from the hospital; and
8. Monthly CCS Referral Log (See Attachments, "Monthly CCS Referral Log and "Care Management California Children's Services Review Tool" in Section 25).

D. Upon request, the IPA must submit a complete and comprehensive Corrective Action Plan (CAP) to IEHP that adequately addresses all deficiencies noted on the audit tool.[15] See Policy 25A4, "Delegation Oversight – Corrective Action Plan Requirements" for more information.

[15] DHCS PL 14-004 Supersedes PL 02-002, "Site Reviews: Facility and Review and Medical Record Review.

25. DELEGATION AND OVERSIGHT

C. Care Management Requirements

1. Delegation and Monitoring

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

25. DELEGATION AND OVERSIGHT

C. Care Management Requirements
2. Reporting Requirements

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP maintains the responsibility of ensuring that IPAs continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.[1]

B. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated care management activities.[2,3] Oversight activities include but are not limited to reviewing reports submitted by the IPAs, as described below.

PROCEDURES:

A. On a monthly basis, IEHP staff reviews care management and care coordination case files for appropriate follow-up and care of the Member, and to ensure all required elements are being captured. All reports must be submitted to IEHP within the timeframes specified and in the correct format. Files not submitted in the correct format will be rejected, and the IPA will be required to resubmit in the required format.

B. Reporting requirements include a monthly assessment of care management data, including California Children's Services (CCS) activity. Monthly reports are to be submitted to IEHP via the Secure File Transfer Protocol (SFTP) server within the timeframes specified in the Medi-Cal IPA Reporting Requirements Schedule even if it falls on a holiday or weekend (see Attachment, "IPA Reporting Requirements Schedule – Medi-Cal" in Section 25). Reporting requirements include:

1. **Care Management Log** - Monthly report should include previously opened active cases and newly identified cases for the month reporting. Each IPA must submit the information noted in the Monthly Care Management Log (see Attachment, "Monthly Care Management Log" in Section 25).

2. **CCS Logs –** IPAs must submit a log that identifies Members that IPAs referred to CCS during the month reporting. Each IPA must submit the information noted in the Monthly CCS Referral Log (see Attachment, "Monthly CCS Referral Log" in Section 25).

C. Repeated failure to submit required reports timely and in the right format may result in the request of a Corrective Action Plan (CAP), freezing of new Member enrollment or termination

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, "Subcontractual Relationships and Delegation"
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[3] Title 28 California Code of Regulations (CCR) § 1300.70

or non-renewal of the IEHP Agreement.[4] Upon request, the IPA must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies noted. Please see Policy 25A4, "Delegation Oversight – Corrective Action Plan Requirements" for more information.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2001
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2022

[4] DHCS APL 17-004

25. DELEGATION AND OVERSIGHT

D. Quality Management

1. Quality Management Reporting Requirements

APPLIES TO:

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

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and Federal laws, contractual and reporting requirements.[1]

B. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated quality improvement (QI) activities.[2,3] Oversight activities include but are not limited to the review of annual reports.

DEFINITION:

~~—~~Delegate- A medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medi-Cal eligible IEHP Member. ~~Delegate – For this purpose of this policy, this is defined as a medical group, Health Plan, IPA, or any contracted organization delegated to maintain and/or provide Quality Management (QM) programs and activities.~~

A.

PROCEDURES:

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

1. Reporting requirements include a QM semi-annual assessment, which documents the progress of the QM, QI, ~~and~~ Utilization Management (UM) activities found in the QM Work Plan and Utilization Management (UM) and Credentialing (CR) System Controls.

   a. **Quality Management** – Reports must identify and address the following:

      1) Quality of Clinical Care;[4]

      2) Quality of Service;[5]

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, "Subcontractual Relationships and Delegation"
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[3] Title 28 California Code of Regulations (CCR) § 1300.70
[4] National Committee for Quality Assurance (NCQA), 2022~~1~~ Health Plan Standards and Guidelines, QI 1, Element B, Factor 1
[5] Ibid.

3) Safety of Clinical Care;[6]
4) Members' Experience;[7]
5) Program Scope;
6) Yearly Objectives;
7) Yearly Planned Activities;
8) Timeframe within which each activity is to be achieved;[8]
9) Staff member(s) responsible for each activity;[9]
10) Monitoring of previously identified issues;[10] and
11) Evaluation of the QM/QI program.[11]

2. QM Semi-Annual Reports must be submitted to IEHP via IEHP's Secure File Transfer Protocol (SFTP) by these due dates, regardless of whether these dates fall on a weekend or holiday:
   a. 1st Semi-Annual report covers period from January 1st through June 30th and must be submitted by August 15th; and
   b. 2nd Semi-Annual report covers period from July 1st through December 31stand must be submitted by February 15th.
3. Failure to submit required reports may result in actions that include, but are not limited to, request for Corrective Action Plan (CAP), being frozen to new Member assignment, or termination or non-renewal of the IEHP Agreement. See Policy 25A4 "Delegation Oversight - Corrective Action Plan Requirements."

B. **Annual Reporting Requirements:** The following reports must be submitted annually to IEHP via IEHP's SFTP no later than the 15th of February each calendar year regardless of whether this date falls on a weekend or holiday:

1. **Quality Management**[12]
   a. **Quality Management Program Description:** Reassessment of the QM Program Description must be done on an annual basis by the QM Committee and reported to IEHP. The following must be included with the submission to IEHP:

[6] Ibid.
[7] Ibid.
[8] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element B, Factor 2
[9] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element B, Factor 3
[10] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element B, Factor 4
[11] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element B, Factor 5
[12] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 8, Quality Improvement Annual Report

1) Any changes made to the QM Program Description during the past year or intended changes identified during the annual evaluation; and

2) Signature page noting date of committee approval.

b. **Quality Management Work Plan:** Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include planned audits, follow-up activities and interventions related to identified problem areas.

c. **Quality Management Program Annual Evaluation:** The evaluation should include a description, trending, barrier analysis and evaluation of the overall effectiveness of the QM Program.

Please see Policy 25D2, "Quality Management - Quality Management Program Structure Requirements," for more information.

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

1. Review of all monthly and annual Delegate reports for tracking and trending levels of activity; comparison to other Delegates, variances compared to other Delegates and other significant data issues. Reports include but are not limited to those listed above.

2. Review and approval of the annual reports submitted by the Delegates (e.g., QM Program Description and Work Plan).

Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

D. Quality Management
2. Quality Management Program Structure Requirements

APPLIES TO:

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

POLICY:

A. IEHP is accountable for all quality improvement functions and responsibilities that are delegated,[1,2] and maintains the responsibility of ensuring that Delegates ~~continue to be in~~maintain compliance with all applicable State and Federal laws, contractual and reporting requirements.[3]

B. Delegates are required to have a Quality Management (QM) Program per their Delegation Agreement with IEHP and as outlined in the IEHP Provider Manual (See Attachment "IPA Delegation Agreement – Medi-Cal" in Section 25).[4] IEHP monitors Delegates' QM Program Structure and implementation of quality management activities to ensure the delegate is continuously monitoring and improving the quality of care, access to care, service and patient safety delivered to IEHP Members.[5]

C. Delegates must maintain a written QM Program Description, ~~Global Quality P4P~~QM Work Plan~~,~~, Annual QM Evaluation, and related QM Policies and Procedures that meet Department of Health Care Services (DHCS), National Committee for Quality Assurance (NCQA) and IEHP standards for Quality Management.

DEFINITION:

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

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

PROCEDURES:

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 1, General Requirement
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[3] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, "Subcontractual Relationships and Delegation"
[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[5] Title 28, California Code of Regulations (CCR) §1300.70(b)(2)(G)(1)

A. **QM Program Requirements**[6] – Delegates' QM Program must consist of the following:

1. **Quality Management**

   a. **Quality Structure** –Delegates are required to have a structure in place that monitors quality activities, including a formal Committee structure and sufficient personnel in place to perform quality management activities.

   b. **Quality Studies** – Delegates are required to perform a minimum of two (2) quality studies for their Membership per calendar year. One (1) study must be in the area of access; the other study should be an area pertinent to the Delegate, IEHP Membership served by the Delegate, and quality issues identified by the Delegate. Study results must be made available to Primary Care Providers (PCPs) and IEHP Members upon request. IEHP has the right to mandate the type of access study required if IEHP has identified quality or access issues.

   c. **Peer Review** – Delegates must perform peer review. All Delegates are required to have a Peer Review Committee made up of Physicians and representatives of the network that provides peer review of any Practitioner noted to have potential quality issues. The Delegates' Peer Review Committees are responsible for reviewing Provider, Member, or Practitioner grievances and/or appeals, Practitioner-related quality issues and other peer review matters. Should a significant practitioner problem or quality issue arise that cannot be resolved at this level, the Delegate's QM Committee may refer the issue to the IEHP Peer Review Subcommittee for resolution. In addition, the Delegate's Peer Review Committee performs oversight of the Credentialing Program and activities, grievance and appeals processes with recommendations for modification as necessary. Data utilized to identify candidates for peer review include quality studies by IEHP or the Delegate, grievances received by the Delegate or IEHP, utilization and/or encounter data, and other data sources.

   d. **Clinical Data** – IEHP provides Member experience and clinical performance data to all Delegates in order for them to conduct quality studies and perform all delegated functions. This data will be provided upon request from the Delegate or as both parties agree to specific quality studies where IEHP has the necessary data. In addition, all Delegates are free to collect their own clinical and Member experience data to support Quality Improvement (QI) initiatives.

2. **Utilization Management (UM)** – IEHP delegates the utilization management process to those Delegates that have sufficient administrative capacity, with accompanying policies and procedures, to meet all IEHP, DHCS, CMS, and NCQA standards for utilization management activities. Refer to Section 14, "Utilization Management" and see ~~policy~~

[6] National Committee for Quality Assurance (NCQA), 2022~~1~~ Health Plan Standards and Guidelines, QI 1, Element A, Factor 1

Policy 25E1, "Utilization Management - Delegation and Monitoring," for more information.

3. **Credentialing/Recredentialing** – IEHP may delegate the responsibility for credentialing and recredentialing of participating Practitioners, as identified in Section 25, "Delegation and Oversight." This includes a signed attestation by the Delegate's Medical Director that states all Practitioner-required reviews were conducted. IEHP's Chief Medical Officer, Chief Quality Officer and/or Medical Director designee review all Providers (PCPs and Specialists) individually for quality-related issues prior to assignment of Members. The IEHP Peer Review Subcommittee performs peer review on Practitioners and Providers identified through the Ongoing Monitoring of Sanctions process conducted by Credentialing and those Practitioners referred by the Chief Medical Officer, Chief Quality Officer, or Medical Director for potential quality of care concerns. IEHP also performs Credentialing/Recredentialing functions for those Practitioners that are directly contracted with IEHP.

4. **Care Management (CM)** – IEHP delegates care management for Members including case finding, assessment of needs and care coordination, referral to outside agencies, and all other necessary care management activities. Refer to Section 12, "Coordination of Care" and see ~~policy~~ Policy 25C1, "Care Management - Delegation and Monitoring," for more information.

5. **Practitioner Education**[7] – Delegates and IEHP share Provider education and training responsibilities including orientation to managed care, delineation of IEHP policies and procedures pertinent to the Practitioner, site and medical record audit preparation, specialized support, and training such as pediatric or adult preventive services and health education.

   a. Delegates are also required to be aware and require their Practitioners' use of certain forms, supplied by IEHP on the Provider website, including~~:~~ the Perinatal Risk Assessment Forms, Individual Health Education Behavioral Assessment (IHEBA) forms, etc. IEHP forms are available online at www.iehp.org.

~~5.~~6. **Health Education** – IEHP notifies the Delegate's CM department for the purpose of individualized care management and referral to appropriate health education programs. IEHP works collaboratively with Providers and Practitioners to identify and educate these Members. IEHP provides certain network-wide health education programs to all Members. IEHP supplies Delegates and PCPs with health education brochures, materials, forms and a Provider Resource Directory. Refer to Section 15, "Health Education" for more information.

[7] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 7, Provision 5, Network Provider Training

~~6.~~7. **Medical Records Maintenance**[8] –IEHP and Delegates are required to monitor Physician offices for compliance with medical record requirements. Practitioners are required to maintain policies and procedures consistent with IEHP requirements, see policy 7A, "Provider and Delegated IPA Medical Records Requirements."

~~7.~~8. **Preventive Care and Non-Preventive Care Guidelines** – Practice guidelines are developed by IEHP using current published literature, current practice standards, and expert opinions. They are based upon specific medical issues commonly found within IEHP's Membership. Delegates are expected to monitor Practitioner's care related to clinical practice guidelines as applicable.

~~8.~~9. **Access Standards**[9] – Delegates are required to adhere to IEHP standards for availability and accessibility of services, see policy 9A, "Access Standards." IEHP ensures network compliance with the standards for appointment availability, after-hours access, Practitioner office wait time, Physician site hours, emergency service availability, medical triage both during and after hours, proximity of Specialists and Hospitals, and follow-up care through studies and audits. The Delegate is required to perform access studies on their Practitioners to ensure they meet IEHP requirements.

B. **Pre-Delegation Audit -** To ensure that newly contracted Delegates have the capacity and capability to perform required functions and meet regulatory requirements, IEHP performs pre-delegation audit within twelve (12) months prior to implementing delegation activities using an audit tool that reflects current NCQA, DHCS, and IEHP standards.[10,11,12]

C. **Annual Quality Management Program Description**

1. Contracted Delegates must have a written QM Program Description that is reviewed at least annually and describes the structure of the Delegate's QM Program.[13] This program must include the following:

   a. QM Program goals, objectives, and structure;[14,15]

   b. Accountability to the Delegate's Governing Body;[16]

[8] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 13, Medical Records
[9] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 4, Access Standards
[10] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[11] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 5, Element B
[12] NCQA, 2022~~1~~ HP Standards and Guidelines, MED 15, Element C
[13] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description
[14] Ibid.
[15] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element A, Factor 1
[16] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 2, Accountability

c. Designated Physician involvement in the QM Program;[17,18,19]

d. Patient Safety;

e. Member Experience;

f. Description of behavioral health care aspects of the program, as applicable;[20]

g. Description of behavioral health care Practitioner involvement in behavioral health care aspects of the program; as applicable;[21]

h. Description of QM Committee oversight of quality management functions;[22]

i. Role, structure and function of the QM Committee[23] and related Subcommittees including meeting frequency;[24]

j. An annual work plan;

k. Description of the resources that devote time and staff dedicated to meeting the objectives of the QM Program (~~i.e.~~ i.e., employees, consultants, data sources, and analytic resources such as statistical persons and/or programs);[25]

l. Objectives for serving a culturally and linguistically diverse membership;[26] and

m. Objectives for serving Members with complex health needs and Seniors and Persons with Disabilities (SPD).

2. The Delegate must document all resources devoted to the QM Program, not merely the QM Program staff. Documentation must indicate the planned number and type of quality management activities to ensure activities are completed in a competent and timely manner.

3. The Delegate must have access to, and the ability to manage, the data supporting measurement of quality management activities documented in the QM Work Plan.

4. There must be evidence of the Board of Directors' review and approval of the QM

[17] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 6, Medical Director
[18] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 2, Accountability
[19] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element A, Factor 3
[20] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element A, Factor 2
[21] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element A, Factor 4
[22] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 2, Accountability
[23] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description
[24] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element A, Factor 5
[25] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element A, Factor 1
[26] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element A, Factor 6

Program Description on an annual basis.[27,28]

5. The Delegate's QM Program Description must outline their approach to address Members with complex needs. Members with complex needs can include individuals with physical or developmental disabilities, multiple chronic conditions, and severe mental illness.[29]

D. **Quality Management Work Plan**[30]

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

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

1. The Delegate's QM Semi-Annual Reports document the progress of the QM activities found in the QM Work Plan and assist the Delegate in its development of the QM annual evaluation.
2. The QM Semi-Annual Report must include:

[27] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 3, Governing Body
[28] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 7, Written Description
[29] Ibid.
[30] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element B

a. Component/Activity;

1) Clinical Improvement;

2) Continuity and Coordination of Care;

- General Medical Care
- General Medical and Behavioral Health

3) Access;

4) Experience Improvement;

5) Patient Safety; and

6) Other QI Activities.

b. Each Component must include:

1) Objectives;

2) Activities planned;

3) Responsible person for each activity; and

4) Timeframe within which each activity is to be completed.

c. Semi-annually, the Delegate must include a description of the following areas for each separate component:

1) Reporting Period;

2) Key findings;

3) Interventions taken;

4) Analysis of findings along with progress; and

5) Any follow-up actions.

3. QM Semi-Annual Reports must be submitted to IEHP. Please see policy 25D1, "Quality Management - Quality Management Reporting Requirements" for information on schedule and method of submission.

F. **QM Program Annual Evaluation**[31]

1. The QM Annual Evaluation may be included in the QM Work Plan or be a separate document. The Annual Evaluation must evaluate the Delegate's performance on planned QM Activities described in its QM Program Description and Work Plan, including all delegated activities. The Annual Evaluation must include the following:

a. A description of completed and ongoing QM and QI activities that address quality

[31] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element C

and safety of clinical care and quality of service;

b. Trending of measures to assess performance in the quality and safety of clinical care and quality of service;

c. Analysis of the results of QM and QI initiatives, including barrier analysis; and

d. Analysis and evaluation of the overall effectiveness of the QM program and of its progress toward influencing network-wide safe clinical practices.

2. The QM Annual Evaluation must be submitted to IEHP. See policy 25D1, "Quality Management - Quality Management Reporting Requirements" for information on schedule and method of submission.

G. **QM Reporting Requirements**[32,33] - Delegates are required to report the following information on a periodic basis. See Policy 25D1, "Quality Management - Quality Management Reporting Requirements," for more information on these reporting requirements.

1. QM Program Description;
2. QM Work Plan;
3. QM Semi-Annual Reports of quality improvement activities; and
4. QM Program Annual Evaluation; and
5. Quality Studies performed by the Delegate when appropriate or as requested by IEHP.

H. **Quality Management Committee**[34,35,36]

1. The QM Committee is an interdisciplinary committee with participation from the Delegate's appointed Practitioners who represent network Physicians. The Delegate's QM Committee is responsible for monitoring, measuring, and evaluating the quality, effectiveness, safety, coordination and appropriateness of the care provided by Practitioners to Members for the purpose of continued quality improvement.
2. The Delegate's description of the QM Committee must include the following:
   a. Role;
   b. Function;
   c. Structure that includes organizational structure and reporting responsibility;

[32] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[33] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 5, Element C
[34] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee
[35] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element A, Factor 5
[36] NCQA, 2022~~1~~ HP Standards and Guidelines, MED 15, Element D

d. Membership;

e. Terms of service;

f. Voting rights;

g. Quorum definition;

h. Meeting frequency;

i. Minute format and storage; and

j. Committees associated with oversight of delegated activities.

3. The Delegate's description of the QM Committee must include its involvement and oversight of the following activities:[37]

   a. Recommending policy decisions;

   b. Analyzing and evaluating QM Activity findings;

   c. Ensuring Practitioners' participation in the QM Program through planning, design and implementation or review;

   d. Implementing needed actions;

   e. Ensuring needed follow-up; and

   f. Maintain signed and dated meeting minutes.

4. The Delegate's QM Committee must meet at least quarterly and follow a prescribed agenda.

5. The Delegate's QM Committee discussions, conclusions, recommendations, and actions must be documented in the signed Committee minutes.

I. **Confidentiality -** Providers must fully comply with all State, Federal and IEHP regulatory requirements pertaining to confidentiality, privacy and information disclosure of medical records. See Policy 7B "Information Disclosure and Confidentiality of Medical Records."

1. **Medical Records Release –** Medical records contain confidential information that must not be released to any party other than the Member's Primary Care Provider (PCP) without the expressed written consent of the Member or legal representative. The PCP must maintain procedures for obtaining such written consent prior to release of records. See Policy 7B, "Information Disclosure and Confidentiality of Medical Records," for more information.

2. **Members' Right to Confidentiality** – Members have the right to confidentiality of

[37] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element D

medical information.[38,39] All Provider contracts and subcontracts include the provision to safeguard the confidentiality of Member health records and treatment in accordance with applicable state and federal laws. Release of Member medical information may be necessary to protect the health of the Member and/or for coordination of services between Practitioners, Specialists, or other health care Providers of service. See Policy 7B, "Information Disclosure and Confidentiality of Medical Records" for more information.

3. **Education of PCP Staff Regarding Confidentiality Issues –** Delegates must educate Providers and associated staff regarding confidentiality issues. Signed confidentiality statements are required for participation in the IEHP Practitioner network and monitored as part of the facility site review process. Referral or access to sensitive services requires the maintenance of high standards of confidentiality. Members requiring family planning services, treatment for sexually transmitted diseases, abortion information and/or treatment, and Human Immunodeficiency Virus (HIV) testing or are requesting assistance with highly sensitive issues, must be treated with respect and consideration for confidentiality. See Policy 9E, "Access to Services with Special Arrangements."

4. **Conflict of Interest[40] –** Should an issue arise involving care provided by a Physician member of the QM Committee or any Subcommittee, that Physician is replaced by a substitute until the issue is resolved. The Member involved in the issue has all rights normally given to anyone with a case presented to the Committee or Subcommittee. Committee members are required to sign a confidentiality and conflict of interest statement.

5. **Informed Consent for Treatment** – Practitioners must obtain appropriate written consent for treatment prior to actual procedure performance.[41] See Policy 7C, "Informed Consent," for more information.

J. **Provider Participation**

1. **Provider Information[42]** – Delegates are required to inform network Practitioners of guidelines, policy and procedure changes, and other important information. Delegates' methods of Practitioner education or notification are evaluated annually during Delegation Oversight Audits. Providers are informed of policy and procedure changes and other important information through the IEHP Provider Newsletter, letters,

[38] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 1, Member Rights and Responsibilities
[39] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 13, Medical Records
[40] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 4, Quality Improvement Committee
[41] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements
[42] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 7, Provision 5, Network Provider Training

memorandums, distribution of updates to the Provider Manual, and training sessions. Delegates are notified through letters, memorandums, Provider Manual updates, training sessions for specific issues, Joint Operations Meetings, and by attending IEHP University, when available.

2. **Provider Cooperation -** IEHP requires that Delegates and Hospitals cooperate with IEHP QM Program studies, audits, monitoring, and quality related activities.[43] Requirements for cooperation are included in Hospital and Delegate Provider contract language that describes contractual agreements for access to information.

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

1. Delegate and Provider Agreements include the following provisions:

   a. Delegate is subject to, and agrees to participate in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievance and/or appeal resolution.

   b. Delegate shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records, financial records pertaining to the cost of operations and income received by Delegate for medical services rendered to Members. Delegate shall ensure that Providers allow IEHP to access and use Provider performance data.

   c. Delegate shall cooperate with IEHP's QM Program and, upon reasonable request, shall provide IEHP with summaries of or access to records maintained by Delegate and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.

   d. Delegate shall not impede open Practitioner-patient communication. Members are allowed to participate with doctors in decision-making about their own health care including the ability to talk with their doctor about their medical condition regardless of cost or benefit.

2. Hospital contracts include provisions for the following:

   a. Hospital agrees to participate with IEHP in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievances and resolution. Hospital shall also provide access to IEHP utilization review and case management personnel for the purpose of conducting concurrent review and case management on Members who are receiving Hospital services.

[43] NCQA, 2022~~1~~ HP Standards and Guidelines, QI 1, Element D, Factor 3

b. Hospital shall implement an ongoing QM Program and shall develop procedures for ensuring that the quality of care provided by Hospital conforms with generally accepted Hospital practices prevailing in the managed care industry. Hospital shall develop written procedures for remedial action whenever, as determined by the QM Program, inappropriate or substandard services have been furnished, or services that should have been furnished have not been furnished.

c. Hospital shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records and financial records pertaining to the cost of operations and income received by Hospital with a five (5) working day prior written notice of any such inspection. Hospital shall ensure that Providers allow IEHP to access and use Provider performance data.

d. Hospital shall cooperate with IEHP's QM Program and, upon reasonable request, provide IEHP with summaries of or access to records maintained by Hospital and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.

L. **Auditing and Monitoring Activities**[44,45] - IEHP performs a series of activities to monitor Delegate functions including the following:

1. **Delegation Oversight Audit** – IEHP performs an annual Delegation Oversight Audit of all contracted Delegates using an audit tool that is based upon current NCQA, DHCS and IEHP standards. This audit assesses Delegate's operational capabilities in the areas of QM, QI, Credentialing, UM, CM, and Compliance. See Policy 25A2, "Delegation Oversight – Audit," for more information.

2. **Joint Operations Meetings (JOMs)** – JOMs with Delegates are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities that the Delegates are required to perform. JOMs may address specific UM, QM, QI, CM, grievance, study results, or any other pertinent quality issues.

3. **Member or Practitioner Grievance Review -** IEHP reviews individual grievances and their resolutions for Delegate policies or procedures, actions, or behaviors that could potentially negatively impact health care delivery or Member health status.

4. **Specified Audits -** IEHP performs specific audits of Delegates and PCPs to assess compliance with IEHP standards. These audits include facility reviews, claims audits, CM audits, and health education audits.

[44] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[45] 28 CCR §1300.70(b)(2)(G)(3)

5. **Focused Audits:** IEHP performs focused audits of Delegates or Practitioners as indicated whenever a quality or clinical issue is identified.
6. **Review of Referral Universes -** All Delegates are required to submit monthly referral universes to IEHP, as well as~~,~~ all denial letters sent to Members. All denials are reviewed for appropriateness and trends or patterns of concern. See Policy 25E2, "Utilization Management - Reporting Requirements" for complete information on UM reporting requirements.
7. **Review of CM Logs and Case Files -** All Delegates are required to submit monthly CM Logs to IEHP listing all CM cases from the previous month. In addition, Delegates are required to submit copies of CM files. All files are reviewed for appropriateness and trends or patterns of concern. See Policy 25C2, "Care Management - Reporting Requirements" for complete information on CM reporting requirements.
8. **Delegated Reporting Requirements Review -** IEHP performs review of scheduled submitted reports as defined in the IPA Reporting Requirements Schedule (See Attachment, "~~-~~IPA Reporting Requirements Schedule – Medi-Cal" in Section 25), and delegated activities as defined in the Delegation Agreement (See Attachment, "IPA Delegation Agreement – Medi-Cal in Section 25).
9. **Focused Referral and Denial Audits -** IEHP performs focused audits of the referral and denial process for Delegates when quality of care issues are identified. Audits examine source data at the Delegate to review referral process timelines, appropriateness of denials and the denial process, including denial letters. Refer to Policy 25E3, "Utilization Management – Referral and Denial Audits" for more information.
10. **Member and Physician Experience Surveys -** IEHP performs Member and Physician experience surveys to assess their experience with IEHP, their Delegate and managed care.

M. Delegates that are out of compliance with QM requirements will be issued a Corrective Action Plan (CAP). See Policy 25A4, "Delegation Oversight – Corrective Action Plan Requirements."

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief ~~Medical~~ Quality Officer	**Revision Date:**	January 1, 2023~~2~~

25. DELEGATION AND OVERSIGHT

E. Utilization Management
1. Delegation and Monitoring

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its Delegates shall develop, implement, and continuously update and improve a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services.[1]

B. IEHP maintains responsibility of ensuring that its Delegates continue to be in compliance with all applicable State and Federal laws and other requirements set forth by the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), National Committee for Quality Assurance (NCQA), and IEHP.

C. Authorization and financial responsibilities are delineated in the Division of Financial Responsibilities (DOFR). Delegated responsibilities are outlined in the IPA's Delegation Agreement.

PURPOSE:

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

DEFINITION:

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

PROCEDURES:

UM Program Requirements

A. Delegates must have a UM Program Description that includes, at minimum, the following information:[2]

1. Mission statement, goals, and objectives;
2. Program structure, which includes at minimum:

[1] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
[2] NCQA, 2022 HP Standards and Guidelines, UM 1, Element A

a. UM staff's assigned activities;

b. UM staff who have the authority to deny coverage;

c. Involvement of a designated physician;

d. The process for evaluating, approving and revising the UM Program, and the staff responsible for each step;

e. The UM Program's role in the Quality Improvement (QI) program, including how the organization collects UM information and uses it for QI activities; and

f. The organization's process for handling appeals and making appeal determinations;

3. Senior-level physician involvement, including their responsibilities in setting UM policies, supervising program operations, reviewing UM cases, participating on the UM committee, and evaluating the overall effectiveness of the UM program;

4. Processes and information sources used to make determinations, which includes but is not limited to:

a. UM functions, the services covered by each function or protocol and the criteria used to determine medical necessity;

b. How medical necessity and benefits coverage for inpatient and outpatient services are determined and guide the UM decision-making process; and

c. The description of the data and information the Delegate uses to make determinations; and

5. Other UM program requirements.

B. Delegates must, on at least an annual basis, evaluate their UM program to ensure that this remains current and appropriate. Delegates must update their UM program based on this program evaluation, which must include but not be limited to the review of the following:[3]

1. UM program structure;

2. Program scope, processes, information sources used to determine benefit coverage and medical necessity;

3. The level of involvement of the senior-level physician in the UM program; and

4. Member and Provider experience data.

C. Delegates must have the following UM structure in place:

1. Delegates must have a designated senior-level physician who holds an unrestricted license in the state of California, responsible for the following. Please see Policy 18N,

[3] NCQA, 2022 HP Standards and Guidelines, UM 1, Element B

"IPA Medical Director Standards" for more information: [4]

a. Ensuring the process by which the Delegate reviews and approves, partially approves (modifies) or denies, based in whole or in part on medical necessity, requests by Providers prior to, retrospectively, or concurrent with the provision of health care services to Members comply with State, federal and contractual requirements;[5,6]

b. Ensuring that medical decisions are rendered by qualified medical personnel and are not influenced by fiscal or administrative management considerations; [7,8]

c. Participation in staff training;[9]

d. Monitoring documentation for adequacy;[10]

e. Be available to UM staff on site or by telephone;[11]

f. Signing off on all internal policies and procedures related to UM; and

g. Chairing the UM Committee or designating a Chair.

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

2. **UM Committee -** Delegates must establish a UM Committee that directs the continuous monitoring of all aspects of UM, including the development of appropriate standards administered to Members, with oversight by the Medical Director.[12] For more information on a UM Committee's functions, structure, membership, and other requirements, please see Policy 2G, "Utilization Management Subcommittee."

3. **Use of Appropriate Professionals for UM Decisions:** To ensure that first-line UM decisions are made by individuals who have the knowledge and skills to evaluate working diagnoses and proposed treatment plans, IEHP requires its Delegates to adopt the following standards for personnel making review decisions and reviewing denials. The following types of personnel can perform the functions listed, as delegated to do so: [13]

a. UM Technicians/Coordinators – eligibility determination, editing of referral form for completeness, interface with Provider offices to obtain any needed non-medical

[4] NCQA, 2022 HP Standards and Guidelines, UM 1, Element A, Factor 1
[5] California Health and Safety Code (Health & Saf. Code) §1367.01
[6] NCQA, 2022 HP Standards and Guidelines, UM 4, Element A, Factor 1
[7] Title 22, California Code of Regulations (CCR) § 53857
[8] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 6, Medical Director
[9] NCQA, 2022 HP Standards and Guidelines, UM 4, Element A, Factor 1
[10] Ibid.
[11] Ibid.
[12] NCQA, 2022 HP Standards and Guidelines, UM 1, Element A, Factor 3
[13] NCQA, 2022 HP Standards and Guidelines, UM 4, Element A, Factor 2

information,[14] and approval of authorizations as determined appropriate (auto authorizations). Delegates should be able to provide a list of all services approvable by UM Technicians/Coordinators.

b. Licensed Vocational Nurses (LVN) – initial review of medical information, initial determination of benefit coverage, concurrent inpatient, obtaining additional medical information, as needed, from the Provider's offices,[15] and approval of referrals based on IEHP-approved authorization criteria, and initiate denials for non-covered benefits and carve outs.

c. Registered Nurses (RN) – initial review of medical information, initial determination of benefit coverage, obtaining additional medical information as needed, from the Provider's office, [16] approval of referrals based on medical necessity or IEHP-approved authorization criteria, and providing medical necessity recommendation to the physician reviewer.

d. Physician-Reviewer - A designated physician with unrestricted license in the state of California must review all denials and partial approvals (modifications) based in whole or in part on medical necessity and obtain additional medical information from the treating physician as needed.[17,18, 19,20,21]

4. **Use of Board-Certified Physicians for UM Decisions:** Delegates must have written policy and procedure demonstrating their use of designated physicians with current unrestricted license for UM decisions. [22,23]

a. When a case review falls outside the clinical scope of the reviewer, or when medical decision criteria do not sufficiently address the case under review, a Board-certified physician in the appropriate specialty must be consulted prior to rendering a decision.

b. Delegates must either maintain a list of Specialists to be utilized for UM decisions or consult with an organization contracted to perform such review. The interaction may be completed by a telephone call to a network Specialist, a written request for review, or use of a contracted vendor that provides Board Specialist review.

[14] NCQA, 2022 HP Standards and Guidelines, UM 6, Element A
[15] NCQA, 2022 HP Standards and Guidelines, UM 6, Element A
[16] Ibid.
[17] CA Health & Saf. Code § 1367.01(e)
[18]DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[19] NCQA, 2022 HP Standards and Guidelines, UM 4, Element A, Factor 1
[20] NCQA, 2022 HP Standards and Guidelines, UM 4, Element C
[21] NCQA, 2022 HP Standards and Guidelines, UM 6, Element A
[22] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
[23] NCQA, 2022 HP Standards and Guidelines, UM 4, Element F, Factors 1 and 2

c. The physician reviewer determines the type of specialty required for consultation.

Clinical Criteria for UM Decisions

A. Delegates must use nationally recognized clinical criteria and/or IEHP UM Subcommittee-Approved Authorization Guidelines, when making decisions related to medical care.[24] Criteria sets approved by IEHP include Title 22 of the California Code of Regulations, InterQual, Apollo Managed Care Guidelines/Medical Review Criteria, Milliman Care Guidelines, Department of Health Care Services (DHCS) Medi-Cal Provider Manual, DHCS All Plan Letters (APLs), and IEHP UM Subcommittee-Approved Authorization Guidelines.[25,26,27] IEHP may distribute additional criteria following approval by the IEHP UM Subcommittee.

1. **Development:** Criteria or guidelines that are developed by IEHP and used to determine whether to authorize, partially approve (modify), or deny health care services are developed with involvement from actively practicing health care Practitioners.[28,29] IEHP ensures these criteria or guidelines are consistent with sound clinical principles and processes and are evaluated at least annually and updated if necessary.[30,31,32]

2. **Application:** Delegates must apply criteria in a consistent and appropriate manner based on available medical information and the needs of individual Members.[33] The application of criteria takes into consideration individual factors such as age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment.[34] Decisions to deny services cannot be solely based on codes being listed as non-covered, i.e. Medi-Cal Treatment Authorization Request (TAR) and Non-Benefit list of codes. Additionally, criteria applied takes into consideration whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual Member's treatment plan. The organization also considers characteristics of the local delivery system available for specific Members, such as:[35]

[24] NCQA, 2022 HP Standards and Guidelines, UM 2, Element A
[25] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
[26] CA Health & Saf. Code § 1363.5(b)
[27] NCQA, 2022 HP Standards and Guidelines, UM 2, Element A, Factor 1
[28] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
[29] NCQA, 2022 HP Standards and Guidelines, UM 2, Element A, Factor 4
[30] CA Health & Saf. Code §1363.5
[31] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
[32] NCQA, 2022 HP Standards and Guidelines, UM 2, Element A, Factor 5
[33] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
[34] NCQA, 2022 HP Standards and Guidelines, UM 2, Element A, Factor 2
[35] NCQA, 2022 HP Standards and Guidelines, UM 2, Element A, Factor 3

a. Availability of services, including but not limited to skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the Member after hospital discharge;

b. Coverage of benefits for skilled nursing facilities, subacute care facilities, home care where needed, Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Managed Long-Term Services and Support (MLTSS), Multipurpose Senior Services Program (MSSP), or Behavioral Health; and

c. Local in-network hospitals' ability to provide all recommended services within the estimated length of stay.

Delegates must ensure consistent application of UM criteria by following this specific order as the Delegate is licensed to use:[36,37,38]

a. IEHP Member Handbook (Evidence of Coverage); **then**

b. DHCS Medi-Cal Provider Manual **or** Title 22 of California Code of Regulations (CCR); **then**

c. National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium **or** IBM Watson Health Products: Micromedex; **then**

d. MCG Health Informed Care Strategies Care Guidelines; **then**

e. InterQual Criteria; **then**

f. Apollo Medical Review Criteria Guidelines for Managing Care; **then**

g. IEHP Utilization Management (UM) Subcommittee Approved Authorization Guidelines **or** Pharmacy and Therapeutics (P&T) Subcommittee Approved Prior Authorization Criteria.

3. **Annual Review and Adoption of Criteria**: IEHP develops and/or presents criteria to the IEHP UM Subcommittee for adoption and implementation. Delegates may develop and recommend criteria for review and approval by the IEHP UM Subcommittee. After approval by UM Subcommittee, the criteria are sent to the IEHP Quality Management (QM) Committee for reference and disseminated to Delegates and Providers via letter,

[36] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
[37] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[38] NCQA, 2022 HP Standards and Guidelines, UM 2, Element A, Factor 1

website or email. Members of the IEHP UM Subcommittee and Practitioners in the appropriate specialty, review clinical criteria annually and update, as necessary. [39,40]

4. **Process for Obtaining Criteria**: Delegates must disclose to Providers, Members, Member's representatives, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the procedure or condition requested.[41,42]

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

   a. In writing by mail, fax, or e-mail; or

   b. On its website if it notifies Providers that information is available online.

   The Notice of Action (NOA) must state the address and phone number to call for obtaining the utilization criteria or benefits provision used in the decision.[43,44] Every disclosure must be accompanied by the following statement: "The materials provided to you are guidelines used by the plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your Health Plan" (See Attachment, "Response to Request for UM Criteria" in Section 25). [45] Delegates must maintain a log of all requests for criteria (See Attachment, "Request for UM Criteria Log" in Section 25).

5. **Annual Assessment of Consistency of UM Decisions (Inter-rater Reliability):** Delegates are responsible for evaluating, at least annually, the consistency with which health care professionals involved in utilization review apply appropriate criteria for decision-making.[46,47] Delegates must act on identified opportunities to improve consistency.[48] The sample assessed must be statistically valid, or Delegates may use one (1) of the following three (3) auditing methods: [49]

   a. Five percent (5%) or fifty (50) of its UM determination files, whichever is less;

[39] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
[40] NCQA, 2022 HP Standards and Guidelines, UM 2, Element A, Factor 5
[41] CA Health & Saf. Code §1363.5
[42] NCQA, 2022 HP Standards and Guidelines, UM 2, Element B, Factors 1 and 2
[43] DHCS All Plan Letter (APL) 21-011 Supersedes APL 17-006, "Grievance and Appeals Requirements, Notice and "Your Rights" Templates
[44] NCQA, 2022 HP Standards and Guidelines, UM 7, Element B, Factor 3
[45] CA Health & Saf. Code §1363.5
[46] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
[47] NCQA, 2022 HP Standards and Guidelines, UM 2, Element C, Factor 1
[48] NCQA, 2022 HP Standards and Guidelines, UM 2, Element C, Factor 2
[49] NCQA, 2022 HP Standards and Guidelines, UM 2, Element C, Factor 1

b. NCQA's 8/30 methodology; or

c. Ten (10) hypothetical cases.

Review of UM Data

A. Delegates must collect, report, and analyze UM data related to Members for potential over or under utilization.[50]

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

UM Authorization Process Requirements

A. Delegates must have written policies and procedures regarding the process to review, approve, partially approve (modify) or deny prospective, concurrent or retrospective requests by Providers concerning provision of health care services for Members. These policies and procedures must be available to the public upon request. [51]

1. **Specialty Referral Systems:** Delegates must maintain a specialty referral system to track and monitor referrals requiring prior authorization. The system shall include approved, partially approved (modified), and denied referrals received from both contracted and non-contracted providers, as well as the timeliness of these referrals.[52]

[50] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 4, Review of Utilization Data
[51] CA Health & Saf. Code § 1367.01(b)
[52] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program

2. **System Controls:** Delegates must have and be able to demonstrate system controls to protect data specific to denial and appeal notifications and receipt dates from being altered outside of prescribed protocols.[53]

3. **Out-of-Network Services:** Authorization and notification of decision for proposed services, referrals, or hospitalizations involves utilizing information such as medical records, test reports, specialist consults, and verbal communication with the requesting Provider. Part of this review process is to determine if the service requested is available in network. If the service is not available in network, arrangements are made for the Member to obtain the service from an out of-network provider for this episode of care.[54,55]

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

4. **Prior Authorization Requirements:** Delegates must maintain a list of services that require prior authorization or a list of services that do not require prior authorization like below, at minimum.

   a. The prior authorization process described in this policy do not apply to these services, which do not require prior authorization:

      1) Emergency services and services necessary to treat and stabilize an emergency medical condition (See Policy 14C, "Emergency Services");[56,57,58]

      2) Family planning (See Policy 10G, "Family Planning Services");[59,60]

[53] NCQA, 2022 HP Standards and Guidelines, UM 12, Element A
[54] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 16, Out-of-Network Providers
[55] NCQA, 2022 HP Standards and Guidelines, MED 1, Element D
[56] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[57] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization
[58] NCQA, 2022 HP Standards and Guidelines, MED 9, Element C, Factors 1 through 3
[59] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[60] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements

3) Abortion services (See Policy 9E, "Access to Services with Special Arrangements"); [61]
4) Sexually Transmitted Infection (STI) services (See Policy 10H, "Sexually Transmitted Infection (STI) Services"); [62,63]
5) Sensitive and confidential services (See Policy 9E, "Access to Services with Special Arrangements");
6) HIV testing and counseling (See Policy 10I, HIV Testing and Counseling"); [64,65]
7) Immunizations (See Policy 10C2, "Pediatric Preventive Services – Immunization Services"); [66]
8) Routine OB/GYN services, including prenatal care by Family Care Practitioner (credentialed for obstetrics) within the IPA's network; [67,68]
9) Out of area renal dialysis; [69]
10) Biomarker testing for advanced or metastatic stage 3 or 4 cancers; [70,71]
    a) Please visit the United States Food and Drug Administration (FDA) website for a continually updated list of FDA-approved cancer therapies for which associated biomarker tests may be ordered. [72]
11) Urgent Care; [73] and

[61] DHCS APL 15-020 Supersedes PL 99-08, "Abortion Services"
[62] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[63] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements
[64] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[65] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements
[66] DHCS All Plan Letter (APL) 18-004 Supersedes Policy Letter (PL) 96-013 and APL 07-015, "Immunization Requirements"
[67] Ibid.
[68] NCQA, 2022 HP Standards and Guidelines, MED 1, Element A
[69] DHCS Medi-Cal Provider Manual, "Dialysis: End Stage Renal Disease Services"
[70] California Health and Safety Code (CA HSC) §1367.665
[71] DHCS APL 22-010 "Cancer Biomarker Testing"
[72] https://www.accessdata.fda.gov/scripts/cder/daf/
[73] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 4, Access Standards

12) Preventive services,[74] which includes the following services and those listed in the DHCS Medi-Cal Provider Manual Preventive Services List:[75]

a) Bone Density Screening (CPT Codes: 77080 and 77081);

b) Diagnostic Mammograms for ages 40 and above (CPT Codes: 77065, 77066 and 77063);

c) Lung Cancer Screening (CPT Codes: S8032 and 71271).

b. Upon receipt of a request for prior authorization of a preventive service, Delegates must utilize the DHCS-approved Member letter "Prior Authorization Not Required" to inform the Member and Provider that authorization is not required. See the section on "Notification Requirements" within this policy.

c. Delegates must allow Members direct access to Specialists, appropriate for their condition and identified need for special healthcare needs.[76]

d. Delegates shall ensure Members have access to American Indian Health Services Programs (AIHSP). AIHSP, whether contracted or not, can provide referrals directly to network Providers without first requesting a referral from a PCP.[77]

5. **Medical Necessity Determination:** Delegates must determine medical necessity for a specific requested service as follows: [78]

a. Employ IEHP-approved UM authorization guidelines, as outlined in this policy, and utilize the following definitions for determining medical necessity of a healthcare service: [79]

1) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity," when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

2) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity," when the service is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.

b. If information reasonably necessary to make a determination is not available with the referral, the requesting Provider should be contacted for the additional clinical

[74] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[75] Preventive Services (prev) (ca.gov)
[76] NCQA, 2022 HP Standards and Guidelines, MED 1, Element B, Factor 1
[77] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements
[78] NCQA, 2022 HP Standards and Guidelines, UM 1, Element A, Factor 5
[79] CA Welfare and Institutions Code (Welf. & Inst. Code) § 14059.5

information by telephone at least two (2) times and with a third attempt being made by a Medical Director.[80] The request for additional information must be annotated and include the date of request.[81]

c. Consider all factors related to the Member including barriers to care related to access or compliance, impact of a denial on short- and long-term medical status of the Member and alternatives available to the Member if denied; and

d. Obtain input from Specialists in the area of the health care services requested either through an UM Committee member, telephonically, or use of an outside service.[82,83]

6. **Review Process and Timeframes:** Mandated timeframes for decisions including approval, denial or partial approval (modification) of a request and subsequent notification to the Member and Provider are outlined in this Provider Manual (see Attachment, "UM Timeliness Standards – Medi-Cal" in Section 14).

a. The prior authorization process is initiated when the Member's Physician requests a referral or authorization for a procedure or service. Please see Policies 14A1, "Review Procedures – Primary Care Provider Referrals" and 14D, "Pre-Service Referral Authorization Process" for more information.

~~1) Providers must submit urgent preservice and urgent concurrent referrals within 24 hoursthe same day of the determination that the referral is necessary.~~

~~2) For non-urgent preservice or concurrent referrals, Providers have fivetwo (52) working days from the determination that a referral is necessary, to submit the referral and all supporting documentation.~~

~~3) Providers must sign and date the referral and provide a direct phone number and fax number to the referring Physician for any questions or communication regarding the referral.~~

b. Delegates may extend the authorization timeframe by up to fourteen (14) calendar days if:

1) The Member or the Provider requests an extension; or

2) The Delegate can justify its need for additional information and demonstrate how the extension is in the Member's interest.

If the Member requires an extension of the initial authorization timeframe, the Delegate must immediately notify the requesting Provider to request all specific

[80] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[81] NCQA, 2022 HP Standards and Guidelines UM 6, Element A
[82] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
[83] NCQA, 2022 HP Standards and Guidelines, UM 4, Element F, Factors 1 and 2

information the Delegate still needs to make its authorization decision. Delegates must provide documentation of the justification of such extension, upon request.

Using the "Notice of Delay" template, the Delegate must notify the Member and requesting Provider within the required timeframe, or as soon as the Delegate becomes aware that it will not meet the initial authorization timeframe, whichever is earlier.[84] This notification must include the specific information requested but not received, expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied.[85] See the section on "Notification Requirements" within this policy.

c. Delegates will identify upon intake any prior authorization request for which IEHP is responsible to authorize and will ensure these requests are forwarded to IEHP within one (1) business day of receipt by forwarding the request through the IEHP secure Provider portal. Examples of services/items to be forwarded are requests for behavioral health, general anesthesia for dental treatment, inpatient surgery requests when the facility is not contracted with IEHP, POV purchase/repair.

d. For concurrent decisions, care shall not be discontinued until the Member's treating Provider has been notified of the plan's decision and a care plan has been agreed upon by the treating Provider that is appropriate for the medical needs of the Member.[86]

e. *Urgent Preservice or Concurrent Requests:* Delegates have forty-eight (48) hours after receipt of an urgent preservice or concurrent request to determine and communicate to the requesting Provider if it meets the following definition for an urgent pre-service or urgent concurrent request.

   1) Member's condition is such that the Member faces an imminent and serious threat to their health, including but not limited to potential loss of limb or other major bodily function, or when the non-urgent timeframe for making a determination would be detrimental to the Member's life or health, or could jeopardize Member's ability to regain maximum function; [87] or

   2) In the opinion of a Provider with knowledge of the Member's medical condition, delay would subject the Member to severe pain that cannot be adequately managed without the requested care or treatment.

   Examples of requests that may not be downgraded from urgent preservice or urgent concurrent to non-urgent are Hematology/Oncology and Total Fracture Care.

[84] CA Health & Saf. Code § 1367.01(h)(5)
[85] DHCS APL 21-011
[86] CA Health & Saf. Code § 1367.01
[87] CA Health & Saf. Code § 1367.01(h)(2)

The determination that a request does not meet the definition of urgent pre-service or urgent concurrent must be made and documented by the Delegate RN or physician reviewer. If the request does not meet the definition of urgent pre-service or urgent concurrent, the Delegate RNor physician reviewer must successfully communicate to the requesting Provider either telephonically or by fax that the request did not meet the definition of urgent pre-service or urgent concurrent:

1) Telephonic communication must be documented, including date, time, name of contact person at the Provider's office, name of the RN/LVN, or physician reviewer.

2) Faxed communication to the Provider should state that the request did not meet the definition of urgent pre-service as outlined above.

Delegate must notify both the Provider and Member utilizing the IEHP-approved "Notice of Action" template and provide "Your Rights" attachment with all denials that instructs a Member or Member's representative about the appeal/grievance process. See the section on "Notification Requirements" within this policy.

If accepted as an urgent pre-service or urgent concurrent request, the Delegate must render a decision and notify the Member and Provider as expeditiously as the Member's health condition requires but no more than regulatory timeframes (see Attachment, "UM Timeliness Standards – Medi-Cal").

f. *Post-Service Decisions (Retrospective Review):* Services that require prior authorization and rendered without such authorization will be reviewed retrospectively to determine medical necessity and/or benefit coverage. This can include out-of-area admissions, continuity of care, and/or services or treatments rendered by a contracted or non-contracted Provider without prior authorization.

1) If a request for retrospective review is received more than one hundred twenty (120) calendar days after the date that the service was rendered, the Delegate must direct the Provider to instead submit a request for claims payment.

2) Relevant clinical information must be obtained and reviewed for medical necessity based on IEHP-approved authorization criteria. [88] If medical necessity is not met, denial determinations must be made by the Delegate Medical Director.[89]

3) Both the Member and Provider must be notified of post-service (retrospective review) determinations,[90] using the appropriate "Notice of Action" template. In case of a denial or partial approval of post-service requests, IEHP recommends

[88] NCQA, 2022 HP Standards and Guidelines, UM 6, Element A
[89] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[90] Ibid.

the following language: "Your Provider's request to approve the services you already received on <MM/DD/YYYY> does not meet the criteria and is not medically necessary. Please note that, as the Member, you are not responsible for paying for any of these services. If you receive a bill from your Provider, please inform <IPA Name> immediately by calling Member Services at <IPA Contact Information, including TTY>." See the section on "Notification Requirements" within this policy.

g. The timeframes for rendering decisions and sending notifications to the Provider and Member are outlined in this Provider Manual (See Attachment, "UM Timeliness Standards – Medi-Cal" in Section 14). These timeframes allow the Member sufficient time to request Aid Paid Pending, if applicable.

7. **Experimental and Investigational Determinations:** The determination for all experimental and investigational services is the responsibility of IEHP.[91]

   a. The Delegate must send to IEHP all authorization requests for experimental/investigational services as soon as possible after receipt of the request. This must be sent through IEHP's secure Provider portal. The request must include all supporting clinical information including diagnosis (ICD) and procedure (CPT) codes.

   b. The Milliman Care Guidelines (MCG) term "role remains uncertain" does not indicate that a request is considered experimental/investigational. The Delegate must review these requests utilizing the next criteria set in the hierarchy. If there are no other criteria to review, the Delegate must forward the request to IEHP as outlined above.

   c. IEHP is responsible for decision-making and notifying the Provider, Member and Delegate of the determination, per standard timeframes for level of urgency.

8. **Out-of-Network/Capitated Providers**: Prior to redirecting a referral from an out-of-network provider or tertiary facility to a contracted or capitated Provider, the Delegate must first verify and document the following:

   a. That the redirected Provider is of the same discipline and able to provide equivalent service dependent on the Member's medical condition; and

   b. That the Member can receive services within IEHP's access standards. Please see Policy 9A, "Access Standards" for more information.

   Documentation of the above must include:

   a. Name and title of contact at Provider's office;

[91] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 9, Investigational Services

b. Date of outreach;

c. Expected date of Member's appointment; and

d. Confirmation that the Provider is of the same discipline and able to provide equivalent service dependent on the Member's medical condition.

9. **Notification Requirements**: Any decision to deny a service authorization based on medical necessity or to authorize a service that is less than requested in an amount, duration, or scope must be reviewed and approved by the Delegate Medical Director or physician designee. [92,93,94] Members and Providers must receive denial letters for any requested referral that is denied or modified.[95]

   a. All IEHP-approved notification templates are available online at www.iehp.org. The Delegate is responsible for ensuring they are utilizing the most recent version of the template. Notices of Action must adhere to the following:

      1) Include required DMHC language (in bold within template online);

      2) Include required DHCS language;

      3) Written in a manner, format, and language that can be easily understood; [96,97,]

      4) Fully translating the Notice of Action including the clinical rationale for the health plan's decision, in the Member's required language;[98]

      5) Include information about how to request translation services and alternative formats, which shall include materials that can be understood by persons with limited English proficiency;[99]

      6) Include the right to appeal the decision, file a grievance, ask for an Independent Medical Review (IMR), refer to "Your Rights;"[100,101,102,103]

[92] CA Health & Saf. Code § 1367.01
[93] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
[94] NCQA, 2022 HP Standards and Guidelines, UM 4, Element A
[95] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests
[96] NCQA, 2022 HP Standards and Guidelines, UM 7, Element B, Factor 1
[97] NCQA, 2022 HP Standards and Guidelines, UM 7, Element E, Factor 1
[98] DHCS APL 21-011
[99] NCQA, 2022 HP Standards and Guidelines, UM 7, Element E, Factor 1
[100] CA Health & Saf. Code § 1367.01
[101] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 8, Denial, Deferral or Modification of Prior Authorization Requests
[102] NCQA, 2022 HP Standards and Guidelines, UM 7, Element C
[103] NCQA, 2022 HP Standards and Guidelines, UM 7, Element F

7) Include language appropriate for the Member population describing the reason for the denial:

- Medical necessity denials must cite the criteria used and the reason why the clinical information did not meet criteria; [104,105,106]
- Non-covered benefit denials must cite the specific provision in the Evidence of Coverage (EOC) (i.e., the IEHP Member Handbook), Medi-Cal Provider Manual or State or Federal regulations that exclude that coverage including the section. Non-covered benefits cannot be solely based on a code not being covered;
- Information on how the Member and Provider can obtain the utilization criteria or benefits provision used in the decision;[107]
- Member-specific denial language should be at a readability level of 6th grade[108] and should not include CPT Codes and abbreviations; and

8) Information for the Member regarding alternative direction for follow-up care or treatment.

For partially translated Member notices mailed during the implementation period, IEHP is required to meet the requirements, including but not limited to inserting a sentence that informs the Member, in their required language, how to obtain oral interpretation of the clinical rationale on an expedited basis, as well as mailing a fully translated correspondence, with a fully translated clinical rationale, as soon as possible but not later than 30 calendar days from the date the partially translated notice was sent.[109]

b. The written communication to a Provider of a denial based on medical necessity must include the name and telephone number of the UM Medical Director or physician designee responsible for the denial.[110] Such communication must offer the requesting Provider the opportunity to discuss with the physician reviewer any issues or concerns regarding the decision.[111] This written notification of denial or partial approval (modification) must include language informing the Provider of the appeal

[104] CA Health & Saf. Code § 1367.01
[105] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2 Prior Authorizations and Review Procedures
[106] DHCS APL 21-011
[107] NCQA, 2022 HP Standards and Guidelines, UM 7, Element B, Factor 3
[108] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 13, Provision 4, Written Member Information
[109] DHCS APL 21-011
[110] CA Health & Saf. Code § 1367.01
[111] NCQA, 2022 HP Standards and Guidelines, UM 7, Element A

process. [112,113] See Section 16, "Grievance and Appeals Resolution System" for more information.

c. On a monthly basis, for monitoring purposes, the Delegate must send to IEHP all documentation for each denial including the following. Please see Policy 25E2, "Utilization Management – Reporting Requirements" for more information.
   1) Referral Universe;
   2) Letters and attachments;
   3) Clinical documentation;
   4) Referral;
   5) Outreach/call logs, if any
   6) Supporting evidence of the following:
      - Received Date;
      - Decision Date and Time;
      - RN/LVN or physician reviewer note from medical management system; and
      - Proof of date and time letter was mailed to the Member
   7) Criteria used for the determination
   8) Initial notification including opportunity to discuss; and
   9) Audit trail to include all changes and dates made to the case.

Other UM Program Requirements

A. **Referral Requests:** PCPs are responsible for supervising, coordinating, and providing initial primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. [114] PCP and Specialist requests for referral to specialty care should be initiated through the Member's IPA. Please see Policies 14A1, "Review Procedures – Primary Care Provider (PCP) Referrals" and 14D, "Pre-Service Referral Authorization Process."

B. **Continuity of Care:** Delegates must maintain policies and procedures that ensure Members are given the option to continue treatment for up to twelve (12) months with an out-of-network

[112] NCQA, 2022 HP Standards and Guidelines, UM 7, Element C
[113] NCQA, 2022 HP Standards and Guidelines, UM 7, Element F
[114] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit E, Attachment 1, Definitions

provider per DHCS requirements. [115,116] Please see Policy 12A2, "Coordination of Care – Continuity of Care."

C. **Standing Referrals**: Delegates must have policies and procedures by which a PCP may request a standing referral to a Specialist for a Member who requires continuing specialty care over a prolonged period of time or an extended referral to a Specialist or specialty care center for a Member who has a life threatening, degenerative, or disabling condition that requires coordination of care by a Specialist.[117,118,119] Delegates must have a system in place to track open, unused, and standing referrals. Please see Policy 14A2, "Standing Referral and Extended Access to Specialty Care" for more information.

D. **Second Opinions:** IEHP provides for its Members second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network, if services are not available within the network. [120,121] Refer to Policy 14B, "Second Opinions," for more information.

E. **Vision Services**: IEHP is responsible for utilization management associated with vision services for Medi-Cal Members.

F. **Supplemental Benefits:** Supplemental benefits may vary and are the responsibility of the Health Plan. Please refer to IEHP's website for a list of current benefits.

G. **Communication Services**: IEHP and its Delegates must provide access to staff for Members and Providers seeking information about the UM process and the authorization of care by providing these communication services: [122]

1. IEHP and its Delegates shall maintain telephone access for Providers to request authorization for healthcare services.[123]

2. IEHP and its Delegates' UM staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.[124]

[115] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members
[116] DHCS All Plan Letter (APL) Supersedes APL 15-019, "Continuity of Care for Medi-Cal Who Transition into Medi-Cal Managed Care"
[117] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 6, Standing Referral
[118] CA Health & Saf. Code § 1374.16
[119] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 6, Standing Referrals
[120] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management Program
[121] NCQA, 2022 HP Standards and Guidelines, MED 1, Element C
[122] NCQA, 2022 HP Standards and Guidelines, UM 3, Element A, Factors 1 through 5
[123] CA Health & Saf. Code § 1367.01
[124] NCQA, 2022 HP Standards and Guidelines, UM 3, Element A, Factor 1

Communications received after normal business hours will be returned on the next business day.

3. Outbound communication from staff regarding inquiries about UM are made during normal business hours;
4. Staff identify themselves by name, title, and organization when initiating or returning calls regarding UM issues. [125]
5. Staff can receive inbound communication regarding UM issues after normal business hours.
6. There is a toll-free TDD/TTY service for Members who are deaf, hard-of-hearing, or speech-impaired. [126]
7. Language assistance is available for IEHP Members to discuss UM issues. [127]

IEHP will audit to assure that all policies and procedures state that IEHP and its Delegates have these services in place.

H. **Rescinding or Modifying Authorization** - Any authorization provided by a Delegate must not be rescinded or modified after the Provider has already rendered the health care service in good faith pursuant to the authorization.[128]

I. **Record Retention:** Delegates shall retain information on decisions, e.g., authorizations, denials or partial approvals (modifications) for a minimum period of ten (10) years. [129]

J. **Documentation of Medical Information and Review Decisions:** IEHP and its Delegates must base review decisions on documented evidence of medical necessity provided by the attending physician. Regardless of criteria, the Member's condition must always be considered in the review decision. [130]

1. **Physician Documentation:** Attending Physicians must maintain adequate medical record information to assist the decision-making process. The requesting Provider must document the medical necessity for requested services, procedures, or referrals and submit all supporting documentation with the request.
2. **Reviewer Documentation:** Delegate reviewers must abstract and maintain review process information in written format for monitoring purposes. Decisions must be based on clinical information and sound medical judgment with consideration of local standards of care. Documentation must be legible, logical, and follow a case from beginning to

[125] NCQA, 2022 HP Standards and Guidelines, UM 3, Element A, Factor 3
[126] NCQA, 2022 HP Standards and Guidelines, UM 3, Element A, Factor 4
[127] NCQA, 2022 HP Standards and Guidelines, UM 3, Element A, Factor 5
[128] CA Health & Saf. Code § 1371.8
[129] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 2, Prior Authorizations and Review Procedures
[130] NCQA, 2022 HP Standards and Guidelines, UM 1, Element A, Factor 6

end. Rationale for approval, partial approval (modification) or denial must be a documented part of the review process. Documentation must also include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based.

3. **Documentation:** Delegates must have a procedure in place to log requests by date and receipt of information so that timeframes and compliance with those timeframes can be tracked. Delegate documentation of authorizations or referrals must include, at a minimum: Member name and identifiers, description of service or referral required, medical necessity to justify service or referral, place for service to be performed or name of referred physician, and proposed date of service. Delegate documentation must also include a written assessment of medical necessity, relevant clinical information, appropriateness of level of care, and the specific criteria upon which the decision was based. Any denial of a proposed service or referral must be signed by Medical Director or physician designee.
4. **Member Access to Documentation:** Members may request, free of charge, copies of all documents and records the Delegate relied on to make its decision, including any clinical criteria or guidelines used.[131]

K. **Inpatient Stay**: If delegated to perform inpatient utilization management activities, the process must include:

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

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

L. **Discharge Planning:** If delegated to perform inpatient utilization management activities, the process must include coordination of care with IEHP and facilities and the following activities related to discharge planning: [132]

1. Arranging necessary follow-up care (home health, follow-up PCP or specialty visits, etc.); and
2. Facilitating transfer of the discharge summary and/or medical records, as necessary, to the PCP office.

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

M. **Repatriation:** Delegates must assist with the transfer of Members, as medically appropriate, back into the IEHP network during an inpatient stay, as applicable.

[131] 42 CFR § 438.404(b)(2)
[132] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 11, Provision 2, Discharge Planning and Care Coordination

N. **Non-Discrimination:** All Members must receive access to all covered services without restriction based on race, color, ethnicity, ethnic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claim experience, medical history, claims history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, marital status, or source of payment. Please see Policy 9H3, "Cultural and Linguistic Services – Non-Discrimination" for more information.

O. **Confidentiality:** IEHP recognizes that Members' confidentiality and privacy are protected. It is the policy of IEHP and its Delegates to protect the privacy of individual Member health information by permitting UM staff to obtain only the minimum amount of Protected Health Information (PHI) necessary to complete the healthcare function of activity for Member treatment, payment or UM operations.

P. **Affirmative Statement Regarding Incentives:** UM decisions for Members must be based only on appropriateness of care and service and existence of coverage.[133] Delegates do not provide specifically reward Practitioners or other individuals conducting utilization review for issuing denials of coverage or service.[134] Delegates ensure that contracts with physicians do not encourage or contain financial incentives for denial of coverage or service.[135] The Affirmative Statement about incentives is distributed annually to all Practitioners, Providers, and employees involved in authorization review, as well as Members.

Q. **Economic Profiling:** Economic profiling is defined as any evaluation performed by the physician reviewer based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician reviewer. Delegates that engage in economic profiling must document the activities and information sources used in this evaluation and ensure that decisions are rendered, unhindered by fiscal and administrative management.[136]

R. **Prohibition of Penalties for Requesting or Authorizing Appropriate Medical Care**: Physicians cannot be penalized in any manner for requesting or authorizing appropriate medical care.

Grievance and Appeals Process

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

[133] NCQA, 2022 HP Standards and Guidelines, MED 9, Element D, Factor 1
[134] NCQA, 2022 HP Standards and Guidelines, MED 9, Element D, Factor 2
[135] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 1, Provision 1, Utilization Management Program
[136] CA Health & Saf. Code § 1367.02

B. A Member or Provider who is not able to obtain a timely referral to an appropriate Provider can file a complaint with the DMHC:[137]

1. Member complaint line: By phone toll-free at (888)466-2219
   By email at helpline@dmhc.ca.gov
2. Provider complaint line: By phone toll-free at (877)525-1295
   By email at plans-providers@dmhc.ca.gov

Monitoring Activities and Oversight

A. IEHP monitors and oversees delegated UM activities performed by its Delegates. The following oversight activities are performed to ensure compliance with IEHP UM and regulatory standards:

1. **Delegation Oversight Audits (DOA)** – IEHP performs a Delegation Oversight Audit of its Delegates' UM program and objectives, policies, procedures, activities and their progress. This audit re-assesses the Delegates' operational capabilities in the areas of UM and other delegated activities. Please refer to Policy 25A1, "Delegation Oversight Audit" for further details.
2. **Analysis of Provider Data Reports** – Through its delegation oversight process, IEHP reviews health plan and Delegate reports and utilization data including second opinion tracking logs, referral universes and letters, annual and semi-annual work plans. Provider reports and utilization data is subsequently reviewed by the Delegation Oversight Committee (DOC).
3. **Review of Approvals and Denials** – IEHP and its Delegates are required to submit a monthly Referral Universe from which authorizations are selected for review. Please refer to Policy 25E2, "Utilization Management – Reporting Requirements" for more information.
4. **Focused Referral and Denial Audits:** IEHP performs focused audits of the referral and denial process for Delegates. Please refer to Policy 25E3, "Referral and Denial Audits." Audits examine source data at the Delegate to determine referral process timelines and appropriateness of denials and the denial process, including denial letters.
5. **Member or Provider Grievance Review:** IEHP performs review, tracking, and trending of Member or Provider grievances and appeals related to UM. IEHP reviews Delegate grievances and recommended resolutions for policies, procedures, actions, or behaviors that could potentially negatively impact Member health care.
6. **Joint Operations Meetings (JOMs):** JOMs are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities delegated to Delegates. JOMs may address specific Provider Services, UM, QM, CM, grievance, study results, or any other pertinent quality

[137] CA Health & Saf. Code § 1367.01(e)

issues affecting Providers, Hospitals or Delegates. They are held with Delegates and Hospital partners, as applicable. These meetings are designed to address issues from an operational level.

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

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

25. DELEGATION AND OVERSIGHT

E. Utilization Management
1. Delegation and Monitoring

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023

25. DELEGATION AND OVERSIGHT

E. Utilization Management
2. Reporting Requirements

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.[1]

B. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated utilization management activities.[2,3] Oversight activities include but are not limited to the review of these monthly, quarterly, and annual reports.

DEFINITION:

~~A.~~ Delegate – A ~~A~~ medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medi-Cal eligible IEHP Member. ~~Delegate – A medical group, IPA, or any contracted organization delegated to provide utilization management services.~~

A.

PROCEDURES:

A. **Monthly Reporting Requirements:**

1. Monthly reports are due to IEHP by the 15th of the month following the month in which services were approved, denied, ~~or~~ partially approved (modified), or cancelled and include the following:

   a. **Referral Universe** - Using the universe template in Excel file format, the Delegate must report all approved, denied, partially approved (modified), and cancelled referrals during the report period (See Attachment, "Referral Universe" in Section 25).

   b. **Denials and Partial Approvals (Modifications)** – The Delegate must submit all referral and clinical information, as well as copies of all denial letters from the reporting period. Partial approvals (modifications) occur when a decision is made

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, "Subcontractual Relationships and Delegation"
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[3] Title 28 California Code of Regulations (CCR) § 1300.70

and proposed care is denied or altered. The overall denial rate must not exceed 5%, which may include non-benefit, out-of-network, medical necessity denials, etc.

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

- **Not Medically Necessary** – Does not meet approved nationally recognized criteria or IEHP UM Subcommittee Approved Authorization Guidelines. Please see Policy 25E1, "Utilization Management Delegation and Monitoring" for a list of these criteria.
- **Out-of-Network** – Requested provider is a non-contracted Provider. Out-of-Network requests must be reviewed by a physician and must be considered as a medical necessity decision.
- **CCS** – Services requested are carved-out to California Children's Services. Member must have an open, active case and active Service Authorization Request (SAR) for the service requested.
- **Experimental** – Requested service has not been approved by the Food and Drug Administration (FDA) and/or is not an accepted practice in the medical community and/or has not been proven to have a therapeutic benefit.
- **Non-Benefit** – Not a covered benefit.

c. **Approval File Review –** Using the referral universe submitted by the Delegate, IEHP will select ten (10) pre-service/retrospective files to audit. Delegate submissions of Approval Letters need to include the supporting documentation used to make the decisions. Delegates must submit all required documentation related to the file selections by the 15th day of the following month.

d. **Second Opinion Tracking Log –** Using the Second Opinion Tracking Log, the Delegate must report all authorizations, partial approvals (modifications), and denial information for second opinion requests. The Log must include the reason the second opinion was requested (See Attachment, "Second Opinion Tracking Log" in Section 25).

B. **Quarterly Reporting Requirements:**

1. Quarterly report deadlines are outlined in Policy Attachment 25, "IPA Reporting Requirements Schedule - Medi-Cal." Delegates should refer to this document for specific report due dates.~~s are due to IEHP by February 15th, May 15th, and August 15th, and November 15th.~~ The reports should include, at a minimum the Delegates' IEHP ~~m~~Member-~~ ~~specific UM goals and activities, trending of utilization activities for under and over utilization, Member and Practitioner satisfaction activities, interrater reliability activities, and a narrative of barriers and improvement activities. The quarterly reports

~~due in February~~ must also include:

a. **UM Program Annual Evaluation/HICE Report** - The Delegate's evaluation of the overall effectiveness of the UM Program, including whether goals were met, data, performance rates, barrier analysis, and improvement activities; and

b. **UM Workplan Update -** Submit an update of the Annual Workplan which includes planned activities for the year, timelines, responsible person(s) and committee(s). The Work Plan should include measurable goals, planned audits, follow-up activities and interventions related to identified problem areas.

C. **Annual Reporting Requirements:** The following reports must be submitted annually to IEHP February 15th.

1. **UM Program Description:**[4] Reassessment of the UM Program Description must be done on an annual basis by the UM Committee and/or QM Committee and reported to IEHP including the following:

   a. Any changes made to the UM Program Description during the past year or intended changes identified during the annual evaluation; and

   b. UM Program Description Signature Page.

2. **UM Work Plan/Initial HICE Report:** Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include measurable goals, planned audits, follow-up activities and interventions related to identified problem areas.

D. Delegate reports must be received by IEHP electronically using a Secure File Transfer Protocol (SFTP) server.

E. Reports are due on or before the due dates regardless of whether~~if~~ the due date lands on ~~is~~ a weekend or a holiday.

F. Repeated failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), freezing of new Member enrollment, termination, or non-renewal of the IEHP Agreement.

[4] National Committee for Quality Assurance (NCQA), 2022~~21~~ Health Plan Standards and Guidelines, UM 13, Element C, Factor 1

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
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25. DELEGATION AND OVERSIGHT

E. Utilization Management
3. Referral and Denial Audits

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continues to be, in compliance with all applicable State and federal laws, contractual and reporting requirements[1]

B. IEHP oversees, monitors and evaluates performance of delegated and non-delegated utilization management activities.[2,3] Oversight activities include but are not limited to monthly, annual and focused audits.

DEFINITION:

A. Delegate – A ~~– A~~ medical group, health plan, independent physician association, individual or entity contracted with IEHP to provide administrative services or health care services for a Medi-Cal eligible IEHP Member.
~~A. Delegate – A medical group, IPA or any contracted organization delegated to provide utilization management (UM) services.~~

PROCEDURES:

Monthly Retrospective Audit of Denials and Partial Approvals (Modifications)

A. IEHP performs a monthly retrospective audit of up to thirty (30) denied and partially approved (modified) referrals submitted by the Delegate (See Attachment, "Denial Log Review Tool" in Section 25).

B. IEHP may request for more denied and partially approved referral files in addition to those submitted monthly by the Delegate.

C. IEHP evaluates referral timeliness using the Referral Universe received from the IPA and documents the examined referral results.

D. In order to pass the Monthly Retrospective Audit of Denials and Partial Approvals (Modifications), the Delegate must achieve an overall score of 90%.

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004, "Subcontractual Relationships and Delegation"
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities
[3] Title 28 California Code of Regulations (CCR) § 1300.70

1. See the Denial Log Review Tool for a list of Audit Elements (see Attachment, "Denial Log Review Tool" in Section 25).
2. The overall denial rate must not exceed 5%, which may include non-benefit, out-of-network, medical necessity denials, etc.
3. IEHP may require the Delegate to overturn a denial and/or partial approval decision that was not medically appropriate and issue a new Member and Provider notification of the overturned decision.

E. If the Delegate fails to achieve a Compliance score of 90% for two (2) consecutive months, on any of the audit areas above, a Corrective Action Plan (CAP) will be issued. IEHP may issue a CAP in any given month for significant declines in performance. At its discretion, IEHP may also enforce one (1) or more of the following:

1. Concurrent denial/partial approval review for a percentage of total denials/partial approvals (modifications) may be initiated at which time the Delegate may receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
3. A focused meeting with the Delegate's administration and IEHP's leadership;
4. Sanctions may be enforced as outlined in the Delegate's contract with IEHP under Retrospective Denial Audits; and/or
5. Other actions as recommended by IEHP's Delegation Oversight Committee.

F. Repeated non-compliance may result in the termination of the Delegate's contract.

G. Delegates who disagree with the audit score can appeal in writing to the IEHP Senior Medical Director within thirty (30) calendar days after the release of the final audit results.

Monthly Retrospective Audit of Approvals

A. IEHP performs a monthly retrospective audit of ten (10) approved referral files selected by IEHP from the Referral Universe submitted by the Delegate for the reporting month.

B. IEHP may request for more approved referral files in addition to those submitted monthly by the Delegate.

C. IEHP evaluates referral timeliness using the Referral Universe received from the IPA and documents the examined referral results (See Attachment, "Referral Universe" in Section 25).

D. In order to pass the Monthly Retrospective Audit of Approvals, the Delegate must achieve a score of 90% or greater on the Overall Approval File Review (See Attachment, "Approved Referral Audit Tool" in Section 25).

E. If the Delegate fails to achieve a Compliance score of 90% for two (2) consecutive months, a Corrective Action Plan (CAP) will be issued. IEHP may issue a CAP in any given month for significant declines in ~~A~~performance. At its discretion, IEHP may also enforce one (1) or more of the following:

1. Concurrent approval review for a percentage of total approvals may be initiated at which time the Delegate may receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
3. A focused meeting with the Delegate's administration and IEHP's leadership; and
4. Other action as recommended by the Delegation Oversight Committee.

F. Repeated non-compliance may result in the termination of the Delegate's contract.

G. Delegates who disagree with the audit score can appeal in writing to the IEHP Senior Medical Director within thirty (30) calendar days after the release of the final audit results.

Delegation Oversight Audit (DOA)

A. IEHP performs an annual ~~onsite~~ Delegation Oversight Audit DOA of all Delegates to review their UM process. Please see Policy 25A1, "Delegation Oversight – Audit" and the Delegation Oversight Audit Preparation Instructions (See Attachment, "Delegation Oversight Audit Preparation Instructions – Medi-Cal" in Section 25) for more information.

B. UM Process Review Components:

1. IEHP selects, at minimum, fifteen (15) approved/denied/partially approved/cancelled referrals to review. File review will be performed via webinar. The Delegate is responsible for walking IEHP through each referral via the Delegate's medical management system.
2. IEHP ensures that mechanisms are in place to ensure data integrity.
3. One (1) hour before the audit, the Delegate will be provided with the list of referrals to be reviewed with the exception of the cancelled referrals.
4. IEHP will request details of the process used by the Delegate to ensure ongoing compliance with Federal and State regulations, NCQA accreditation standards, and Plan policies.

C. In order to pass the UM Referral and Denial audit sections of the DOA, the Delegate must achieve a score of at least 90% on the file review.

D. Delegates that score below 90% on the approved referral and/or denial and partial approval (modification) sections above are required to submit a CAP addressing all deficiencies noted at the audit within a specified timeframe. Delegates who disagree with the audit results can

appeal through the IEHP Provider appeals process by submitting an appeal in writing to the IEHP Senior Medical Director within thirty (30) calendar days after the release of the final audit results.

E. Delegates that score 90% may still be required to submit a CAP to address any deficiencies.

F. Audit results are included in the overall annual assessment of Delegates.

Focused Audits

A. Focused audits are conducted under the following circumstances:

1. Follow-up audit for deficiencies identified from prior audits including but not limited to the DOA and monthly retrospective audit;
2. Review [LN1][AH2]of approvals, denials, ~~and/or~~ partial approvals (modifications), and/or cancellations demonstrate that decisions are being made inconsistently, do not appear to be medically appropriate, or are not based on nationally recognized clinical criteria.
3. Number of Corrective Action Responses (CARs) issued to Delegate as a result of IEHP routine monitoring;
4. Compliance issues self-reported by the Delegate;
5. Potential risk areas identified by IEHP (i.e., Member and Provider grievances, appeals);
6. Number of months IEHP has placed Delegate on concurrent review for specific delegated UM functions;
7. Significant increase in volume of IEHP assigned Members in the applicable LOB;
8. A specific inquiry initiated by the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), or National Committee for Quality Assurance (NCQA); and/or
9. Any other circumstance that in the judgment of the IEHP Chief Medical Officer or designee requires a focused audit.

B. Prior to the Focused Audit case file review the Delegate must submit the requested universe within the specified timeframe and successfully complete the Universe Integrity Audit.

1. Five (5) samples are randomly selected by the auditor and provided to the Delegate one (1) hour before the start of the audit webinar.
2. Each data element or column of the universe must be validated against the Delegate's medical management system or documentation to ensure the information is consistent and accurate. Inconsistent or inaccurate data must be substantiated; otherwise, the case is considered a fail.
3. The Delegate must successfully pass three (3) of the five (5) cases selected. A failed Universe Integrity Audit will result in the auditor requesting the Delegate's resubmission

of a corrected universe. Three (3) failed universe resubmissions will result in an audit finding.

C. IEHP is responsible for conducting timeliness tests on identified measures via submitted universes, to ensure the Delegate's compliance. Timeliness results falling below thresholds will be considered non-complaint and will be noted as a finding in the audit report.

D. IEHP selects thirty (30) cases which consist of approvals, denials and partial approvals (modifications) for the case file review. The cases are provided to the Delegate one (1) hour before the start of the audit webinar. Sample cases are reviewed against defined compliance standards to determine any areas of non-compliance and/or systemic problems within the Delegate's utilization management process.

E. IEHP will also select five (5) cancelled referrals from the submitted universe to review for appropriateness. The cancelled referrals will not be provided to the Delegate prior to the audit webinar.

F. If IEHP identifies a potential issue during the case file review, additional detail will be required to determine:

1. If the issue is systemic;
2. The root cause of the issue; and
3. How many Members were impacted.

If the issue negatively impacted (the) Member(s), an Impact Analysis is requested immediately following the case file review to provide the Delegate adequate time to research and respond while still providing the auditors time to evaluate and influence the findings report.

G. IEHP determines the significance of audit findings based on results of the case review and impact analysis, if applicable. Audit findings can result in an Immediate Corrective Action Required, Corrective Action Required, an Invalid Data Submission, or Observation as described below:

1. **Immediate Corrective Action Required (ICAR)** – An ICAR is the result of a systemic deficiency identified during an audit that is so severe that it requires immediate correction. These types of issues are limited to situations where the identified deficiency resulted in a lack of access to medications and/or services or posed an immediate threat to the Member's health and safety. ICARs must be immediately addressed or remediated within three (3) business days from receipt of ICAR notification.
2. **Corrective Action Required (CAR)** – A CAR is the result of a systemic deficiency identified during an audit that must be corrected but does not rise to the level of significance of an ICAR. These issues may affect Members but are not of a nature that immediately affects their health and safety. Generally, they involve deficiencies with

respect to non-existent or inadequate policies and procedures, systems, internal controls, training, operations or staffing. CARs must be addressed within thirty (30) calendar days from receipt of CAR notification.

3. **Invalid Data Submission (IDS)** – An IDS condition is cited when the Delegate fails to produce an accurate universe within three (3) attempts.
4. **Observations (OBS)** – Observations are identified conditions of non-compliance that are not systemic or represent a "one-off issue".

H. IEHP will issue the audit findings report which will include the following and any corrective action requests:

1. Executive summary of the audit detailing the audit elements, the audit period, the number of cases reviewed, and the number of cases failed during the Universe Integrity audit (by category);
2. Universe integrity findings by listing noncompliance with instructions for populating each column in the Referral Universe;
3. The results of timeliness testing for each authorization priority level (urgent, routine and retrospective), including the percent of compliance for decision-making, Member notification and Provider notification; and
4. All identified findings (conditions) for each authorization priority level (urgent, routine and retrospective) referencing the specific regulation, accreditation standard or Plan policy found deficient, including specific examples from the case review audit, and the action steps required.

I. IEHP will review and approve ICARs and CARs after IEHP determines that CAPs adequately address all the identified deficiencies.

J. IEHP will perform a CAP validation webinar audit to ensure that all CAPs have been implemented per Delegate's CAP.

K. Once validation is complete and all findings have been resolved, then IEHP will close out the focused audit CAP and notify the Delegate accordingly. Any unresolved findings will require for the CAP to remain open. At its discretion, IEHP may also enforce one (1) or more of the following:

L. Concurrent denial review for a percentage of total denials may be initiated at which time the Delegate will receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;

1. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly Focused audit for two (2) consecutive months;
2. A focused meeting with the Delegate's Administration and IEHP's leadership; and/or

3. Sanctions may be enforced as outlined in the Delegate's contract with IEHP under Retrospective Approval and Denial Audits.

INLAND EMPIRE HEALTH PLAN		
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25. DELEGATION AND OVERSIGHT

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
IPA Reporting Requirements Schedule - Medi-Cal	25B10
Credentialing and Recredentialing Report for Delegated Networks	25B10
Practitioner Profile Template	5A8
Approved Referral Audit Tool	25E1
Precontractual Audit Preparation Instructions – Medi-Cal	
CCS Review Tool	25C1
Credentialing DOA Audit Tool	5A8, 25B8
Credentialing and Recredentialing Report	25B10
IEHP Care Management Referral Form – Medi-Cal	25C2
IPA Biographical Information Sheet	25A2
IPA Care Management Review Tool – Medi-Cal	25C1
Delegated IPA Delegation Agreement – Medi-Cal	25A1
IPA Reporting Requirements Schedule – Medi-Cal	25C1, 25C2, 25D2
Delegated IPA Denial Log Review Tool	25E3
Delegated IPA Performance Evaluation Tool	25A3
Delegation Oversight Audit Preparation Instructions – Medi-Cal	5A8, 25A2, 25E3
Delegation Oversight Audit Preparation Instructions – Medi-Cal (NCQA Certified)	25C3
IEHP Care Management Referral Form	12A1, 12R, 25C1
Monthly Care Management Log	25A2, 25E3 25C1, 25C2
Monthly CCS Referral Log	25C1, 25C2
QI NET ME UM CM DOA Audit Tool	14A2, 14D, 25E1, 25E2, 25E3
Referral Universe	
Request for UM Criteria Log	25E1
Response to Request for UM Criteria	25E1
Second Opinion Tracking Log	14E, 25E2
Subcontracted Facility Services and Delegated Functions	25A2
DOA CAP Response Form (Template)	25D3

Utilization Management
Delegation Oversight Audit Tool
2022 Medi-Cal

Delegation Oversight Annual Audit

IPA:	
Date:	
UM Total Score:	#DIV/0!

NCQA UM 1: Utilization Program Structure					
The organization's UM program has clearly defined structures and processes, and assigns responsibility to appropriate individuals.					
Element A: Written Program Description		**Point Value**			
The organization's UM program description includes the following:		0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	A written description of the program structure.				
2	Involvement of a designated senior-level physician in UM program implementation.				
3	The program scope and process used to determine benefit coverage and medical necessity.				
4	Information sources used to determine benefit coverage and medical necessity.				
5	Allows for a second opinion from a qualified health professional at no cost to the Member.				
6	A established specialty referral system to track and monitor referrals requiring prior authorization. System shall include authorized, denied, deferred, or modified referrals, and the timeliness of the reviews.				
Total Requirements Element A - Written Program Description		0		Score	
Requirement Met		0	0	#DIV/0!	
% of Requirement Met		#DIV/0!			
Element B: Annual Evaluation		**Point Value**			
The organization annually evaluates and updates the UM program, as necessary.		0	1	Include: Document Name, Page and Sections	Comment /Guidance
Total Requirements Element B - Annual Evaluation		0		Score	
Requirement Met		0	0	#DIV/0!	
% of Requirement Met		#DIV/0!			
NCQA UM 2: Clinical Criteria for UM Decisions					
The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria.					
Element A: UM Criteria		**Point Value**			
The organization applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.		0	1	Include: Document Name, Page and Sections	Comment /Guidance
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.				
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.				
Total Requirements Element A - UM Criteria		0		Score	
Requirement Met		0	0	#DIV/0!	
% of Requirement Met		#DIV/0!			
Element B: Availability of Criteria		**Point Value**			
The organization:		0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	States in writing how practitioners can obtain UM criteria.				
2	Makes the criteria available to its practitioners upon request.				
Total Requirements Element B - Availability of Criteria		0		Score	
Requirement Met		0	0	#DIV/0!	
% of Requirement Met		#DIV/0!			
Element C: Consistency in Applying Criteria		**Point Value**			
At least annually, the organization:		0	1	Include: Document Name, Page and Sections	Comment /Guidance
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.				
Total Requirements Element C - Consistency in Applying Criteria		0		Score	
Requirement Met		0	0	#DIV/0!	
% of Requirement Met		#DIV/0!			

Utilization Management
Delegation Oversight Audit Tool
2022 Medi-Cal

NCQA UM 3: Communication Services					
The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.					
Element A: Access to Staff		**Point Value**			
The organization provides the following communication services for members and practitioners:		0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	Staff are available at least eight 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.				
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	Language assistance for members to discuss UM issues.				
	Total Requirements Element A - Access to Staff	0		Score	
	Requirement Met	0	0	#DIV/0!	
	% of Requirement Met	#DIV/0!			
NCQA UM 4: Appropriate Professionals					
Qualified licensed health professionals assess the clinical information used to support UM decisions.					
Element A: Licensed Health Professionals		**Point Value**			
The organization has written procedures:		0	1	Include: Document Name, Page and Sections	Comment /Guidance
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.				
	Total Requirements Element A - Licensed Health Professionals	0		Score	
	Requirement Met	0	0	#DIV/0!	
	% of Requirement Met	#DIV/0!			
Qualified licensed health professionals assess the clinical information used to support UM decisions.					
Element B: Use of Practitioners for UM Decisions		**Point Value**			
The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:		0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	Education, training or professional experience in medical or clinical practice.				
2	A current clinical license to practice or an administrative license to review UM cases.				
	Total Requirements Element A - Use of Practitioners for UM Decisions	0		Score	
	Requirement Met	0	0	#DIV/0!	
	% of Requirement Met	#DIV/0!			
Element C: Practitioner Review of Nonbehavioral Healthcare Denials		**Point Value**			
The organization uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity.		0	1	Include: Document Name, Page and Sections	Comment /Guidance
Total Requirements Element C - Practitioner Review of Nonbehavioral Healthcare Denials		0		Score	
Requirement Met		0	0	#DIV/0!	
% of Requirement Met		#DIV/0!			
Element F: Use of Board-Certified Consultants		**Point Value**			
The organization:		0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	Has written procedures for using board-certified consultants to assist in making medical necessity determinations.				
2	Provides evidence that it uses board-certified consultants for medical necessity determinations.				
	Total Requirements Element F - Use of Board-Certified Consultants	0		Score	
	Requirement Met	0	0	#DIV/0!	
	% of Requirement Met	#DIV/0!			

Utilization Management
Delegation Oversight Audit Tool
2022 Medi-Cal

NCQA UM 5: Timeliness of UM Decisions					
The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation.					
Element A: Notification of Nonbehavioral Decisions		**Point Value**			
The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care.		0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.				
2	For urgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.				
3	For nonurgent preservice decisions, the organization makes the decision within 5 business days of the request and gives electronic or written notification of the decision to practitioners and members within 2 business days from the date of the decision of the request (Health and Safety Code 1367.01(h)(1)(3))				
4	For postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request.				
5	Process to provide notification to Members regarding denied, deferred or modified referrals.				
	Total Requirements Element A - Notification of Nonbehavioral Decisions	0		Score	
	Requirement Met	0	0	#DIV/0!	
	% of Requirement Met	#DIV/0!			
Element D: UM Timeliness Report		**Point Value**			
The organization monitors and submits a report for timeliness of:		0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	Nonbehavioral UM decision making.				
2	Notification of nonbehavioral UM decisions.				
	Total Requirements Element D - UM Timeliness Report	0		Score	
	Requirement Met	0	0	#DIV/0!	
	% of Requirement Met	#DIV/0!			
When determining coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner.					
Element A: Relevant Information for Nonbehavioral Healthcare Decisions					
		Point Value			
There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.		0	1	Include: Document Name, Page and Sections	Comment /Guidance
Total Requirements Element A - Relevant Information for Nonbehavioral Healthcare Decisions		0		Score	
Requirement Met		0	0	#DIV/0!	
% of Requirement Met		#DIV/0!			

Utilization Management
Delegation Oversight Audit Tool
2022 Medi-Cal

NCQA UM 7: Denial Notices					
Element A: Discussing a Denial With a Reviewer	**Point Value**				
The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer.	**0**	**1**	**Include: Document Name, Page and Sections**	**Comment /Guidance**	
Total Requirements Element A - Discussing a Denial With a Reviewer	0		**Score**		
Requirement Met	0	0	#DIV/0!		
% of Requirement Met	#DIV/0!				
Element B: Written Notification of Nonbehavioral Healthcare Denials					
	Point Value				
The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information:	**0**	**1**	**Include: Document Name, Page and Sections**	**Comment /Guidance**	
1 The specific reasons for the denial, in easily understandable language.					
2 A reference to the benefit provision, guidelines, 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, guidelines, protocol or other similar criterion on which the denial decision was based, upon request.					
Total Requirements Element B - Written Notification of Nonbehavioral Healthcare Denials	0		**Score**		
Requirement Met	0	0	#DIV/0!		
% of Requirement Met	#DIV/0!				
Element C: Nonbehavioral Healthcare Notice of Appeal Rights/Process					
	Point Value				
The organization's written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information:	**0**	**1**	**Include: Document Name, Page and Sections**	**Comment /Guidance**	
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.					
3 A description of the expedited appeal process for urgent preservice or urgent concurrent denials.					
4 Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.					
Total Requirements Element C - Nonbehavioral Healthcare Notice of Appeal Rights/Process	0		**Score**		
Requirement Met	0	0	#DIV/0!		
% of Requirement Met	#DIV/0!				
NCQA UM 12: UM System Controls					
The organization has UM system controls to protect data from being altered outside of prescribed protocols.					

Delegation Oversight Audit Tool
Member Experience
2022 NCQA Standards

IPA:	
Date:	
ME Total Score:	0%

NCQA ME 1: Statement of Members' Rights and Responsibilities						
The organization has a written policy that states its commitment to treating members in a manner that respects their rights, and its expectations to members' responsibilities.						
Element B: Distribution of Rights Statement		**Point Value**				
	The organization distributes its member rights and responsibilities statement to the following groups:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1	New members, upon enrollment.	X				
2	Existing members, if requested.	X				
3	New practitioners, when they join the network.	X				
4	Existing practitioners, if requested.	X				
	Total Requirements Element B: Distribution of Rights Statement	4			Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		

NCQA ME 2: Subscriber information						
The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care.						
Element B: Interpreter Services		**Point Value**				
	Based on linguistic need of its subscribers, the organization provides interpreter or bilingual services in its Member Services department and telephone functions.	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
		X				
	Total Requirements Element B: Interpreter Services	1			Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		

NCQA ME 4: Functionality of Claims Processing						
The organization provides members with timely and accurate information about their claims.						
Element A: Functionality - Websites		**Point Value**				
	Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1	The stage in the process.	X				
2	The amount approved.	X				
3	The amount paid.	X				
4	The member's cost.	X				
5	The date paid.	X				
	Total Requirements Element A: Functionality - Websites	5			Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		
Element B: Functionality - Telephone Requests		**Point Value**				
	Members can track the status of their claims in the claims process and obtain the following information over the telephone in one	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1	The stage in the process.	X				
2	The amount approved.	X				
3	The amount paid.	X				
4	The member's cost.	X				
5	The date paid.	X				
	Total Requirements Element B: Functionality - Telephone Requests	5			Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		

NCQA ME 5: Pharmacy Benefit Information						
The organization provides members with the information they need to understand and use their pharmacy benefit.						
Element A: Pharmacy Benefit Information - Website		**Point Value**				
	Members can complete the following actions on the organization's website in one attempt or contact:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1	Determine their financial responsibility for a drug, based on the pharmacy benefit.	X				
2	Initiate the expectations process.	X				
3	Order a refill for an existing, unexpired mail-order prescription.	X				
4	Find a location for an in-network pharmacy.	X				
5	Conduct a pharmacy proximity search based on zip code.	X				
6	Determine the availability of generic substitutes.	X				
	Total Requirements Element A:	6			Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		

Delegation Oversight Audit Tool
Member Experience
2022 NCQA Standards

IPA:	
Date:	
ME Total Score:	0%

NCQA ME 1: Statement of Members' Rights and Responsibilities

The organization has a written policy that states its commitment to treating members in a manner that respects their rights, and its expectations to members' responsibilities.

Element B: Distribution of Rights Statement	Point Value				
The organization distributes its member rights and responsibilities statement to the following groups:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1 New members, upon enrollment.	X				
2 Existing members, if requested.	X				
3 New practitioners, when they join the network.	X				
4 Existing practitioners, if requested.	X				
Total Requirements Element B: Distribution of Rights Statement	4			Score	
Requirement Met	0	0	0	0%	
% of Requirement Met	0%	0%	0%		

NCQA ME 2: Subscriber information

The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care.

Element B: Interpreter Services	Point Value				
Based on linguistic need of its subscribers, the organization provides interpreter or bilingual services in its Member Services department and telephone functions.	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
	X				
Total Requirements Element B: Interpreter Services	1			Score	
Requirement Met	0	0	0	0%	
% of Requirement Met	0%	0%	0%		

NCQA ME 4: Functionality of Claims Processing

The organization provides members with timely and accurate information about their claims.

Element A: Functionality - Websites	Point Value				
Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1 The stage in the process.	X				
2 The amount approved.	X				
3 The amount paid.	X				
4 The member's cost.	X				
5 The date paid.	X				
Total Requirements Element A: Functionality - Websites	5			Score	
Requirement Met	0	0	0	0%	
% of Requirement Met	0%	0%	0%		

Element B: Functionality - Telephone Requests	Point Value				
Members can track the status of their claims in the claims process and obtain the following information over the telephone in one	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1 The stage in the process.	X				
2 The amount approved.	X				
3 The amount paid.	X				
4 The member's cost.	X				
5 The date paid.	X				
Total Requirements Element B: Functionality - Telephone Requests	5			Score	
Requirement Met	0	0	0	0%	
% of Requirement Met	0%	0%	0%		

Delegation Oversight Audit Tool
Quality Management
2022 NCQA Standards

IPA:	
Date:	
QI Total Score:	0%

NCQA QI 1: Program Structure and Operations						
The organization clearly defines its quality improvement (QI) program structure and processes, assigns responsibility to appropriate individuals and operationalizes its QI program.						
Element A: QI Program Structure		**Point Value**				
	The organization's QI program description specifies:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1	The QI program structure.	X				
2	Involvement of a designated physician in the QI program.	X				
3	Oversight of QI functions of the organization by the QI Committee.	X				
	Total Requirements Element A: QI Program Structure		3		Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		
Element B: Annual Work Plan		**Point Value**				
	The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1	Yearly planned QI activities and objectives.	X				
2	Time frame from each activity's completion.	X				
3	Staff members responsible for each activity.	X				
4	Monitoring of previously identified issues.	X				
5	Evaluation of the QI program.	X				
	Total Requirements Element B: Annual Work Plan		5		Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		
Element C: Annual Evaluation		**Point Value**				
	The organization conducts an annual written evaluation of the QI program that includes the following information:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1	A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.	X				
2	Trending of measures of performance in the quality and safety of clinical care and quality of service.	X				
3	Evaluation of the overall effectiveness of the QI program and of its progress toward influencing networkwide safe clinical practices.	X				
	Total Requirements Element C: Annual Evaluation		3		Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		
Element D: QI Committee Responsibilities		**Point Value**				
	The organization's QI Committee:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1	Recommends policy decisions.	X				
2	Analyzes and evaluates the results of QI activities.	X				
3	Ensures practitioner participation in the QI program through planning, design, implementation or review.	X				
4	Identifies needed actions.	X				
5	Ensures follow-up, as appropriate.	X				
	Total Requirements Element D: QI Committee Responsibilities		5		Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		
NCQA NET 4: Continued Access to Care						
The organization monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.						
Element A: Notification of Termination		**Point Value**				
	The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1		X				
	Total Requirements Element A: Notification of Termination		1		Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		
Element B: Continued Access to Practitioners		**Point Value**				
	If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows:	0	0.5	1	Include: Document Name, Page and Sections	Comment /Guidance
1	Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.	X				
2	Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.	X				
	Total Requirements Element B: Continued Access to Practitioners		2		Score	
	Requirement Met	0	0	0	0%	
	% of Requirement Met	0%	0%	0%		

File Review for
IEHP Auditor Use Only

Privacy Incidents

#	Reported Issue Description	Date Delegate was Notified of the Incident	Issue Determination (Substantiated or Unsubstantiated)	Privacy Issues Investigations				Comments
				Evidence Reported to Delegate's Privacy/Compliance Officer.	Evidence of completed Risk Assessment for issue/breach.	Evidence that Notification was sent to IEHP within HIPAA BAA requirements. (Within 15 days after discovery of incident.)		
				Pass = 1, Fail = 0, N/A	Pass = 1, Fail = 0, N/A	Date reported to IEHP	Pass = 1, Fail = 0, N/A	
1	TBD	00/00/0000				00/00/0000		
2	TBD	00/00/0000				00/00/0000		
3	TBD	00/00/0000				00/00/0000		
4	TBD	00/00/0000				00/00/0000		
5	TBD	00/00/0000				00/00/0000		

File Review for
IEHP Auditor Use Only

HIPAA Confidentiality Statement & Privacy Training

Section A. New Hire Confidentiality Statement and Privacy Training									
#	Employee First Name	Employee Last Name	Employee Title	Hire Date	New Hire Confidentiality Statement Upon Hire		New Hire Privacy Training Upon Hire		Comments
					Date Signed	Pass = 1, Fail = 0	Date Signed	Pass = 1, Fail = 0	
1	Jane	Doe	Physician	00/00/0000	00/00/0000		00/00/0000		
2	TBD	TBD	TBD	00/00/0000	00/00/0000		00/00/0000		
3	TBD	TBD	TBD	00/00/0000	00/00/0000		00/00/0000		
4	TBD	TBD	TBD	00/00/0000	00/00/0000		00/00/0000		
5	TBD	TBD	TBD	00/00/0000	00/00/0000		00/00/0000		

Section B. Annual Confidentiality Statement and Privacy Training									
#	Employee First Name	Employee Last Name	Employee Title	Hire Date	Annual Confidentiality Statement		Annual Privacy Training		Comments
					Date Signed	Pass = 1, Fail = 0	Date Signed	Pass = 1, Fail = 0	
1	Jane	Doe	Physician	00/00/0000	00/00/0000		00/00/0000		
2	TBD	TBD	TBD	00/00/0000	00/00/0000		00/00/0000		
3	TBD	TBD	TBD	00/00/0000	00/00/0000		00/00/0000		
4	TBD	TBD	TBD	00/00/0000	00/00/0000		00/00/0000		
5	TBD	TBD	TBD	00/00/0000	00/00/0000		00/00/0000		

Audit Period: MM/DD/CCYY to MM/DD/CCYY

Privacy Incidents Universe

Instructions to Delegate: Create a list of reported suspected privacy incidents impacting IEHP lines of business that were received or closed during the audit period defined above. Include reports such as, but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, investigations outcomes and/or audit & monitoring findings. A sample of 5 incidents will be selected to perform the file review in ***Tab 2. File Review_ PrivacyIncidents*** .

Note: Failure to provide a complete and accurate universe may subject in a "non-compliant" score for the attributes under review in ***Tab 2. File Review_PrivacyIncidents*** .

☐ Check off box if there are no activities to report. By checking this box, you attest that there are no privacy incidents to report during the audit period.

	Brief Description of the Suspected Breach	Date Delegate was Notified of the Incident	Issue Determination	Date Incident was Substantiated or Identified
1				
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HIPAA Privacy DOA Tool 2021
Compliance

HIPAA PRIVACY RULE
(45 CFR Part 160 and Subparts A, D & E of Part 164)

***Instructions*: The Audit Period is MM/DD/CCYY to MM/DD/CCYY.** Review each of the requirements below. Please **ONLY** complete the Supporting Documentation Column, indicate page number and section number for any supporting documentation in the provided Supporting Documentation Column. IEHP will complete the Compliant, Non-Compliant, and Comment/Guidance columns.

A. Confidentiality of Member Information						
The delegate has policies and procedures that:	**Supporting Documentation: Please list the name/title of the document that demonstrates requirement is met**	**Please include page and section numbers where applicable within Supporting Documentation**	**Compliant**	**Non-Compliant**	**N/A**	**Comment/Guidance (IEHP use Only)**
1. Identify the designation of a Privacy Official/Officer who is responsible for the development and implementation of the policies and procedures of the IPA and/or MSO.						
2. Are designed to comply with the standards, implementation specifications, and other requirements of the HIPAA Privacy Rule.						
3. Articulate that only entities and their respective staff members with a legitimate business "need to know" may access, use or disclose Member information. This includes all activities related to treatment, payment and health care operations on behalf of the IPA and/or MSO.						
4. Articulate that processes have been implemented to use or disclose the minimum information necessary to perform staff designated role regardless of the extent of access provided to them.						
5. Articulate policies and processes for uses and disclosures of Member PHI.						
6. Desribe policies and processes to obtain valid authorization when required to disclose confidential information.						
7. That ensures its contracts document that the delegate requires sub-contractors or agents to whom the delegate provides PHI and/or ePHI to agree to the same restrictions and conditions that apply to the delegate.						
8. To verify the identity of persons who request PHI.						

HIPAA Privacy DOA Tool 2021
Compliance

HIPAA PRIVACY RULE
(45 CFR Part 160 and Subparts A, D & E of Part 164)

B. General Security Controls						
The delegate has policies and procedures that:	**Supporting Documentation: Please list the name/title of the document that demonstrates requirement is met**	**Please include page and section numbers where applicable within Supporting Documentation**	**Compliant**	**Non-Compliant**	**N/A**	**Comment/Guidance (IEHP use Only)**
1. Has policies and procedures to ensure that all persons who work with PHI/ePHI sign a confidentiality statement, upon hire or start and annually thereafter; statement to include, at a minimum, general use, security and privacy safeguards, unacceptable use, and enforcement policies.						
File Review: A selection of ten (10) Employees are selected from the Employee Universe to test for the following:						
Evidence confidentiality statements are completed upon hire/start.	Tab: 1. File Review_PrivacyTraining					
Evidence confidentiality statements are completed annually.	Tab: 1. File Review_PrivacyTraining					

C. HIPAA Privacy Training for Staff						
The delegate:	**Supporting Documentation: Please list the name/title of the document that demonstrates requirement is met**	**Please include page and section numbers where applicable within Supporting Documentation**	**Compliant**	**Non-Compliant**	**N/A**	**Comment/Guidance (IEHP use Only)**
1. Has policies and procedures demonstrating that all employees are required to receive HIPAA Privacy training upon hire or start and annually thereafter.						
2. Evidence that Training includes, at a minimum:	***This is verified through a review of the Privacy Training provided.***					
a. Definitions of PHI and PII						
b. Use and Disclosures for PHI						
c. Rights of the Member						
d. How to report privacy concerns/breaches						
e. Best Practices for safeguarding PHI						
File Review: A selection of ten (10) Employees are selected from the Employee Universe to test for the following:						
Evidence HIPAA Privacy Training is conducted upon hire/start.	Tab: 1. File Review_PrivacyTraining					
Evidence HIPAA Privacy Training is conducted upon annually.	Tab: 1. File Review_PrivacyTraining					

HIPAA Privacy DOA Tool 2021
Compliance
HIPAA PRIVACY RULE
(45 CFR Part 160 and Subparts A, D & E of Part 164)

D. Record Retention						
The delegate maintains policy and procedures that:	**Supporting Documentation: Please list the name/title of the document that demonstrates requirement is met**	**Please include page and section numbers where applicable within Supporting Documentation**	**Compliant**	**Non-Compliant**	**N/A**	**Comment/Guidance (IEHP use Only)**
1. Document the record retention policy is no less than ten (10) years for related medical records data.						
2. Implement an individual's right to an accounting of disclosures of PHI.						

E. Paper Document Controls						
The delegate maintains policy and procedures:	**Supporting Documentation: Please list the name/title of the document that demonstrates requirement is met**	**Please include page and section numbers where applicable within Supporting Documentation**	**Compliant**	**Non-Compliant**	**N/A**	**Comment/Guidance (IEHP use Only)**
1. Documenting that PHI in paper form shall not be left unattended at any time unless it is locked up. Applies to work and non-work related settings (i.e., home office, transportation, travel, fax machines, copy machines etc.).						
2. That ensures visitors to areas where PHI is contained shall be escorted and PHI shall be kept out of sight while visitors are in the area, unless they are authorized to review PHI.						
3. That requires PHI to be disposed of through confidential means, such as cross- shredding or pulverizing, in a manner that prevents reconstruction of contents. There must be evidence of PHI destruction in accordance with HIPAA if an external vendor is utilized.						
4. Stating that PHI is not to be removed from the delegate's premises except for routine business purposes.						
5. Any transmission of PHI shall be sent in a secure manner.						

HIPAA Privacy DOA Tool 2021
Compliance

HIPAA PRIVACY RULE
(45 CFR Part 160 and Subparts A, D & E of Part 164)

F. Notification and Investigation of Breach and Security Incident						
The delegate maintains policy and procedures that:	**Supporting Documentation: Please list the name/title of the document that demonstrates requirement is met**	**Please include page and section numbers where applicable within Supporting Documentation**	**Compliant**	**Non-Compliant**	**N/A**	**Comment/Guidance** (IEHP use Only)
1. Indicate reports suspected breaches of PHI or security incidents to the Privacy Officer or delegate.						
2. Articulate the requirement to conduct a risk assessment when investigating a suspected breach without reasonable delay. Risk assessments should include: The nature and extent of the PHI/ePHI involved, including the types of identifiers and the likelihood of re-identification, whether the PHI/ePHI information was disclosed, and the extend to which the risk to the PHI/ePHI has been mitigated.						
3. Detail the mechanisms in place to comply with HIPAA BAA requirements including assurances that the delegate will appropriately safeguard PHI/ePHI, and notify IEHP of any unauthorized use, access or disclosure of unsecured PHI and/or ePHI or any other security incident with respect to PHI and/or ePHI.						
4. Articulate the obligation to notify the affected Member(s) when a PHI breach is suspected to occur.						
5. Articulate that suspected privacy and security incidents are investigated and, if breach criteria is met, reported to regulatory agencies.						
File Review: A selection of five (5) privacy incidents are selected from the Privacy Incidents Universe to test for the following:						
Evidence Incident was Reported to Delegate's Privacy Office/Officer.	Tab: 2. File Review_PrivacyIncidents					
Evidence risk assessment of privacy incidents are conducted, and reported to IEHP if it is determined a breach occurred.	Tab: 2. File Review_PrivacyIncidents					

HIPAA Privacy DOA Tool 2021
Compliance

HIPAA PRIVACY RULE
(45 CFR Part 160 and Subparts A, D & E of Part 164)

G. Actions to Mitigate Breach Risk and Security Incidents						
The delegate maintains policy and procedures that:	**Supporting Documentation: Please list the name/title of the document that demonstrates requirement is met**	**Please include page and section numbers where applicable within Supporting Documentation**	**Compliant**	**Non-Compliant**	**N/A**	**Comment/Guidance (IEHP use Only)**
1. Demonstrate and document that prompt corrective action to mitigate any risks or damages involved with the breach or security incident are taken.						
2. Demonstrate and document that apply appropriate sanctions against members of the workforce who fail to comply with the privacy policies and procedures of the entity or the Privacy Rule.						

Delegation Oversight Audit Summary Page
HIPAA Privacy
2021

Delegate:_____ Review Date:_____
Reviewed by:_____ Score:_____

HIPAA PRIVACY	Points Received	Points Possible	% Compliant
A. Confidentiality of Member Information		8	0%
B. General Security Controls		1	0%
C. HIPAA Training for Staff		6	0%
D. Record Retention		2	0%
E. Paper Document Controls		5	0%
F. Notification and Investigation of Breach and Security Incident		5	0%
G. Actions to Mitigate Breach Risk and Security Incidents		2	0%
SUBTOTAL	0	29	0%

File Review - Training	Points Received	Points Possible	% Compliant
A. New Hire Confidentiality Statement		5	0%
B. New Hire Privacy Training		5	0%
C. Annual Confidentiality Statement		5	0%
D. Annual Privacy Training		5	0%
SUBTOTAL	0	20	0%

File Review - Privacy Incidents	Points Received	Points Possible	% Compliant
A. Evidence of Date Reported to Delegate's Privacy/Compliance Officer		5	0%
B. Evidence of completed Risk Assessment for issue/breach.		5	0%
SUBTOTAL	0	10	0%

TOTAL	0	59	0%

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Listed below are the items required for your Pre-contractual Audit
All Desktop documents are due by the date specified in the Notice of Pre-Contractual Audit Letter.

DESKTOP	ON-SITE	DELEGATION OVERSIGHT
✓		Biographical Information
✓		Sub-Contracted Service by Facility/Agency
✓		**All sections** of the Audit tool documented with **road mapping** instructions for each element (see sample roadmap)
✓		Organizational chart(s)
✓		Current job descriptions as relevant to the audit
✓		Delegation Agreements with any sub-delegated provider
✓		Ownership and Control Documentation

DESKTOP	ON-SITE	QUALITY MANAGEMENT
✓		Quality Improvement Committee meeting minutes from last 12 months to include agenda, sign-in sheet (attendance) and signed confidentiality statement.
✓		- Recommendation of policy decisions
✓		- Review and evaluation of QI activities
✓		- Practitioner participation in the QI program through planning, design, implementation or review
✓		- Identification and follow up of needed actions
✓		Sample Program Plan and Description
✓		Sample Annual WorkPlan
✓		Sample Annual Program Evaluation
✓		Notification of Termination policy and evidence that members were notified of practitioner termination
✓		Continued Access to Practitioners policy and evidence that the delegate followed policy requirements
✓		Sample supportive documentation or materials such as studies, audits, and surveys completed during the reporting period

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DESKTOP	ON-SITE	UTILIZATION MANAGEMENT
✓		Sample Program, Plan and Description
✓		Sample Annual Work Plan
✓		Sample Annual Program Evaluation
✓		Policies and Procedures
✓		Committee meeting minutes from last twelve (12) months for:
✓		- Board of Directors
✓		- Utilization Management Committee
✓		- Subcommittee Meeting Minutes
✓		Annual Inter-rater Reliability Audit
✓		Sample if Semi-Annual Health Plan Reports for the last twelve (12) months;
✓		Two (2) examples that demonstrate the use of Board Certified consultants to assist with determinations
✓		Criteria for Length of Stay and Medical Necessity used during the past two (2) years
✓		Fifteen (15) redacted referral files to include Denials, Modifications, Cancellations and Approvals;
		Utilization Management statistics from the last twelve (12) months;
✓		Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions;
✓	✓	Evidence, other than via a denial letter, that the providers have been notified that they may contact a physician reviewer to discuss denial decisions;
✓		Sample Provider communications from last twelve (12) months
✓		Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO)) and Employees (Registered Nurse (RN), Licensed Vocational Nurse (LVN)) who make UM Decisions
✓		Copies of most recent mailroom policies

DESKTOP	ON-SITE	CARE MANAGEMENT
✓		Program Plan and Description and CM applicable policies and procedures if different from UM;

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DESKTOP	ON-SITE	CARE MANAGEMENT
		Five (5) Redacted CM files with all required attachments
✓		Five (5) Redacted sample cases of Carve Out/ Waiver Programs files **(WebEx)**
✓		California Children's Services (CCS) logs- Redacted: - Five (5) CCS Case Management files
✓		Five (5) sample cases with documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services in accordance with California-specific measure CA1.7 on Care Coordination

DESKTOP	ON-SITE	CREDENTIALING (Look back period of)
✓		Credentialing Policies and Procedures
✓	✓	Sample Credentialing meeting minutes including date and voting attendees from the look back period, which may include, but not limited to, references from:
✓	✓	- Quality Management Committee Minutes
✓	✓	- Credentialing Committee Minutes
✓	✓	- Peer Review Committee Minutes
✓		40 Credentialing files selected for Delegate
✓		40 Recredentialing files selected for Delegate
✓	✓	Evidence of Ongoing Monitoring of Sanctions
✓	✓	Practitioner files of those providers terminated for Quality Issues
✓	✓	Practitioner files that have appealed a decision
✓		~~Sample~~ Delegation Agreements with ~~any~~ sub-delegated ~~provider~~entities
✓	✓	HIV/AIDS Annual Survey

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DESKTOP	ON-SITE	CREDENTIALING (Look back period of)
✓	✓	Policy and File review will include, but not limited to, review for the following items: - Performance Monitoring; - ~~Medicare Opt-Out Review;~~ - Medicare Exclusions/Sanctions; - Medi-Cal Suspended & Ineligibility; - Reporting to Authorities; - Fair Hearing Panel Composition; - Assessment of Organizational Providers; - Delegation Agreements for all Sub-Delegation Arrangements; - Human Immunodeficiency Virus (HIV/AIDS) Identification Process; - Drug Enforcement Administration (DEA) Verifications within one hundred and eighty (180) calendar days; - Work History verification within one hundred and eighty (180) calendar days; and - Hospital Admitting Privileges.

DESKTOP	ON-SITE	CLAIMS
✓		Policies and Procedures
✓		Contracts Boilerplate(s) for:
		• PCP's, Specialists, Ancillary Providers, Hospitals
✓		Blinded Claims Sample:
		• 15 Paid (See Claims Sample Detail Below)
		• 5 Denied (See Claims Sample Detail Below)
		• 5 Provider Payment Disputes (See Claims Sample Detail Below)
✓		Sample Reports and Logs:
		• Paid Claims (See Claims Sample Detail Below)
		• Denied Claims (See Claims Sample Detail Below)
		• Resolved Provider Disputes (See Claims Sample Detail Below)
		• Pended Claims (See Claims Sample Detail Below)

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DESKTOP	ON-SITE	CLAIMS
		• Open Claims/Inventory (See Claims Sample Detail Below)
		• Overpayments (See Claims Sample Detail Below)
		• Check Mailing Attestation Log (See Claims Sample Detail Below)
		• Redirected Claims (See Claims Sample Detail Below)
	✓	Claims Processing Systems Review
	✓	Operational Review

DESKTOP	ON-SITE	COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 1 year 1)
✓		Compliance Policies and procedures
✓		Fraud, Waste and Abuse Policies and procedures
✓		Sanction/Exclusion Screening Process policies and procedures
✓		Standards/Code of Conduct
✓		Copies of Compliance and FWA Training provided during the audit period
✓		Compliance Committee Meeting minutes from the last 12 months to include agenda and sign-in sheet (attendance)
✓		Annual Compliance Work Plan
✓		Annual Audit and Monitoring Plan If one does not exist, please complete Tab A - A&M Activities Universe of the Compliance and FWA Audit Tool.
✓		Annual Risk Assessment Report
✓		Employee Universe: Submit a list of all current employees who have performed job duties related to IEHP's lines of business. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The definition of employees includes full and part time employees as well as temporary employees, interns, or volunteers. Members of the Governing Body/Board of Directors should also be included. Refer to *Employee Universe* Template

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DESKTOP	ON-SITE	COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 1 year 1)
✓		Downstream Entity/Subcontractors Universe: Submit a list of all downstream entities/subcontractors contracted with the IPA and/or MSO anytime during the audit period, including Individual/Entity Name, detailed description of service provided, contract start and end dates, refer to tab B. *Universe_Subcontractors* of the Compliance and FWA Audit tool for required template.
✓		A sample* of (10) ten employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the Employee Universe by the IEHP Auditor for which evidence of the following will be requested: 1. New Hires: a. Pre-hire exclusion check of the Office of Inspector General (OIG), List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA), System for Award Management (SAM), and Medi-Cal Suspended & Ineligible Provider List (S&I) b. Completion of Compliance, FWA, within ninety (90) days of hire or start. c. Standards/Code of Conduct distribution 2. Established Employees: a. Monthly exclusion checks performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of (3) three consecutive months. b. Completion of Annual Compliance and FWA Training
✓		A sample of five (5) audits and/or monitoring activities will be selected from the IPA's Audit and Monitoring Plan or A&M Activities Universe. Evidence of the following will be required: a. Results/Findings Reports b. Activity outcomes were reported to an oversight body, senior leadership, and/or the board of directors and corrective actions were developed and implemented, as applicable.

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DESKTOP	ON-SITE	COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 1 year 1)
✓		A sample of three (3) Downstream Entities/Subcontractors will be selected in tab 4. File Review_FDR Oversight. Evidence of the following will be required: c. Auditing or monitoring oversight activities; d. Activity outcomes were reported to an oversight body, senior leadership, and/or the board of directors; and corrective actions, if applicable.

DESKTOP	ON-SITE	HIPAA PRIVACY PROGRAM
✓		HIPAA Privacy Program policies and procedures
✓		Copies of HIPAA Privacy Training provided during the audit period
✓		Privacy Incident Universe: Submit a list of reported suspected privacy incidents impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period. Refer to tab A. *Universe_Privacy Incidents* of the HIPAA Privacy tool for required template.
✓		A sample* of 10 employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the *Employee Universe* by the IEHP Auditor for which evidence of the following will be requested: 1. New Hires: a. Completion of HIPAA Privacy & Security Training upon hire/start b. Completion of Confidentiality Statement prior to access to PHI 2. Established Employees: a. Completion of HIPAA Privacy & Security Training Annual completion of Confidentiality Statement

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✓		A sample of five (5) privacy incidents will be selected from the *Privacy Incidents Universe*. Evidence of the following will be required: a. Date incident was reported to the Privacy/Compliance Officer; b. Completion of a Risk Assessment for issue/investigation; c. Notification was sent to IEHP with HIPAA BAA Requirements of discovery of a suspected breach; and d. Corrective actions taken, if applicable.

DESKTOP	ON-SITE	IT SECURITY
✓		The name of the medical management system(s) used for the utilization management, care management, and claims functions.

Claims Sample Details

Applicant Entity Name:	
Audit Date:	

PROVIDE FOLLOWING DOCUMENTS FOR CLAIMS REVIEW:	
1	**Paid/Denied (15 paid claims; 5 denied claims; include a mix of contracted and non-contracted outpatient hospital, emergency claims, professional, radiology, labs, anesthesia, other for Medi-Cal and Commercial paid or denied in past 90 days)**
	a. Actual Claim Form and supporting documentation submitted with claim (include a mix of contracted and non-contracted outpatient hospital, emergency claims, professional, radiology, labs, anesthesia, other for Medi-Cal and Commercial)
	b. Provider explanation of benefits or remittance advice for claims and resolved disputes
	c. Copy of check with documentation regarding date the check was cashed
	d. Denial letters

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	e. Acknowledgement of Receipt or Proof of Date Entered in System
	f. Any correspondence and/or pertinent information related to the claim or dispute, including evidence of medical review, eligibility screens, authorizations, information request letters, overpayment/adjustment requests, dispute documentation, original claim information for disputed claims (including claim and EOB/RA), overpayment documentation, applied overpayments (refunds or retractions), etc.
	g. Copy of fee schedule or contract rate applied to each claim or dispute. This can be in the form of a page from a contract or a screen print identifying the type of schedule applied (i.e., Medi-Cal, Medicare, etc.). For non-contracted providers, a copy of the policy identifying basis for payment.
	h. Copies of contracts or letter of agreements for any providers of service wherein provider has agreed to upcoding or downcoding of services rendered; claims submission or payment timeframes that supersede regulatory requirements; or retraction of overpayments, if applicable.
2	**Provider Disputes (5 disputes - both overturns and upholds for contracted and non-contracted providers within past 90 days)**
	a. Dispute Form and supporting documentation submitted with dispute
	b. Original Claim (face sheet with date of receipt visible) and EOB
	c. EOB for Resolved Dispute
	d. Provider Dispute acknowledgement Letter
	e. Provider Dispute Resolution Letter(s)
	f. Other supporting documentation or correspondence pertinent to the outcome of the dispute and related adjustment, as applicable.

Report/ Log Required Fields

Type of Report	Required fields

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Paid Claims	• Member name • Member ID# • Date of Service • Provider of Service • Provider Contract Status • Amount Billed • Date claim received • Claim Number • Amount paid • Date claim paid • Age of claim
Denied Claims	• Member Name • Member ID # • Date of service • Provider of service • Provider Contract Status • Amount billed • Date claim received • Claim Number • Date claim denied • Reason for denial • Age of claim
Pended Claims	• Member name • Member ID# • Date of service • Provider of service • Amount billed • Date claim received • Claim Number • Date claim pended • Pend Reason (must separately identify requests for ER Notes, Medical Records and all other information) • Age of claim • Processor Initials

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Open Claims/Inventory	• Member name • Member ID# • Date of Service • Provider of Service • Amount Billed • Date claim received • Status of claim • received • Status of claim
Overpayments	• Member Name • Member ID# • Original Claim # • Date original claim Paid/Denied • Provider of service • Provider Contract Status • Date of request for overpayment • Date overpayment processed in System • Recovery Type (i.e., withhold, refund, none) • Total Dollars Recovered
Resolved Provider Disputes	• Service Date of Claim being Disputed • Original Claim # • Date Dispute Received • Dispute ID # • Submission Type of Dispute (i.e., paper, electronic) • Date Dispute Acknowledged • Provider Submitting Dispute • Disputing Provider Contract Status • Dispute Decision (i.e., upheld, overturned, goodwill) • Date Dispute Resolved • Working Days to Resolution
Redirected Claims	• Date Received • Billing Provider of Service • Date of Service • Patient Identifier (name, ID#, etc.) • Date Redirected • Where Redirected

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	• Claim # (if applicable)
Check Mailing Attestation Log	• Check # • Check Date • Check Amount • Payee • Signature • Title of Signee • Date Mailed

DATA DICTIONARY

FIELD NAME
NETWORK
INITIAL or RECRED
INITIAL DATE
RECRED DATE
TYPE
LAST NAME
FIRST NAME
M.I.
SUFFIX
DEGREE
NPI
S.S.N.
D.O.B.
GENDER
ETHNICITY
PROVIDER LANGUAGE 1
PROVIDER LANGUAGE 2
PROVIDER LANGUAGE 3

DATA DICTIONARY

FIELD NAME
SPECIALTY 1
SPECIALTY 2
PROVIDER'S AGE RANGE
SUPERVISING PHYSICIAN
SUPERVISING PHYSICIAN SPECIALTY
PRIMARY PRACTICE NAME
PRIMARY ADDRESS
PRIMARY CITY
PRIMARY STATE
PRIMARY ZIP
PRIMARY PHONE
PRIMARY FAX
PRIMARY TAX IDENTIFICATION NUMBER (TIN)
PRIMARY NAME AFFILIATED WITH TIN
PRIMARY OFFICE HOURS MONDAY
PRIMARY OFFICE HOURS TUEDSDAY
PRIMARY OFFICE HOURS WEDNESDAY
PRIMARY OFFICE HOURS THURSDAY
PRIMARY OFFICE HOURS FRIDAY
PRIMARY OFFICE HOURS SATURDAY
PRIMARY OFFICE HOURS SUNDAY

DATA DICTIONARY

FIELD NAME
SECONDARY PRACTICE NAME
SECONDARY ADDRESS
SECONDARY CITY
SECONDARY STATE
SECONDARY ZIP
SECONDARY PHONE
SECONDARY FAX
SECONDARY TAX IDENTIFICATION NUMBER (TIN)
SECONDARY NAME AFFILIATED WITH TIN
SECONDARY OFFICE HOURS MONDAY
SECONDARY OFFICE HOURS TUEDSDAY
SECONDARY OFFICE HOURS WEDNESDAY
SECONDARY OFFICE HOURS THURSDAY
SECONDARY OFFICE HOURS FRIDAY
SECONDARY OFFICE HOURS SATURDAY
SECONDARY OFFICE HOURS SUNDAY
TERTIARY PRACTICE NAME
TERTIARY ADDRESS
TERTIARY CITY
TERTIARY STATE
TERTIARY ZIP
TERTIARY PHONE
TERTIARY FAX
TERTIARY TAX IDENTIFICATION NUMBER (TIN)
TERTIARY NAME AFFILIATED WITH TIN
TERTIARY OFFICE HOURS MONDAY
TERTIARY OFFICE HOURS TUEDSDAY
TERTIARY OFFICE HOURS WEDNESDAY
TERTIARY OFFICE HOURS THURSDAY
TERTIARY OFFICE HOURS FRIDAY
TERTIARY OFFICE HOURS SATURDAY
TERTIARY OFFICE HOURS SUNDAY
FOURTH PRACTICE NAME
FOURTH ADDRESS
FOURTH CITY
FOURTH STATE
FOURTH ZIP
FOURTH PHONE
FOURTH FAX
FOURTH TAX IDENTIFICATION NUMBER (TIN)
FOURTH NAME AFFILIATED WITH TIN

DATA DICTIONARY

FIELD NAME
FOURTH OFFICE HOURS MONDAY
FOURTH OFFICE HOURS TUEDSDAY
FOURTH OFFICE HOURS WEDNESDAY
FOURTH OFFICE HOURS THURSDAY
FOURTH OFFICE HOURS FRIDAY
FOURTH OFFICE HOURS SATURDAY
FOURTH OFFICE HOURS SUNDAY
FIFTH PRACTICE NAME
FIFTH ADDRESS
FIFTH CITY
FIFTH STATE
FIFTH ZIP
FIFTH PHONE
FIFTH FAX
FIFTH TAX IDENTIFICATION NUMBER (TIN)
FIFTH NAME AFFILIATED WITH TIN
FIFTH OFFICE HOURS MONDAY
FIFTH OFFICE HOURS TUEDSDAY
FIFTH OFFICE HOURS WEDNESDAY
FIFTH OFFICE HOURS THURSDAY
FIFTH OFFICE HOURS FRIDAY
FIFTH OFFICE HOURS SATURDAY
FIFTH OFFICE HOURS SUNDAY
SIXTH PRACTICE NAME
SIXTH ADDRESS
SIXTH CITY
SIXTH STATE
SIXTH ZIP
SIXTH PHONE
SIXTH FAX
SIXTH TAX IDENTIFICATION NUMBER (TIN)
SIXTH NAME AFFILIATED WITH TIN
SIXTH OFFICE HOURS MONDAY
SIXTH OFFICE HOURS TUEDSDAY
SIXTH OFFICE HOURS WEDNESDAY
SIXTH OFFICE HOURS THURSDAY
SIXTH OFFICE HOURS FRIDAY
SIXTH OFFICE HOURS SATURDAY
SIXTH OFFICE HOURS SUNDAY
MEDICAL LICENSE#

DATA DICTIONARY

FIELD NAME
MEDICAL LICENSE EXPIRATION DATE
DEA CERTIFICATE #
DEA EXPIRATION DATE
MALPRACTICE INSURANCE CARRIER NAME
MALPRACTICE INSURANCE POLICY#
MALPRACTICE INSURANCE PER CLAIM AMOUNT
MALPRACTICE INSURANCE PER AGGREGATE AMOUNT
MALPRACTICE INSURANCE EXPIRATION DATE
HOSPITAL NAME PRIMARY
HOSPITAL PRIVILEGE TYPE PRIMARY
HOSPITAL SPECIALTY PRIMARY
HOSPITALIST AGE RANGE PRIMARY
HOSPITAL NAME SECONDARY
HOSPITAL PRIVILEGE TYPE SECONDARY
HOSPITAL SPECIALTY SECONDARY
HOSPITALIST AGE RANGE SECONDARY
HOSPITAL NAME TERTIARY
HOSPITAL PRIVILEGE TYPE TERTIARY

DATA DICTIONARY

FIELD NAME
HOSPITAL SPECIALTY TERTIARY
HOSPITALIST AGE RANGE TERTIARY
NAME OF BOARD 1
BOARD SPECIALTY 1
BOARD STATUS 1
BOARD CERTIFICATION EFFECTIVE 1
BOARD CERTIFIATION EXPIRATION 1
BOARD VERIFICATION DATE (if applicable) 1
NAME OF BOARD 2
BOARD SPECIALTY 2
BOARD STATUS 2
BOARD CERTIFICATION EFFECTIVE 2
BOARD CERTIFIATION EXPIRATION 2
BOARD VERIFICATION DATE (if applicable) 2
NAME OF BOARD 3
BOARD SPECIALTY 3
BOARD STATUS 3
BOARD CERTIFICATION EFFECTIVE 3
BOARD CERTIFIATION EXPIRATION 3
BOARD VERIFICATION DATE (if applicable) 3
MEDICAL SCHOOL
GRADUATION DATE
INTERNSHIP INSTITUTION
INTERNSHIP SPECIALTY
INTERNSHIP START DATE
INTERNSHIP END DATE
RESIDENCY INSTITUTION 1
RESIDENCY SPECIALTY 1
RESIDENCY START DATE 1

DATA DICTIONARY

FIELD NAME
RESIDENCY END DATE 1
RESIDENCY INSTITUTION 2
RESIDENCY SPECIALTY 2
RESIDENCY START DATE 2
RESIDENCY END DATE 2
FELLOWSHIP INSTITUTION 1
FELLOWSHIP SPECIALTY 1
FELLOWSHIP START DATE 1
FELLOWSHIP END DATE 1
FELLOWSHIP INSTITUTION 2
FELLOWSHIP SPECIALTY 2
FELLOWSHIP START DATE 2
FELLOWSHIP END DATE 2

DATA DICTIONARY

IEHP NOTES
Name of Delegated Network
Identify whether packet is Initial or Recredentialing
Provider's Credentialing Approval Date
Provider's Recredentialing Approval Date
Identify whether the practitioner is a Specialist, PCP or Both
Last Name as Listed on License
First Name as Listed on License
First Letter of Middle Name as Listed on License
Suffix (i.e. Jr., Sr., III…) as listed on License
Degree M.D. (Medical Doctor) D.O.(Doctor of Osteopathic Medicine) D.P.M. (Podiatry) L.M.F.T. (Licensed Marriage Family Therapist) L.C.S.W. (Licensed Clinical Social Worker) Ph.D., Psy.D. (Doctor of Psychology) D.C. (Doctors of Chiropractic) L.Ac. (Acupuncture) D.D.S. (Doctor of Dental Surgery) D.M.D. (Doctor of Medicine in Dentistry) O.T. (Occupational Therapy) O.D. (Optometry Doctor) P.T. (Physical Therapist) P.A. (Physician Assistant) C.N.M. (Certified Nurse Midwife) N.P. (Nurse Practitioner) S.P. (Speech Pathology) Au. (Audiology) H.A. (Hearing Aids Dispenser)
Please provide the Providers Individual NPI
Social Security Number
Date of Birth
Please identify whether the provide is Male or Female
Provider's cultural background (Optional)
Foreign Language Spoken (Fluently by Physician)
Foreign Language Spoken (Fluently by Physician)
Foreign Language Spoken (Fluently by Physician)

DATA DICTIONARY

IEHP NOTES
Provider's primary specialty IEHP does not accept the following provider are not delegated to the IPA, therefore do not submit: L.M.F.T. (Licensed Marriage Family Therapist) L.C.S.W. (Licensed Clinical Social Worker) Ph.D., Psy.D. (Doctor of Psychology) L.Ac. (Acupuncture) O.D. (Optometry Doctor)
Provider's Secondary specialty IEHP does not accept the following provider are not delegated to the IPA, therefore do not submit: L.M.F.T. (Licensed Marriage Family Therapist) L.C.S.W. (Licensed Clinical Social Worker) Ph.D., Psy.D. (Doctor of Psychology) L.Ac. (Acupuncture) O.D. (Optometry Doctor)
Please provide any age limitations for the provider
Applicable to Mid Level Practitioners only (Physician Assistants & Nurse Practitioners) Please provide the name of the Supervising Physician
Applicable to Mid Level Practitioners only (Physician Assistants & Nurse Practitioners) Please provide Supervising Physician's Specialty
Primary office location that will be marketed under IEHP W-9's and Contracts (1st and signature page, any addendums to ensure that the provider is affiliated with that contract) are required for all offices marketed with IEHP.
Office Hours for the primary location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)

DATA DICTIONARY

IEHP NOTES
Secondary office location that will be marketed under IEHP
Office Hours for the Secondary location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)
Tertiary office location that will be marketed under IEHP
Office Hours for the Tertiary location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)
FOURTH office location that will be marketed under IEHP W-9's and Contracts (1st and signature page, any addendums to ensure that the provider is affiliated with that contract) are required for all offices marketed with IEHP.

DATA DICTIONARY

IEHP NOTES
Office Hours for the FOURTH location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)
FIFTH office location that will be marketed under IEHP
Office Hours for the FIFTH location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)
SIXTH office location that will be marketed under IEHP
Office Hours for the SIXTH location (i.e. 9 am-5pm or 9am-12 pm 2pm-5pm, or Closed)
Medical License # as listed on License

DATA DICTIONARY

IEHP NOTES
Date Medical License expires (must be current at all times)
DEA Certificate Number as listed on certificate
Date DEA Certificate expires (must be current at all times)
Malpractice Insurance Carrier Information as listed on Certificate (must be current at all times and applicable to all locations where IEHP patients will be treated)
Name of IEHP affiliated Hospital, where the provider has admitting privileges *If the provider is using a Hospitalist, list the name of the IEHP Affiliated Hospital the admitter will be using to admit patients
List the privilege type the provider has at the IEHP affiliated Hospital (provider must have admitting privileges i.e. Provisional, Active, Courtesy) *If the provider is using a Hospitalist, List Hospital Admitter and provide the name of the Hospital Admitter (as it's listed on his/her license)
List the Specialty privileges the provider has at the IEHP affiliated Hospital (Provider must have privileges for the specialty he/she is listed as under IEHP) *If the provider is using a Hospitalist, List the Hospitalists' specialty
* If the provider is using a Hospitalist, list the age range for the Hospitalist who will be admitting patients
Name of IEHP affiliated Hospital, where the provider has admitting privileges *If the provider is using a Hospitalist, list the name of the IEHP Affiliated Hospital the admitter will be using to admit patients
List the privilege type the provider has at the IEHP affiliated Hospital (provider must have admitting privileges i.e. Provisional, Active, Courtesy) *If the provider is using a Hospitalist, List Hospital Admitter and provide the name of the Hospital Admitter (as it's listed on his/her license)
List the Specialty privileges the provider has at the IEHP affiliated Hospital (Provider must have privileges for the specialty he/she is listed as under IEHP) *If the provider is using a Hospitalist, List the Hospitalists' specialty
* If the provider is using a Hospitalist, list the age range for the Hospitalist who will be admitting patients
Name of IEHP affiliated Hospital, where the provider has admitting privileges *If the provider is using a Hospitalist, list the name of the IEHP Affiliated Hospital the admitter will be using to admit patients
List the privilege type the provider has at the IEHP affiliated Hospital (provider must have admitting privileges i.e. Provisional, Active, Courtesy) *If the provider is using a Hospitalist, List Hospital Admitter and provide the name of the Hospital Admitter (as it's listed on his/her license)

DATA DICTIONARY

IEHP NOTES
List the Specialty privileges the provider has at the IEHP affiliated Hospital (Provider must have privileges for the specialty he/she is listed as under IEHP) *If the provider is using a Hospitalist, List the Hospitalists' specialty
* If the provider is using a Hospitalist, list the age range for the Hospitalist who will be admitting patients
Name of the Board who issued the certification (i.e. American Board of Internal Medicine)
Specialty in which the provider holds the certification (i.e. Gastroenterology, Critical Care Medicine, Internal Medicine)
Status of the Board Certification (i.e. Active, Expired)
Board Certification Effective Date
Board Certification Expiration Date (Lifetime Certification, please list lifetime or leave blank)
Board Verification Date (if applicable)
Name of the Board who issued the certification (i.e. American Board of Internal Medicine)
Specialty in which the provider holds the certification (i.e. Gastroenterology, Critical Care Medicine, Internal Medicine)
Status of the Board Certification (i.e. Active, Expired)
Board Certification Effective Date
Board Certification Expiration Date (Lifetime Certification, please list lifetime or leave blank)
Board Verification Date (if applicable)
Name of the Board who issued the certification (i.e. American Board of Internal Medicine)
Specialty in which the provider holds the certification (i.e. Gastroenterology, Critical Care Medicine, Internal Medicine)
Status of the Board Certification (i.e. Active, Expired)
Board Certification Effective Date
Board Certification Expiration Date (Lifetime Certification, please list lifetime or leave blank)
Board Verification Date (if applicable)
Name of Medical School
Date practitioner completed medical school
Name of Internship Institution
Type of Internship
Start Date of Internship
End Date of Internship
Name of residency Institution
Type of Training
Start Date of residency

DATA DICTIONARY

IEHP NOTES
End Date of residency
Name of residency Institution
Type of Training
Start Date of residency
End Date of residency
Name of Fellowship Institution
Type of Training
Start Date of Fellowship
End Date of Fellowship
Name of Fellowship Institution
Type of Training
Start Date of Fellowship
End Date of Fellowship

DATA DICTIONARY

ADDITIONAL DOCUMENTS NEEDED

DATA DICTIONARY

ADDITIONAL DOCUMENTS NEEDED
Delegation of Services Agreement, Supervising Physician Form, Standardized Procedures, as applicable
W-9
Contract

DATA DICTIONARY

ADDITIONAL DOCUMENTS NEEDED
W-9
Contract
W-9
Contract
W-9
Contract

DATA DICTIONARY

ADDITIONAL DOCUMENTS NEEDED
W-9
Contract
W-9
Contract

DATA DICTIONARY

ADDITIONAL DOCUMENTS NEEDED
Hospital Admitter Agreement
Hospital Admitter Agreement
Hospital Admitter Agreement

DATA DICTIONARY

ADDITIONAL DOCUMENTS NEEDED

DATA DICTIONARY

ADDITIONAL DOCUMENTS NEEDED

NETWORK	INITIAL or RECRED	INITIAL DATE	RECRED DATE	TYPE

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	NPI	S.S.N.

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

D.O.B.	GENDER	ETHNICITY	LANGUAGE 1	LANGUAGE 2	LANGUAGE 3

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SPECIALTY 1	SPECIALTY 2	PROVIDER'S AGE RANGE

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SUPERVISING PHYSICIAN	SUPERVISING PHYSICIAN SPECIALTY	PRIMARY PRACTICE NAME

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

PRIMARY ADDRESS	PRIMARY CITY	PRIMARY STATE	PRIMARY ZIP	PRIMARY PHONE

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

PRIMARY FAX	PRIMARY TIN	PRIMARY NAME AFFILIATED WITH TIN	PRIMARY OFFICE HOURS MONDAY	PRIMARY OFFICE HOURS TUESDAY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

PRIMARY OFFICE HOURS WEDNESDAY	PRIMARY OFFICE HOURS THURSDAY	PRIMARY OFFICE HOURS FRIDAY	PRIMARY OFFICE HOURS SATURDAY	PRIMARY OFFICE HOURS SUNDAY	PRIMARY STAFF LANGUAGE 1	PRIMARY STAFF LANGUAGE 2	PRIMARY STAFF LANGUAGE 3

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SECONDARY PRACTICE NAME	SECONDARY ADDRESS	SECONDARY CITY	SECONDARY STATE	SECONDARY ZIP

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SECONDARY PHONE	SECONDARY FAX	SECONDARY TIN	SECONDARY NAME AFFILIATED WITH TIN

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SECONDARY OFFICE HOURS MONDAY	SECONDARY OFFICE HOURS TUESDAY	SECONDARY OFFICE HOURS WEDNESDAY	SECONDARY OFFICE HOURS THURSDAY	SECONDARY OFFICE HOURS FRIDAY	SECONDARY OFFICE HOURS SATURDAY	SECONDARY OFFICE HOURS SUNDAY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SECONDARY STAFF LANGUAGE 1	SECONDARY STAFF LANGUAGE 2	SECONDARY STAFF LANGUAGE 3	TERTIARY PRACTICE NAME	TERTIARY ADDRESS

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

TERTIARY CITY	TERTIARY STATE	TERTIARY ZIP	TERTIARY PHONE	TERTIARY FAX	TERTIARY TIN

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

TERTIARY NAME AFFILIATED WITH TIN	TERTIARY OFFICE HOURS MONDAY	TERTIARY OFFICE HOURS TUESDAY	TERTIARY OFFICE HOURS WEDNESDAY	TERTIARY OFFICE HOURS THURSDAY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

TERTIARY OFFICE HOURS FRIDAY	TERTIARY OFFICE HOURS SATURDAY	TERTIARY OFFICE HOURS SUNDAY	TERTIARY STAFF LANGUAGE 1	TERTIARY STAFF LANGUAGE 2	TERTIARY STAFF LANGUAGE 3	FOURTH PRACTICE NAME

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FOURTH ADDRESS	FOURTH CITY	FOURTH STATE	FOURTH ZIP	FOURTH PHONE

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FOURTH FAX	FOURTH TIN	FOURTH NAME AFFILIATED WITH TIN	FOURTH OFFICE HOURS MONDAY	FOURTH OFFICE HOURS TUESDAY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FOURTH OFFICE HOURS WEDNESDAY	FOURTH OFFICE HOURS THURSDAY	FOURTH OFFICE HOURS FRIDAY	FOURTH OFFICE HOURS SATURDAY	FOURTH OFFICE HOURS SUNDAY	FOURTH STAFF LANGUAGE 1	FOURTH STAFF LANGUAGE 2	FOURTH STAFF LANGUAGE 3

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FIFTH PRACTICE NAME	FIFTH ADDRESS	FIFTH CITY	FIFTH STATE	FIFTH ZIP

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FIFTH PHONE	FIFTH FAX	FIFTH TIN	FIFTH NAME AFFILIATED WITH TIN

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FIFTH OFFICE HOURS MONDAY	FIFTH OFFICE HOURS TUESDAY	FIFTH OFFICE HOURS WEDNESDAY	FIFTH OFFICE HOURS THURSDAY	FIFTH OFFICE HOURS FRIDAY	FIFTH OFFICE HOURS SATURDAY	FIFTH OFFICE HOURS SUNDAY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FIFTH STAFF LANGUAGE 1	FIFTH STAFF LANGUAGE 2	FIFTH STAFF LANGUAGE 3	SIXTH PRACTICE NAME	SIXTH ADDRESS

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SIXTH CITY	SIXTH STATE	SIXTH ZIP	SIXTH PHONE	SIXTH FAX	SIXTH TIN

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SIXTH NAME AFFILIATED WITH TIN	SIXTH OFFICE HOURS MONDAY	SIXTH OFFICE HOURS TUESDAY	SIXTH OFFICE HOURS WEDNESDAY	SIXTH OFFICE HOURS THURSDAY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SIXTH OFFICE HOURS FRIDAY	SIXTH OFFICE HOURS SATURDAY	SIXTH OFFICE HOURS SUNDAY	SIXTH STAFF LANGUAGE 1	SIXTH STAFF LANGUAGE 2	SIXTH STAFF LANGUAGE 3	MEDICAL LICENSE #

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

MEDICAL LICENSE EXPIRATION DATE	DEA #	DEA EXPIRATION DATE	MALPRACTICE INSURANCE CARRIER NAME	MALPRACTICE INSURANCE POLICY #

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

MALPRACTICE INSURANCE PER CLAIM AMOUNT	MALPRACTICE INSURANCE PER AGGREGATE AMOUNT	MALPRACTICE INSURANE EXPIRATION DATE	HOSPITAL NAME PRIMARY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITAL STATUS PRIMARY	HOSPITAL SPECIALTY PRIMARY	HOSPITALIST AGE RANGE PRIMARY	HOSPITAL NAME SECONDARY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITAL STATUS SECONDARY	HOSPITAL SPECIALTY SECONDARY	HOSPITALIST AGE RANGE SECONDARY	HOSPITAL NAME TERTIARY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITAL STATUS TERTIARY	HOSPITAL SPECIALTY TERTIARY	HOSPITALIST AGE RANGE TERTIARY	HOSPITAL NAME FOURTH

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITAL STATUS FOURTH	HOSPITAL SPECIALTY FOURTH	HOSPITALIST AGE RANGE FOURTH	HOSPITAL NAME FIFTH

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITAL STATUS FIFTH	HOSPITAL SPECIALTY FIFTH	HOSPITALIST AGE RANGE FIFTH	HOSPITAL NAME SIXTH

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITAL STATUS SIXTH	HOSPITAL SPECIALTY SIXTH	HOSPITALIST AGE RANGE SIXTH	NAME OF BOARD 1

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

BOARD SPECIALTY 1	BOARD STATUS 1	BOARD CERTIFICATION EFFECTIVE 1	BOARD CERTIFICATION EXPIRATION 1	BOARD VERIFICATION DATE (if applicable) 1	NAME OF BOARD 2	BOARD SPECIALTY 2	BOARD STATUS 2	BOARD CERTIFICATION EFFECTIVE 2

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

BOARD CERTIFICATION EXPIRATION 2	BOARD VERIFICATION DATE (if applicable) 2	NAME OF BOARD 3	BOARD SPECIALTY 3	BOARD STATUS 3	BOARD CERTIFICATION EFFECTIVE 3	BOARD CERTIFICATION EXPIRATION 3	BOARD VERIFICATION DATE (if applicable) 3

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

NETWORK	INITIAL or RECRED	INITIAL DATE	RECRED DATE	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	NPI	S.S.N.

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

D.O.B.	GENDER	ETHNICITY	LANGUAGE 1	LANGUAGE 2	LANGUAGE 3	SPECIALTY 1	SPECIALTY 2	PROVIDER'S AGE RANGE

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SUPERVISING PHYSICIAN	SUPERVISING PHYSICIAN SPECIALTY	PRIMARY PRACTICE NAME	PRIMARY ADDRESS	PRIMARY CITY	PRIMARY STATE	PRIMARY ZIP

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

PRIMARY PHONE	PRIMARY FAX	PRIMARY TIN	PRIMARY NAME AFFILIATED WITH TIN	PRIMARY OFFICE HOURS MONDAY	PRIMARY OFFICE HOURS TUESDAY	PRIMARY OFFICE HOURS WEDNESDAY	PRIMARY OFFICE HOURS THURSDAY	PRIMARY OFFICE HOURS FRIDAY	PRIMARY OFFICE HOURS SATURDAY	PRIMARY OFFICE HOURS SUNDAY	PRIMARY STAFF LANGUAGE 1

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

PRIMARY STAFF LANGUAGE 2	PRIMARY STAFF LANGUAGE 3	SECONDARY PRACTICE NAME	SECONDARY ADDRESS	SECONDARY CITY	SECONDARY STATE	SECONDARY ZIP	SECONDARY PHONE	SECONDARY FAX	SECONDARY TIN

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SECONDARY NAME AFFILIATED WITH TIN	SECONDARY OFFICE HOURS MONDAY	SECONDARY OFFICE HOURS TUESDAY	SECONDARY OFFICE HOURS WEDNESDAY	SECONDARY OFFICE HOURS THURSDAY	SECONDARY OFFICE HOURS FRIDAY	SECONDARY OFFICE HOURS SATURDAY	SECONDARY OFFICE HOURS SUNDAY	SECONDARY STAFF LANGUAGE 1	SECONDARY STAFF LANGUAGE 2	SECONDARY STAFF LANGUAGE 3

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

TERTIARY PRACTICE NAME	TERTIARY ADDRESS	TERTIARY CITY	TERTIARY STATE	TERTIARY ZIP	TERTIARY PHONE	TERTIARY FAX	TERTIARY TIN	TERTIARY NAME AFFILIATED WITH TIN

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

TERTIARY OFFICE HOURS MONDAY	TERTIARY OFFICE HOURS TUESDAY	TERTIARY OFFICE HOURS WEDNESDAY	TERTIARY OFFICE HOURS THURSDAY	TERTIARY OFFICE HOURS FRIDAY	TERTIARY OFFICE HOURS SATURDAY	TERTIARY OFFICE HOURS SUNDAY	TERTIARY STAFF LANGUAGE 1	TERTIARY STAFF LANGUAGE 2	TERTIARY STAFF LANGUAGE 3	FOURTH PRACTICE NAME

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FOURTH ADDRESS	FOURTH CITY	FOURTH STATE	FOURTH ZIP	FOURTH PHONE	FOURTH FAX	FOURTH TIN	FOURTH NAME AFFILIATED WITH TIN	FOURTH OFFICE HOURS MONDAY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FOURTH OFFICE HOURS TUESDAY	FOURTH OFFICE HOURS WEDNESDAY	FOURTH OFFICE HOURS THURSDAY	FOURTH OFFICE HOURS FRIDAY	FOURTH OFFICE HOURS SATURDAY	FOURTH OFFICE HOURS SUNDAY	FOURTH STAFF LANGUAGE 1	FOURTH STAFF LANGUAGE 2	FOURTH STAFF LANGUAGE 3	FIFTH PRACTICE NAME	FIFTH ADDRESS	FIFTH CITY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FIFTH STATE	FIFTH ZIP	FIFTH PHONE	FIFTH FAX	FIFTH TIN	FIFTH NAME AFFILIATED WITH TIN	FIFTH OFFICE HOURS MONDAY	FIFTH OFFICE HOURS TUESDAY	FIFTH OFFICE HOURS WEDNESDAY	FIFTH OFFICE HOURS THURSDAY	FIFTH OFFICE HOURS FRIDAY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

FIFTH OFFICE HOURS SATURDAY	FIFTH OFFICE HOURS SUNDAY	FIFTH STAFF LANGUAGE 1	FIFTH STAFF LANGUAGE 2	FIFTH STAFF LANGUAGE 3	SIXTH PRACTICE NAME	SIXTH ADDRESS	SIXTH CITY	SIXTH STATE	SIXTH ZIP	SIXTH PHONE

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SIXTH FAX	SIXTH TIN	SIXTH NAME AFFILIATED WITH TIN	SIXTH OFFICE HOURS MONDAY	SIXTH OFFICE HOURS TUESDAY	SIXTH OFFICE HOURS WEDNESDAY	SIXTH OFFICE HOURS THURSDAY	SIXTH OFFICE HOURS FRIDAY	SIXTH OFFICE HOURS SATURDAY	SIXTH OFFICE HOURS SUNDAY	SIXTH STAFF LANGUAGE 1	SIXTH STAFF LANGUAGE 2

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

SIXTH STAFF LANGUAGE 3	MEDICAL LICENSE #	MEDICAL LICENSE EXPIRATION DATE	DEA #	DEA EXPIRATION DATE	MALPRACTICE INSURANCE CARRIER NAME	MALPRACTICE INSURANCE POLICY #	MALPRACTICE INSURANCE PER CLAIM AMOUNT	MALPRACTICE INSURANCE PER AGGREGATE AMOUNT	MALPRACTICE INSURANE EXPIRATION DATE

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITAL NAME PRIMARY	HOSPITAL STATUS PRIMARY	HOSPITAL SPECIALTY PRIMARY	HOSPITALIST AGE RANGE PRIMARY	HOSPITAL NAME SECONDARY	HOSPITAL STATUS SECONDARY	HOSPITAL SPECIALTY SECONDARY

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITALIST AGE RANGE SECONDARY	HOSPITAL NAME TERTIARY	HOSPITAL STATUS TERTIARY	HOSPITAL SPECIALTY TERTIARY	HOSPITALIST AGE RANGE TERTIARY	HOSPITAL NAME FOURTH	HOSPITAL STATUS FOURTH

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITAL SPECIALTY FOURTH	HOSPITALIST AGE RANGE FOURTH	HOSPITAL NAME FIFTH	HOSPITAL STATUS FIFTH	HOSPITAL SPECIALTY FIFTH	HOSPITALIST AGE RANGE FIFTH	HOSPITAL NAME SIXTH

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

HOSPITAL STATUS SIXTH	HOSPITAL SPECIALTY SIXTH	HOSPITALIST AGE RANGE SIXTH	NAME OF BOARD 1	BOARD SPECIALTY 1	BOARD STATUS 1	BOARD CERTIFICATION EFFECTIVE 1	BOARD CERTIFICATION EXPIRATION 1	BOARD VERIFICATION DATE (if applicable) 1	NAME OF BOARD 2	BOARD SPECIALTY 2	BOARD STATUS 2

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

BOARD CERTIFICATION EFFECTIVE 2	BOARD CERTIFICATION EXPIRATION 2	BOARD VERIFICATION DATE (if applicable) 2	NAME OF BOARD 3	BOARD SPECIALTY 3	BOARD STATUS 3	BOARD CERTIFICATION EFFECTIVE 3	BOARD CERTIFICATION EXPIRATION 3	BOARD VERIFICATION DATE (if applicable) 3	MEDICAL SCHOOL	GRADUATION DATE	INTERNSHIP INSTITUTION	INTERNSHIP SPECIALTY	INTERNSHIP START DATE	INTERNSHIP END DATE	RESIDENCY INSTITUTION 1	RESIDENCY SPECIALTY 1

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

RESIDENCY START DATE 1	RESIDENCY END DATE 1	RESIDENCY INSTITUTION 2	RESIDENCY SPECIALTY 2	RESIDENCY START DATE 2	RESIDENCY END DATE 2	FELLOWSHIP INSTITUTION 1	FELLOWSHIP SPECIALTY 1	FELLOWSHIP START DATE 1	FELLOWSHIP END DATE 1	FELLOWSHIP INSTITUTION 2	FELLOWSHIP SPECIALTY 2	FELLOWSHIP START DATE 2	FELLOWSHIP END DATE 2

By submitting this spreadsheet, I acknowledge that the IPA is still required to provide a copy of Contracts (1st and signature page) any addendums, W-9, Admitter agreements and CME's (as applicable)

INLAND EMPIRE HEALTH PLAN

MONTHLY CCS REPORT LOG

Newly Referred CCS Cases Log

Delegate Name: IPA NAME

Date Submitted:

Report for Month of:

Submitted By:

Member First Name	Member Last Name	IEHP Member ID #	DOB	*County	Date Identified	Date of Referral by IPA	CCS Eligible Diagnosis

INLAND EMPIRE HEALTH PLAN

Monthly California Children's Services Referral Log 2.0
Instructions & Data Dictionary

Instructions: Submit a monthly report of all newly identified California Children Services (CCS) cases referred to the County in the reporting month. Refer to the data dictionary for specifics on what each field should contain. Always submit the most current template in Excel (.xlsx) format.

Column ID	Field Name	Field Type	Field Length	Description
A	**Member First Name**	CHAR Always Required	50	First name of the Member
B	**Member Last Name**	CHAR Always Required	50	Last name of the Member
C	**IEHP Member ID #**	14 digit numeric characters	14	Cardholder identifier used to identify the beneficiary. This is assigned by IEHP and is 14 digits long.
D	**DOB**	MM/DD/YYYY	10	Member's Date of Birth
E	**County**	CHAR Always Required	50	County Member was referred to for CCS services- Riverside or San Bernardino only.
F	**Date Identified**	MM/DD/YYYY	10	Date CCS-eligible condition was identified.
G	**Date of CCS Referral**	MM/DD/YYYY	10	Date of CCS referral to County for eliglibity determination.
H	**CCS Eligible Diagnosis**	CHAR Always Required	50	ICD-10 code of CCS Eligible medical condition diagnosis used for referral.

Monthly Medi-Cal

Instructions an

Instructions:

Froxpq#LG	Ilhog#Qdph	Ilhog#W|sh
D	Phpehu#Iluvw#Qdph#	FKDU#Dozd|v#Uhtxluhg
E	Phpehu#Odvw#Qdph#	FKDU#Dozd|v#Uhtxluhg
F	LHKS#Phpehu#LG#&	47#gljlw#qxphulf#fkdudfwhuv
G	GRE	PP2GG2\\\\######
H	Uhihuudo#Vrxufh	FKDU#Dozd|v#Uhtxluhg
I	Uhihuudo#Uhdvrq	FKDU#Dozd|v#Uhtxluhg
J	Fdvh#Vwdwxv#+Rshq#ru#Forvhg,	FKDU#Dozd|v#Uhtxluhg
K	Fdvh#Ohyho#+Jhqhudo#ru#Frpsoh{,	FKDU#Dozd|v#Uhtxluhg
L	Fdvh#Rshq#Gdwh#+ru#Uhi#wr#zdlyhu/#FFV,#frpp vhuylfhv#ru	PP2GG2\\\\######
M	Lqglylgxdol}hg#Fduh#Sodq#Grfxphqwhg	FKDU#Dozd|v#Uhtxluhg
N	Gldjqrvlv#+LFG#Frghv2#Ghvfulswlrq,	FKDU#Dozd|v#Uhtxluhg
O	Sureohpv2#Lvvxhv#Lghqwlilhg	FKDU#Dozd|v#Uhtxluhg
P	Jrdov#Lghqwlilhg	FKDU#Dozd|v#Uhtxluhg
Q	Lqwhuyhqwlrqv#Grfxphqwhg#+h{1#prqwko|#iroorz fduh	FKDU#Dozd|v#Uhtxluhg
R	Fduh#Sodq#Vhqw#wr#SFS#Grfxphqwhg	FKDU#Dozd|v#Uhtxluhg
S	Fdvh#Qrwhv	FKDU#Dozd|v#Uhtxluhg
T	Frppxqlfdwlrq#z2#Phpehu#Grfxphqwhg	FKDU#Dozd|v#Uhtxluhg
U	Fdvh#Forvxuh#Gdwh	PP2GG2\\\\######
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Care Management Log

d Data Dictionary

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83	0
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Phpehu*v#Gdwh#ri#Eluwk
Vrxufh#ri#uhihuudo#iru#Phpehu#wr#eh#lq#fduh#pdqdjhphqw#surjudp
Uhdvrq#iru#uhihuudo#Phpehu#ehlqj#hquroohg#lqwr# surjud
Dw#wlph#ri#uhsruwlqj#prqwk#lv#Phpehu*v#fduh#pdqd vwdwxv#Rshq#ru#F
Dw#wlph#ri#uhsruwlqj#prqwk#lv#Phpehu*v#fduh#pdqdj Jhqhudo#ru#Frp:
Gdwh#ri#zkhq#fduh#pdqdjhphqw#fdvh#zdv#rshqhg
Lv#wkhuh#grfxphqwdwlrq#ri#dq#lqglylgxdol}hg#fduh#sodqB
Phpehu*v#gldjqrvlv#frgh+v,#ru#ghvfulswlrq
Lv#wkhuh#grfxphqwdwlrq#ri#Phpehuv#lghqwlilhg#sureohpv#dqg#lvvxhvB#
Duh#Phpehu*v#jrdov#lghqwlilhg#zlwklq#wkh#lqglylgxdol}hg#fduh#sodqB#
Lv#grfxphqwdwlrq#vkrzq#zlwklq#lqglylgxdol lqwhuyhqwl
Lv#grfxphqwdwlrq#vkrzq#wkdw#Phpehu*v#fduh#sodq# Phpehu*v#SFS
Lv#wkhuh#grfxphqwdwlrq#ri#fdvh#qrwhv#zlwkl lqglylgxdol}hg#fdu
Lv#grfxphqwdwlrq#vkrzq#ri#vxffhvvixo#frqwdfw#zlwk#PhpehuB
Li#Fdvh#Vwdwxv#+froxpq#J,#lv#*Forvhg*#zdv#lv pdqdjhphqw#fdvh#zdv#for
Li#Fdvh#Vwdwxv#+froxpq#J,#lv#*Forvhg*#zkdw#z forvxuh#ru#wkh#fdvh#r:

Delegated IPA Medi-Cal SPD Review Tool

Medi-Cal

IPA:			
Reviewer:			
Service Year:	2021	Service Month:	
Review Year:	2021	Review Month:	

Overall Score:	*No Applicable Files Reviewed*

	File Review: #1	Comments:	File Review: #2	Comments:	File Review: #3	Comments:	File Review: #4	Comments:	File Review: #5	Comments:
Date of Review										
Member Last Name										
Member First Name										
IEHP Member ID										
Current Stratification										
Post HRA Stratification										
HRA was reviewed with Member to stratify and determine the appropriate level of care.										
Documentation of at least three (3) contact attempts made to Member within thirty (30) calendar days of HRA completion prior to determining Member is unable to be reached.										
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, and any other needs) are initiated and referrals were sent to resolve any physical or cognitive barriers to timely access.										
Referrals were coordinated for identified community resource needs (housing, meals, energy assistance, intellectual and developmental disability services).										
Referrals were coordinated for identified behavioral health needs.										
Referrals were coordinated for Members identified for potential Complex Case Management Program enrollment.										
Referrals were coordinated for identified health education needs including Advanced Directive.										
Post-discharge care coordination was initiated prior to 30 calendar days from hospital discharge date.										
An Interdisciplinary Care Team (ICT) was offered to the high-risk Member when a need is demonstrated and in accordance with the Member's functional status, assessed need, and the ICP.										
ICT meetings are conducted periodically, including at the Member's request, and includes conference calls that are conducted with the providers, and the Member, as appropriate										
Member's ICT is comprised of all other individuals and providers who are actively involved in Member's care.										
An Individualized Care Plan (ICP) was developed for the newly enrolled high-risk SPD Member and re-evaluation of the ICP was conducted at least annually or upon a significant change in condition.										
Initial ICP was developed within 30 calendar days from HRA completion/CM referral creation date.										
The ICP was developed collaboratively with the PCP, the Member/caregiver, care manager and other members of the ICT as appropriate.										
The ICP includes plan for addressing Member concerns, preferences, and goals, including responsible person and due date for follow up.										
The ICP includes measurable objectives and timetables to meet physical health and LTSS needs as determined through the assessment process, IHSS assessment results, MSSP and CBAS records, and input from members of the ICT, as appropriate										
The ICP includes Member's prioritized goals according to the Member's preference.										
The ICP includes identification of barriers to meeting goals.										
The ICP includes coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies, when appropriate.										

The Member was offered and provided, upon request, a copy (in alternative formats and/or preferred written or spoken language upon request) of the ICP and any amendments made to ICP.									
Individual Score	*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*		*Case not Applicable*
File Summary									

IEHP Care Management Delegation Oversight: SPD File Review - Data Dictionary

Element	Regulatory Criteria / Citations / Policy	Benchmark	Scope	Look-back Period	Data Source	Methodology	Frequency	Sample Size
Identification and Risk Stratification								
HRA was reviewed with Member to stratify and determine the appropriate level of care.	DHCS APL 17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors with Disabilities MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	SPD Members with a completed HRA during lookback period	From enrollment or reassessment due date	Care Management Documentation	Review of CM case notes to assess that the Health Risk Assessment (HRA) is reviewed to identify SPD Members with a higher risk and more complex health needs.	Monthly	5
Documentation of at least three (3) contact attempts made to Member within thirty (30) calendar days of HRA completion prior to determining Member is unable to be reached.	MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	SPD Members with a completed HRA during lookback period	From enrollment or reassessment due date	Care Management Documentation	Review of CM case notes that at a minimum three (3) contact attempts were made reach the Member within thirty (30) calendar days of HRA completion before determining the Member is unable to be reached. Attempts may be telephonic, by mail, by email etc. All contact attempts of the same type on the same day are considered one (1) attempt. All contact attempts must be documented clearly.	Monthly	5
Care Coordination and Care Management Services								
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, and any other needs) are initiated and referrals were sent to resolve any physical or cognitive barriers to timely access.	DHCS Contract - Attachment 11 Case Management and Coordination of Care DHCS APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Support DHCS APL 17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors with Disabilities MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	SPD Members with identified medical care needs		Care Management Medical Management System	Review of CM case notes/ICP to ensure care coordination was facilitated to meet the identified medical care needs (includes primary care, specialty care, DME, medications, and any other needs) and referral was sent to resolve any physical or cognitive barriers to timely access.	Monthly	5
Referrals were coordinated for identified community resource needs (housing, meals, energy assistance, intellectual and developmental disability services).		≥ 90%	SPD Members with identified community resource needs		Care Management Medical Management System	Review of CM case notes/ICP to ensure that referrals for community resources have been initiated when the need is identified.	Monthly	5
Referrals were coordinated for identified behavioral health needs.		≥ 90%	SPD Members with identified behavioral health needs		Care Management Medical Management System	Review of CM case notes/ICP to ensure that referrals for appropriate behavioral health needs have been initiated, including referrals to the appropriate behavioral health care management (BHCM) team as appropriate, when the need is identified.	Monthly	5
Referrals were coordinated for Members identified for potential Complex Case Management Program enrollment.		≥ 90%	Medi-Cal Members with identified potential CCM needs		Care Management Medical Management System	Review of CM case notes/ICP to ensure that Members identified for potential Complex Case Management Program enrollment are referred to IEHP.	Monthly	5
Referrals were coordinated for identified health education needs including Advanced Directive.		≥ 90%	Members with identified health education needs		Care Management Medical Management System	Review of CM case notes/ICP to ensure that referrals to health education services have been initiated when the need is identified.	Monthly	5
Post-discharge care coordination was initiated prior to 30 calendar days from hospital discharge date.	DHCS Contract - Attachment 11 Case Management and Coordination of Care NCQA Standard QI 5, Continuity and Coordination of Medical Care: HEDIS® Plan All-Cause Readmission measure	≥ 90%	SPD Members with an admission to the hospital or institution	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICP to ensure that necessary care, services and supports are in place for an SPD member upon discharge from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the Member and/or caregiver.	Monthly	5

Interdisciplinary Care Team								
An Interdisciplinary Care Team (ICT) was offered to the high-risk Member when a need is demonstrated and in accordance with the Member's functional status, assessed need, and the ICP.	DHCS Contract - Attachment 11 Case Management and Coordination of Care DHCS APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Support IEHP Provider Policy and Procedure Manual - MC_25C2	≥ 90%	High-Risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICT section/ICP to ensure that an ICT has been offered.	Monthly	5
ICT meetings are conducted periodically, including at the Member's request, and includes conference calls that are conducted with the providers, and the Member, as appropriate		≥ 90%	High-Risk SPD Members		Care Management Medical Management System	Review of CM case notes/ICT section/ICP to ensure that an ICT meeting was conducted/offered including any conference calls with providers and the Member as appropriate.	Monthly	5
Member's ICT is comprised of all other individuals and providers who are actively involved in Member's care.		≥ 90%	High-Risk SPD Members		Care Management Medical Management System	Review of CM case notes/ICT section/ICP to ensure that the Member's ICT includes individuals or providers who are actively involved in the care of the Member, if approved by the Member and the individuals or providers are willing to participate in the ICT, when appropriate: hospital discharge planner; nurse, social worker, nursing facility representative, specialized providers, such as physician specialists, pharmacists, physical therapists, and occupational therapists; IHSS provider (if authorized by Member receiving IHSS), CBAS provider (if Member is participating in CBAS), MSSP coordinator (if Member is enrolled in MSSP waiver program), and other professionals, as appropriate.	Monthly	5
Individualized Care Plan								
An Individualized Care Plan (ICP) was developed for the newly enrolled high-risk SPD Member and re-evaluation of the ICP was conducted at least annually or upon a significant change in condition.	DHCS Contract - Attachment 11 Case Management and Coordination of Care DHCS APL 17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors with Disabilities IEHP Provider Policy and Procedure Manual- MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICP to ensure ICP was developed for newly enrolled high-risk SPD Members. The ICP must also be re-evaluated at least annually or upon a significant change in condition.	Monthly	5
Initial ICP was developed within 30 calendar days from HRA completion/CM referral creation date.	IEHP Provider Policy and Procedure Manual- MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	Newly enrolled high-risk SPD Members with HRA with initial ICP development due on/after 5/1/20	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICP to ensure that the initial ICP was developed within a timeframe that is appropriate to address the issues identified in the HRA or other presenting information, but at least within 30 days of the completion of the HRA or referral for care management.	Monthly	5
The ICP was developed collaboratively with the PCP, the Member/caregiver, care manager and other members of the ICT as appropriate.	DHCS Contract - Attachment 11 Case Management and Coordination of Care IEHP Provider Policy and Procedure Manual- MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of CM case notes/ICP to ensure that the ICP is developed with the Member/caregiver and Member's ICT .	Monthly	5
The ICP includes plan for addressing Member concerns, preferences, and goals, including responsible person and due date for follow up.	DHCS Contract - Attachment 11 Case Management and Coordination of Care DHCS APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Support IEHP Provider Policy and Procedure Manual- MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP plan to ensure it addresses Member's concerns, preferences, Member specific goals (not system generated) and includes responsible person and due date for follow up.	Monthly	5
The ICP includes measurable objectives and timetables to meet physical health and LTSS needs as determined through the assessment process, IHSS assessment results, MSSP and CBAS records, and input from members of the ICT, as appropriate	DHCS APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Support IEHP Provider Policy and Procedure Manual- MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP objectives to ensure they are measurable and include timetables to meet Member's needs.	Monthly	5
The ICP includes Member's prioritized goals according to the Member's preference.	DHCS APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Support IEHP Provider Policy and Procedure Manual- MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP goals to ensure they are prioritized according to Member's preference.	Monthly	5
The ICP includes identification of barriers to meeting goals.	IEHP Provider Policy and Procedure Manual- MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP to ensure barriers were identified.	Monthly	5
The ICP includes coordination of carved-out and linked services, and referrals to appropriate community resources and other agencies, when appropriate.	DHCS APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Support IEHP Provider Policy and Procedure Manual- MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members needing coordination of carved out or linked services and/or referrals to appropriate community resources and other agencies	From enrollment or reassessment due date	Care Management Medical Management System	Review of ICP to ensure coordination of carved out or linked services and/or referrals to appropriate community resources and other agencies were addressed when appropriate.	Monthly	5
The Member was offered and provided, upon request, a copy (in alternative formats and/or preferred written or spoken language upon request) of the ICP and any amendments made to ICP.	DHCS APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Support IEHP Provider Policy and Procedure Manual- MC_25C2: Care Management Requirements IPA Responsibilities	≥ 90%	High-risk SPD Members	From enrollment or reassessment due date	Care Management Medical Management System	Review of clinical documentation to show that the Member was offered a copy of the initial/updated ICP and was made available in Member's preferred format.	Monthly	5

Delegated IPA Medi-Cal Care Coordination Review Tool

Medi-Cal

IPA:			
Reviewer:			
Service Year:	2021	Service Month:	
Review Year:	2020	Review Month:	

Overall Score:

	File Review: #1	Comments:	File Review: #2	Comments:	File Review: #3	Comments:	File Review: #4	Comments:	File Review: #5
Member First Name									
IEHP Member ID									
Current Stratification									
Care Coordination Identification Source									
Care coordination for identified medical care needs (includes primary care, specialty care, DME, medications, and any other needs) are initiated and referrals were sent to resolve any physical or cognitive barriers to timely access.									
Referrals were coordinated for identified community resource needs (housing, meals, energy assistance, intellectual and developmental disability services).									
Referrals were coordinated for identified behavioral health needs.									
Referrals were coordinated for Members identified for potential Complex Case Management Program enrollment.									
Referrals were coordinated for identified health education needs including Advanced Directive.									
Individual Score									

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight-Monthly Referral Universe	Monthly	1/1-1/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Referral_Tracking_Log_MM_2023	IPA Oversight / Year/ Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
IPA Oversight-Monthly Second Opinion Log	Monthly	1/1-1/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Second Opinion Log_MM_2023	IPA Oversight / Year/ Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
IPA Oversight-Monthly Denial Files	Monthly	1/1-1/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Den Files_MM_2023	IPA Oversight / Year/ Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Care Management Log	Monthly	1/1-1/31	February 15, 2023	MC 25C3- Care Management Requirements - Reporting Requirements	CM	IPACode_CM_Log_MM_2023	IPA Oversight / Year/Month	Guidelines for Care Management
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
California Children Services (CCS) Log	Monthly	1/1-1/31	February 15, 2023	MC 25C3- Care Management Requirements - Reporting Requirements	CM	IPACode_CCS_Log_MM_2023	IPA Oversight / Year/Month	Guidelines for Care Management
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight- Monthly Approval File Review	Monthly	1/1-1/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Approval File Review_MM_2023	IPA Oversight / Year/ Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Encounter Data	Monthly	See Encounter Data Schedule	See Encounter Data Schedule'	MC 21A - Encounter Data Submission Requirements IEHP Provider EDI Manual- IV-4	EDI	See IEHP Provider EDI Manual for File Naming Conventions	837 Version 5010 / Encounters	Encounter Data Submission Requirement

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Claims Timeliness Reports- MCL	Monthly	1/1-1/31	February 15, 2023	MC 20G - Claims and Provider Dispute Resolution Reporting	Financial Compliance	IPAName_MCL_MTR_MM_2023	Claims Timeliness/Year/Month	28 CCR 1300.71 Section (e)(3)
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Claims & PDR Detail Reports	Monthly	7/1-7/31	February 15, 2023	MC 20G - Claims and Provider Dispute Resolution Reporting	Financial Compliance	IPAName_MCL_Claims & PDR Detail_MM_2023	Claims Timeliness/Year/Month	FDR Oversight
			March 15, 2023					
			April 15, 2023					
			May 15, 2023					
			June 15, 2023					
			July 15, 2023					
			August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					

Inland Empire Health Plan

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Other Healthcare Coverage Post Payment Recovery Report	Monthly	13 month or older	5th of every month	MC 20F - Claims Processing Coordination of Benefits	Financial Compliance	MCPPR.[Assigned Code]_[YYYY_MM]_[FileNumber].xlsx	/OHC/Post Payment Recovery	APL 21-002
Discovery of Other Healthcare Coverage	As needed	1/31-12/31	Within (2) days of discovery	MC_14A3 - Other Health Care Coverage	UM	MCOHC.(IPA Code)_YYYY_MM_FileNumber.xslx	/OHC/Discovery of OHC	APL 21-002
Other Healthcare Coverage Overpayment Recovery Report	Monthly	Up to 12 months	5th of every month	MC 20F - Claims Processing Coordination of Benefits	Financial Compliance	MCPPR.[Assigned Code]_[YYYY_MM]_[FileNumber]_13M.xlsx	/OHC/Post Payment Recovery	APL 21-002
Quarterly Provider Payment Dispute Resolution	Quarterly	1/1-3/31	April 30, 2023	MC 20G - Claims and Provider Dispute Resolution Reporting	Financial Compliance	IPAName_Quarterly PDR_LOB_Q1_2023	Claims Timeliness	28 CCR 1300.71 Section (e)(3)
		4/1-6/30	July 31, 2023			IPAName_Quarterly PDR_LOB_Q2_2023		
		7/1-9/30	October 31, 2023			IPAName_Quarterly PDR_LOB_Q3_2023		
		10/1-12/31	January 31, 2024			IPAName_Quarterly PDR_LOB_Q4_2023		
Quarterly Statement of Deficiencies Report	Quarterly	1/1-3/31	April 30, 2023	MC 20G - Claims and Provider Dispute Resolution Reporting	Financial Compliance	IPAName_Month of Report_LOB_Q1_2023	Claims Timeliness	28 CCR 1300.71 Section (q)(1)
		4/1-6/30	July 31, 2023			IPAName_Month of Report_LOB_Q2_2023		
		7/1-9/30	October 31, 2023			IPAName_Month of Report_LOB_Q3_2023		
		10/1-12/31	January 31, 2024			IPAName_Month of Report_LOB_Q4_2023		
Balance Sheet, Income Statement, Cash flow Statement, Supporting Worksheets for IBNR	Quarterly	1/1-3/31	May 15, 2023	MC 19A - Financial Viability	Financial Compliance	IPAName_Quarterly IBNR_LOB_Q1_2023	Financial Statements	California Code of Regulations: 1300.75.4.2
		4/1-6/30	August 15, 2023			IPAName_Quarterly IBNR_LOB_Q2_2023		
		7/1-9/30	November 15, 2023			IPAName_Quarterly IBNR_LOB_Q3_2023		
		10/1-12/31	February 15, 2024			IPAName_Quarterly IBNR_LOB_Q4_2023		
Organizational Informational Disclosures	Quarterly	1/1-3/31	May 15, 2023	MC 19A - Financial Viability	Financial Compliance	IPAName_Quarterly Financial Info Disc_LOB_Q1_2023	Financial Statements	California Code of Regulations: 1300.75.4.2
		4/1-6/30	August 15, 2023			IPAName_Quarterly Financial Info Disc_LOB_Q2_2023		
		7/1-9/30	November 15, 2023			IPAName_Quarterly Financial Info Disc_LOB_Q3_2023		
		10/1-12/31	February 15, 2024			IPAName_Quarterly Financial Info Disc_LOB_Q4_2023		
		1/1-3/31	May 15, 2023			IPACode_UM Program Evaluation_HICE_Q1_2023		

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight-Quarterly UM Program Evaluation / HICE Report	Quarterly	4/1-6/30	August 15, 2023	MC 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_UM Program Evaluation_HICE_Q2_2023	IPA Oversight / Year/ Quarterly	FDR Oversight
		7/1-9/30	November 15, 2023			IPACode_UM Program Evaluation_HICE_Q3_2023		
		10/1-12/31	February 15, 2024			IPACode_UM Program Evaluation_HICE_Q4_2023		
IPA Oversight-Quarterly UM Workplan Update /Evaluation / HICE Report	Quarterly	1/1-3/31	May 15, 2023	MC 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_UM Program Evaluation_HICE_Q1_2023	IPA Oversight / Year/ Quarterly	FDR Oversight
		4/1-6/30	August 15, 2023			IPACode_UM Program Evaluation_HICE_Q2_2023		
		7/1-9/30	November 15, 2023			IPACode_UM Program Evaluation_HICE_Q3_2023		
		10/1-12/31	February 15, 2024			IPACode_UM Program Evaluation_HICE_Q4_2023		
IPA Oversight-Annual UM Program Description	Annual	1/1-12/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_UM Program Description_2023	IPA Oversight / Year / Annual	FDR Oversight
IPA Oversight-Annual UM Work plan / Initial / HICE Report	Annual	1/1-12/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Initial UM Workplan_HICE Report_2023	IPA Oversight / Year / Annual	FDR Oversight
IPA Oversight-Annual UM Program Evaluation	Annual	1/1-12/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_UM Program Evaluation_2023	IPA Oversight / Year / Annual	FDR Oversight
IPA Oversight-Semi-Annual UM Denial System Controls 2023 Policies and Procedures and Role Based Access Report	Semi-Annual	7/1/2022- 6/30/2023	As required for Annual DOA	MC 25D - Quality Management Reporting Requirements	QM	IPACode_UM System Controls_2023	IPA Oversight / Year / Semi-Annual	FDR Oversight
IPA Oversight- Semi-Annual UM Denial System Controls 2022 Policies and Procedures and Role Based Access Report	Semi-Annual	1/1/2022- 12/31/2022	February 15, 2023	MC 25D - Quality Management Reporting Requirements	QM	IPACode_UM System Controls_2022	IPA Oversight / Year / Semi-Annual	FDR Oversight
IPA Oversight- Semi-Annual Credentialing (CR) System Controls 2023 Policies and Procedures and Role Based Access Report	Semi-Annual	7/1/2022- 6/30/2023	As required for Annual DOA	MC 25D - Quality Management Reporting Requirements	QM	IPACode_CR System Controls_2023	IPA Oversight / Year / Semi-Annual	FDR Oversight

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight- Semi-Annual Credentialing (CR) System Controls 2022 Policies and Procedures and Role Based Access Report Report	Semi-Annual	1/1/2022- 12/31/2022	February 15, 2023	MC 25D - Quality Management Reporting Requirements	QM	IPACode_CR System Controls_2022	IPA Oversight / Year / Semi-Annual	FDR Oversight
Annual QM GQP4P Workplan	Annual	1/1-12/31	As designated by P4P Program	MC 25D - Quality Management Reporting Requirements	QM	As designated by P4P Program	IPA Oversight / Year / Annual	P4P Program
Compliance- Compliance Program Description	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	MMCM Chapter 21
Compliance- FWA Program Description	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24D FWA Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, Part 422 and 423; Code of Federal Regulations, Title 42, §438.608 and §455.2; Federal False Claims Act, US Code, Title 31; Health & Safety Code §1348; Welfare & Institutions Code, §14043.1; CMS 2007 MA-PDP Contract H5640, Attachment A
Compliance- HIPAA Privacy Policies and Procedures	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 23B HIPAA Privacy and Security	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 45, Part 160, 162, and 164; U.S. Dept. of Health and Human Services (DHHS), section 13402(h)(2) of Public Law 111-5 (HITECH ACT).
Compliance - Standards/Code of Conduct	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(1)(i)
Compliance - Copies of Compliance, FWA, and Privacy Trainings	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description MC 24D FWA Program Description MC 23B HIPAA Privacy and Security	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(iv)
Compliance - Compliance Committee or Subcommittee Minutes & Sign Ins	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(iii)
Compliance - Annual Compliance Workplan	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42 §§422.503(b)(4)(vi)(F) & 423.504(b)(4)(vi)(F)
Compliance - Annual Audit Plan	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(vi)
Compliance - Annual Risk Assessment	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(vi)

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Compliance - Sanction/Exclsion Screening Process policies and procedures	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §10011901).
Compliance - List of Downstream Entity/ Subcontractors	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description MC 24D FWA Program Description	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Confidentiality Statement policies and procedures	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 23B HIPAA Privacy and Security	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Employee Universe List	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	
Compliance - List of Privacy Incidents	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 23B HIPAA Privacy and Security	Compliance	N/A	IPA Oversight / Compliance	
Compliance - List of FWA cases	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24D FWA Program Description	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Data Integrity Controls and Access Safeguards policies and procedures	Annual	1/1-12/31	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Medical management systems used for UM, CM, and Claims functions	Annual	1/1-12/31	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - System administration/IT rep for user access to medical management systems used for UM, CM, and Claims functions	Annual	1/1-12/31	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Walkthrough of medical management systems: data interity controls and access safeguards validation	Annual	1/1-12/31	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - User Types Universe	Annual	1/1-12/32	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Active Users Universe	Annual	1/1-12/33	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Annual Claims Payment and Dispute Resolution Mechanism Report	Annual	10/01/2022 – 09/30/2023	11/30/2023	MC_20G Claims and Provider Dispute Reporting	Financial Analysis	IPACode_Annual Claims PDR Resolution_2023	Claims Timeliness	28 CCR 1300.71 Section (q)(2) and (q)(A).
Annual Audited Financial Statements, Including IBNR Certification Financial Statements, Including IBNR Certification	Annual	Fiscal Year	5 Months after end of your IPA's Fiscal Year	MC 19A - Financial Viability	Financial Analysis	IPACode_Annual Financial Statement_2023	Financial Statements	California Code of Regulations: 1300.75.4.2
Credentialing and Recredentialing Report	Quarterly	1/1-3/31	May 15, 2023	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPACode - YYYY-Q1 - Credentialing and Recredentialing Activities Report	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines.
		4/1-6/30	August 15, 2023			IPACode - YYYY-Q2 - Credentialing and Recredentialing Activities Report		
		7/1-9/30	November 15, 2023			IPACode - YYYY-Q3 - Credentialing and Recredentialing Activities Report		

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
		10/1-12/31	February 15, 2024			IPACode - YYYY-Q4 - Credentialing and Recredentialing Activities Report		
Review of Recred Report provided by IEHP (by the 5th of each month)	Quarterly	1/1-3/31	May 15, 2023	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPA - YYYY-Q1 - Recredentialing Report (IEHP to IPA Code)	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
		4/1-6/30	August 15, 2023			IPA - YYYY-Q2 - Recredentialing Report (IEHP to IPA Code)		
		7/1-9/30	November 15, 2023			IPA - YYYY-Q3 - Recredentialing Report (IEHP to IPA Code)		
		10/1-12/31	February 15, 2024			IPA - YYYY-Q4 - Recredentialing Report (IEHP to IPA Code)		
Current Profile, Contract and W-9 (to include any applicable attachments i.e. Attachment I, Practice Agreements, Standardized Procedures, Applicable Contract Addendums)	As needed	Not Applicable	As required for Initial Credentialing Applications	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPA Code_Last Name, First Name_YYYY_MM_DD (YYYY_MM-DD = Date submitted to IEHP)	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
Provider Submission via Excel Spreadsheet	As needed	Not Applicable	As required for Initial Credentialing Applications	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPA_Code_Provider Profile Additions_YYYY_MM_DD (YYYY_MM-DD = Date submitted to IEHP)	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
Written and approved Credentialing, Recredentialing, Peer Review Policies and Procedures	As needed	01/31 - 12/31	Within (30) days following Credentialing Committee approval and prior to on-site and/or desktop audit	MC05A8 - Credentialing Standards - Delegation of Credentialing	Credentialing (CR)	N/A	IPA Oversight/Credentialing	

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, (viii) Claims Adjudication, (ix) and Compliance. All Delegated activities are to be performed in accordance with currently applicable NCQA accreditation standards, DHCS regulatory requirements, DMHC regulatory requirements, and IEHP standards, as modified from time to time. 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.

In accordance, the Health Insurance Portability and Accountability Act, IPA/Medical group shall comply with the following provisions:

1. The IPA has a list of the allowed uses of protected health information. The IPA may only use PHI associated with performing functions outlined in this agreement. It may only be disclosed to the member, their authorized representative, IEHP, and other authorized healthcare entities.
2. The IPA has a process in place for ensuring that members and practitioners information will remain protected. Protections must include oral, written, and electronic forms of PHI.
3. The IPA has a description of the safeguarding the protected health information from inappropriate use or further disclosure.
4. The IPA has a written description stipulating that the delegate will ensure that sub-delegates have similar safeguards when applicable.
5. The IPA has a written description stipulating that the delegate will provide individuals with access to their protected health information. The IPA will have procedures to receive, analyze and resolve members' requests for access to their PHI.
6. The IPA will ensure that its organization will inform the organization if inappropriate uses of information occur. The IPA will have procedures to identify and report unauthorized access, use, disclosure, modification or destruction of PHI and the systems used to access or store PHI.
7. The IPA will ensure that the protected health information is returned, destroyed or protected if the delegation agreement ends.

REQUIRED REPORTING ELEMENTS

Department	Required Documentation/Materials	Frequency	Submission Deadline	Point of Submission
Quality Management and Improvement				SFTP Server
	Annual QM Program Description Annual GQ P4P Quality Workplan	Annually	Feb 28 As designated by P4P Program	
Utilization Management	Monthly Referral Tracking Log Monthly Denial Files Monthly Second Opinion Log Monthly Approval File Review	Monthly	15th 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	Annually	Feb 28	
Care Management	Monthly CM Log Monthly California Children's Services (CCS) Log Monthly CM Files for Review (Care Coordination, CCS and SPD)	Monthly	15th of each month	SFTP Server
Encounter Data	5010 / Encounters	Monthly	Varies within the first days of the month. Refer to *Attachment 13 – Delegated IPA Reporting Requirements Schedule – Medi-Cal* for details.	SFTP Server

* MUST PASS Element

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 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		By the 15th of the following month, after Committee approval	
Credentialing and Recredentialing	Monthly Credentialing and Recredentialing Report	Monthly	15th of each month	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	

* MUST PASS Element

Claims	Annual Claims Payment and Provider Dispute Report	Annually	November 30	SFTP Server
Financial Analysis	Balance Sheet Income Statement, Cash Flow Statement, Supporting Worksheets for IBNR Organizational Informational Disclosures Annual Audited Financial Statements, Including IBNR Certification Financial Statements, Including IBNR Certification	Quarterly Annually	May 15 Aug 15 Nov 15 Feb 15 5 months after end of IPAs Fiscal year	SFTP Server
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	

	Annual Compliance Work Plan	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	

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.	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.
Quality Improvement	IEHP will provide IPA with guidelines for Policies and			IPA is not delegated for this function,	

Program Structure (NCQA QI 1, Elements A, B, C, D and E continued)	Procedures via IEHP Provider Manual.	2. Involvement of a designated physician in the QI program. 3. Oversight of QI functions of the organization by the QI Committee. 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. B. The IPA documents and executes a QI annual work plan that reflects ongoing	Semi-Annual and Annual	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.

		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 previously identified issues. 5. Evaluation of the QI program.			
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 and D 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 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	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	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual		Semi-Annual and Annual	IPA is not delegated for this function, however	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

(NCQA QI 1, Elements A, B, C, D and E continued)		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. E. The IPA promotes Organizational Diversity, Equity and Inclusion.: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural		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.	

		competency, bias or inclusion.			
Delegated Activity	**IEHP Responsibilities**	**Delegate Responsibilities**	**Frequency of Reporting**	**Process for Evaluating Delegates Performance**	**Corrective Actions if Delegate Fails to Meet Responsibilities**

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 D and NET 4 Elements A and B)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA helps with members' transition to other care when their benefit ends, if necessary. The IPA uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system. A. The IPA notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner. B. 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 D 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.

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 program scope and process used to determine benefit coverage and medical necessity including:	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.

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 other regulatory requirements continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	a. How the IPA develops and selects criteria b. How the IPA reviews, updates, and modifies criteria 4. Information sources used to determine benefit coverage and medical necessity. B. The IPA annually evaluates and updates the UM program, as necessary. • Must meet applicable IEHP Standards and are consistent with NCQA, State and Federal health care regulatory agencies standards.	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.

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.

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. States in writing how practitioners and Members can obtain UM criteria. 2. Makes the UM criteria available to its practitioners, and public upon request. 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.

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 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 for 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*. F. 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.

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.

* MUST PASS Element

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
Timeliness of UM Decisions (NCQA UM 5 Element A*) California Health & Safety Code §1367.01(h)(1)(3)	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*: 1. Urgent Concurrent Decisions: The IPA gives electronic or written notification of the decision to Practitioners and Members within seventy two (72) hours of the request. 2. 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. 3. Non-Urgent Pre-Service Decisions: The IPA gives electronic or written notification of the decision to members and practitioners within five (5) calendar days of the request. 4. Post-Service Decisions: The IPA gives electronic or written notification of the decision to Practitioners and members and written notification to the Member within 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.

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. 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.

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)		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.

UM Denial System Controls (NCQA UM 12 Element A*)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA has policies and procedures describing its system controls specific to UM denial notification dates that*: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. The IPA's policies and procedures identify: a. All staff titles or roles authorized to modify dates. Policies and procedures state if no staff are authorized to modify dates under any circumstances. b. The circumstances when modification is appropriate. 5. ~~Specify how the system tracks modified dates~~ The IPA's policies and procedures describe how the system tracks date modifications, and includes: ~~a. Date modifications.~~ ~~b.~~a. When the date was modified. ~~c.~~b. The staff who modified the date. ~~d.~~c. Why the date was modified. 6. Describe system security controls in place to protect data from unauthorized modification. The IPA's policies and procedures describe the process for:	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

UM Denial System Controls (NCQA UM 12 Element A* continued)		a. Limiting physical access to the operating environment that houses utilization management data, including the IPA's computer servers, hardware and physical records and files. ~~a.~~i. "Physical Access" does not refer to the IPA's building or office location. b. Preventing unauthorized access and changes to system data. c. Password-protecting electronic systems, including requirements to: i. ~~U~~use strong passwords, ii. D~~d~~iscourage staff from writing down passwords, iii. ~~u~~Update user IDs and passwords to be unique to each user, ~~c.~~iv. C~~c~~hange passwords when requested by staff or if passwords are compromised. d. Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security. 7. Describe how the ~~organization~~ IPA monitors, at least annually, its compliance with the policies and procedures in factors 1-6~~-~~ and analyzes date modifications that do not meet the IPA's established ~~at least annually and~~policy, and takes appropriate action, when applicable. ~~.~~ At a minimum, the description includes:			

UM Denial System Controls (NCQA UM 12 Element A* continued)		a. The method used to monitor compliance with the ~~organization's~~ IPA's policies and procedures described in factors 1–6. i. If the IPA conducts auditing as the method for monitoring:~~,~~ 1. A~~a~~ll noncompliant modifications must be reviewed if the IPA's system can identify noncompliant modifications. 2. Sampling is allowed only if the IPA does not use a UM system that can identify all noncompliant modifications. b. The staff titles or roles responsible for oversight of the monitoring process. c. The IPA's process for taking actions if it identifies date modifications that do not meet its established policy, including; i. A quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three consecutive quarters.			

UM Denial System Controls (NCQA UM 12 Element A* continued)		ii. The staff roles or departments responsible for the actions. iii. The process for documenting and reporting date modifications that do not meet its established policy. d. Sampling Methodology for auditing: Sampling is allowed for IPA's that use auditing as their monitoring method. i. The IPA must use the "5% or 50 files" audit method: Randomly select 5% or 50 files (whichever is less) from each applicable file type. To review against requirements; 1. UM Denials 2. UM Appeals (UM Appeals are not applicable) ii. For each applicable file type noted above, the organization must determine the sample size of 5% or 50 files (whichever is less) based on all files in the file universe. The file universe includes all files, with or without modifications. The sample that will be audited must include only files with modifications (whether modifications are compliant or noncompliant with the			

UM Denial System Controls (NCQA UM 12 Element A* continued)		IPAs policies and procedures). iii. Once the sample size is calculated from the entire file universe, the IPA determines how it selects the sample. NCQA does not specify how the organization selects the sample once the sample size is determined using the entire file universe. iv. If the IPA: 1. Can identify files with modifications, it may randomly select a sample from the universe that contains modified files. ~~a.~~2. Cannot identify files with modifications, it may randomly select a sample from the entire file universe; the IPA continues to pull files from the entire universe until 5% or 50 files in the sample have modifications. • ~~If the UM system does not allow date modifications under any circumstances, the description includes the functionality of the system that ensures compliance with established policy.~~			

UM Denial System Controls (NCQA UM 12 Element A* continued)		~~Documentation or evidence of advanced system capabilities that automatically record data/dates and prevent modifications that do not meet the agreed upon modification criteria.~~ • ~~If the UM system allows date modifications only under specific circumstances established by policy, the description includes the process for monitoring compliance with established policy.~~ • ~~If the IPA uses system alerts or flags to identify noncompliance, the description indicates how this process is conducted and monitored.~~ • ~~If the IPA conducts auditing, sampling is not an allowable method.~~allowed only if the IPA ~~does not use a UM system that can identify all noncompliant modifications.~~ ~~5% or 50 of its files, whichever is less. The NCQA "8/30 methodology" is available if appropriate.~~ • ~~The description specifies the staff roles or department involved in the audit and the audit frequency.~~ ~~b. The staff titles or roles responsible for oversight of the monitoring process.~~ ~~c. The organization's~~ IPA~~'s process for taking actions if it identifies date~~			

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
UM Denial System Controls (NCQA UM 12 Element A* continued)		~~modifications that do not meet its established policy, including:~~ • ~~A quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three (3) consecutive quarters.~~ • ~~The staff roles or department responsible for the actions.~~ • ~~The process for documenting and reporting date modifications that do not meet its established policy.~~			

UM Denial System Controls Oversight (NCQA UM 12 Element B)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	At least annually, the IPA demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by: 1. ~~1.~~ Identifying all modifications to receipt and decision notification dates that did not meet the IPA's policies and procedures for date modifications. a. The IPA demonstrates that at least annually, it identifies all modifications to UM denial receipt and notification dates that did not meet the IPA's policies and procedures outlined in UM 12 Element A. ~~IPA's policies and procedures for date modifications.~~ 2. ~~2.~~ Analyzing all instances of date modifications that did not meet the IPA's policies and procedures for date modifications. a. The IPA demonstrates that at least annually, it conducts a quantitative and qualitative analysis of all modifications that did not meet its policies and procedures outlined in UM 12 Element A. b. A goal is not required for the quantitative analysis. The IPA reviews all instances of modifications that did not meet its policies and procedures. i. If the IPA uses sampling, it reviews all noncompliant modifications in the sample.	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

UM Denial System Controls Oversight (NCQA UM 12 Element B)		c. The IPA's analysis report includes the number or percentage of noncompliant files. d. NCQA's definition of Qualitative analysis - An examination of the underlying reason for or cause of results, including deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. Qualitative analysis must draw conclusions about why the results are what they are and involves staff responsible for executing a program or process. Also called a causal, root cause or barrier analysis. e. NCQA's definition of Quantitative analysis - A comparison of numeric results against a standard or benchmark, trended over time. Quantitative analysis must draw conclusions about what results mean. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends. ~~and procedures for date modifications~~. 3. ~~3.~~ Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters. a. The IPA identifies and documents all actions it has taken, or plans to take, to address all date modifications that did not meet its			

UM Denial System Controls Oversight (NCQA UM 12 Element B)		policies and procedures, if applicable. One action may be used to address more than one finding, if appropriate. b. The IPA also implements a quarterly monitoring process to assess the effectiveness of its actions on all findings: i. The IPA must continue to monitor until it demonstrates improvement of at least one finding over three consecutive quarters. ii. If the IPA did not demonstrate improvement of at least one finding during the look-back period, it submits all quarterly monitoring reports demonstrating ongoing monitoring. ~~i.~~ iii. If the IPA identified findings less than three quarters before IEHP is required to submit evidence for the NCQA Survey, the IPA will submit all monitoring information it has available. ~~demonstrates improvement for one finding over three consecutive quarters.~~			

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
UM Appeal System Controls (NCQA UM 12 Element C)	Not Applicable	~~a.~~ Appeals are not delegated.	Not Applicable	Not Applicable	Not Applicable
UM Appeal System Controls Oversight (NCQA UM 12 Element D)	Not Applicable ~~IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.~~	Appeals are not delegated. ~~At least annually, the IPA demonstrates that it monitors compliance with its UM appeal controls, as described in Element C, factor 7, by:~~ ~~1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.~~ ~~2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.~~ ~~3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.~~	Not Applicable ~~Annually, at minimum~~	Not Applicable ~~Annual audit of Delegate's policies and procedures~~	Not Applicable ~~See Corrective Action Plan (CAP) Requirements in MC_25 A4.~~

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
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.

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.	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. Reason for referral to CM 6. Case Status (Open or Closed) 7. Case Open Date (or Ref to Waiver, CCS, IRC, etc.) 8. Individualized Care Plan Documented 9. Diagnosis (ICD-10 description) 10. Problems/Issues Identified 11. Goals Identified 12. Interventions Documented 13. Care Plan Sent to PCP Documented 14. Communication w/Member Documented 15. Case Closure Date 16. Reason for Closure/Case Outcome Documented A. Members who are identified as potential Complex (CCM), must be referred to IEHP's Care Management team. B. Complex Case Management (CCM) referrals must include: 1. IPA Care Plan 2. IPA Interventions 3. IPA Case Documentation	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.

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.

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 process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. 7. The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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.	8. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision. 9. The Medical Director or other designated physician's direct responsibility and participation in the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. 11. The process for confirming listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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.

Credentialing System Controls (NCQA CR 1 Element C*)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	The Delegates credentialing process describes*: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. a. When the information was modified. b. How the information was modified. c. Staff who made the modification. d. Why the information was modified. 3. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification (a. Limiting physical access to the operating environment that houses credentialing information. b. Preventing unauthorized access, changes to and release of credentialing information. c. Password-protecting electronic systems, including user requirements to: use strong passwords, discourage staff	Annually, at minimum	Audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

Credentialing System Controls (NCQA CR 1 Element C* continued)		from writing down passwords, use IDs and passwords unique to each user-, change passwords when requested by staff or if passwords are compromised, disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security. 5. How the IPA monitors its compliance with the policies and procedures in factors 1-4 at least annually and takes appropriate action when applicable. At a minimum, the description includes: a. The method used to monitor compliance with the organization's policies and procedures described in factors 1–4. b. The staff titles or roles responsible for oversight of the monitoring process. c. The organization's process for taking actions if it identifies modifications that do not meet its established policy, including: A quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three (3) consecutive quarters. The staff roles or department			

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 System Controls (NCQA CR 1 Element C* continued)		responsible for the actions. The process for documenting and reporting modifications that do not meet established policy.			
Credentialing System Controls Oversight (NCQA CR 1 Element D)	IEHP will provide Delegate- with guidelines for Policies and Procedures via IEHP Provider Manual.	At least annually, the Delegate demonstrates that it monitors compliance with its CR controls, as described in Element C, factor 5, by: 1. Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters.	Annually, at minimum	Review of Reports	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

* MUST PASS Element

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.

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 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.

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

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
Sanction 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.	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

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.	C. 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. 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 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

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
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.

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 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.

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 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

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
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

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
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

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
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

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
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 sanctions or limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4.	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.

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 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.

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

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 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.

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
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.

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
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 • Clinical Laboratories (IEHP Requirement)	Annually, at minimum	IEHP reviews Delegate's policies and procedures.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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.

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
Written Delegation Agreement (NCQA CR 8 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.

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
Written Delegation Agreement (NCQA CR 8 Element A)	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 (continued) (NCQA CR 8 Element A)	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

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
Pre-delegation Evaluation (NCQA CR 8 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.
Review of Credentialing Activities (NCQA CR 8 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	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.

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
Opportunities for Improvement (NCQA CR 8 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		IEHP reviews delegate policies and procedures.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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
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.

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.

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	Please refer to MC_20G.	See Corrective Action Plan (CAP) Requirements in MC_20D.

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
			Dispute Mechanism Report (Annual Report) by November 30th of each year.		

ATTACHMENT IX: REQUIREMENTS OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND PRIVACY PROGRAM

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

Compliance Program (CMS Managed Care Manual Ch. 21 and DHCS Two Plan Contract Exhibit E, Attachment 2)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA has developed and implemented an Effective Compliance Program which includes the following structural components: A. Written Policies, Procedures and Standards of Conduct that articulate a commitment to comply with all applicable Federal and State requirements; B. Designation of a Compliance Officer who reports directly to the CEO and Board of Directors, Compliance Committee at the Board of Directors and/or Senior Leadership level charged with overseeing the compliance program; C. Has an effective Compliance Training program for its employees to receive within 90 days of hire and annually thereafter or as updates/changes occur; D. Distribute Standards/Code of Conduct within 90 days of hire and annually thereafter. E. Effective Lines of Communication between the Compliance Officer, Compliance Committee and employees; F. Well-Publicized Disciplinary Standards; G. Provides guidance on how to report issues of non-compliance that includes non- intimidation and	Precontractual Assessment and Annually as part of the DOA	Initial Assessment Annual DOA	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

ATTACHMENT IX: REQUIREMENTS OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND PRIVACY PROGRAM

Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		non-retaliation for good faith participation. H. Establishment and implementation of an Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks; and I. Implementation of Procedures and System for prompt response to Compliance issues as they are raised, investigation of potential compliance problems as identified through the course of self-evaluation and audits, correction of such problems promptly and thoroughly.			

ATTACHMENT IX: REQUIREMENTS OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND PRIVACY PROGRAM

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Fraud, Waste and Abuse Program (CMS Managed Care Manual Ch. 21 and DHCS Two Plan Contract Exhibit E, Attachment 2)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA has developed and implemented an Effective Fraud, Waste and Abuse (FWA) program that is designed to deter, identify, investigate and resolve potentially fraudulent activities that may occur in daily operations, both internally and with contracted providers. IPA provides monitoring and oversight, both internally and externally, of daily operational activities to detect and/or deter fraudulent behavior. Such activities include, but are not limited to: A. Provider grievances B. Claims activity C. Financial Statements D. Utilization management monitoring E. Chart audits F. Clinical Audits G. Internal auditing and monitoring process H. Risk assessment The IPA has a FWA training program and requires training within ninety (90) days of hire/contracting and annually thereafter or as updates/changes occur. The IPA has a process in place, where needed, for reporting suspected fraudulent behavior to appropriate federal, state, local authorities, and IEHP.	Precontractual Assessment and Annually as part of the DOA	Initial Assessment Annual DOA	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

HIPAA/Privacy Title 45 CFR; HITECH Act ARRA COMIA	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA maintains policies and procedures required by HIPAA and ARRA. A. Uses and disclosures of PHI and PII B. Confidentiality of Member Information C. Auditing/Monitoring of Business Associates, Downstream/Subcontracted and Related Entities D. General Security controls of Facilities and Information Systems E. Record Retention F. Paper Document Controls G. Non-retaliation for exercising rights provided by the Privacy Rule. H. Reporting incidents of HIPAA non-compliance to IEHP A privacy officer has been designated by the IPA. The IPA has a HIPPA Privacy training program and requires training prior to access to PHI is given and annually thereafter or as updates/changes occur. The IPA has implemented a risk assessment process to assess privacy incidents and determine breach or breach exception. Has policies and procedures to ensure that all persons who work with PHI/ePHI sign a confidentiality statement, upon prior to access to PHI is given and annually thereafter. There are appropriate administrative, technical and physical safeguards to	See Attachment IPA Reporting Requirements Schedule in Section 25	Initial Assessment Annual DOA	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

		prevent intentional or unintentional use or disclosure of PHI.			

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Biographical Information

Date of Review:	**Surveyor:**
Name of IPA:	**IPA Code**
Address:	
City/State	
Phone:	**FAX:**
Name of Management Company (if applicable) **Address:** **City/State:**	
Phone:	**FAX:**
Name of Parent Company (if applicable) Address: City/State:	
Phone:	FAX:

IPA Contact Personnel	Phone	FAX	E-Mail
IPA Administrator			
Medical Director:			
QM Chairperson:			
QM Contact/Title:			
UM Chairperson:			
UM Contact/Title:			
CM Contact/Title:			
Credentialing Contact/Title:			
Provider Relations Contact/Title:			
Compliance Officer~~Contact/Title~~:			
Privacy Officer:			
Case Management Contact/Title:			

HEALTH PLAN CONTRACTS/ENROLLMENT		
IPA Total Enrollment in all participating health plans:		
IPA total enrollment for each of the following:		
Commercial:	**MediCare:**	**MediCal:**
IPA Enrollment for (insert health plan) **for each of the following**:		
Commercial:	**MediCare:**	**MediCal:**

Inland Empire Health Plan
20232 IPA Delegation Oversight Audit Tool
Biographical Information

CONTRACTED PHYSICIANS		
~~Total Number:~~	~~Total number of PCP's:~~	~~Total number of specialist:~~
~~Total number of OB's:~~	~~Total number of Pediatricians:~~	
~~Have you included the following in your total:~~		
~~OB/GYN's: yes no~~	~~Pediatricians: yes no~~	
~~Capitated Specialist: (number/specialty)~~		
~~UM Criteria used by IPA:~~ ~~Copyright Date:~~		

IEHP Care Management Referral Form

IEHP® A Public Entity
Inland Empire Health Plan

Member Name: _____ Member ID# _____ Date: _____

Line of Business: ☐ Medi-Cal ☐ Cal MediConnect (LTSS referrals only)

Member DOB: _____ IPA _____ Member Phone: _____ Alt Phone: _____

Caregiver/Family Member Name: _____ Caregiver/Family Phone: _____

Referral Source: ☐ **Member** ☐ **Caregiver** ☐ **PCP** ☐ **IPA** ☐ **Specialist** ☐ **Other**

Referred by _____ **Contact phone** _____ **Contact email** _____

Reason for Referral:

☐ Diagnosis
☐ Social Needs
☐ Rx
☐ High Utilization
☐ Behavioral Health
☐ Maternity/Child Health Needs
☐ Long-Term Services and Supports *(In-Home Support Services, Community-Based Adult Services, Multipurpose Senior Services Program)*

PLEASE CHECK ALL THAT APPLY:

Diagnosis Triggers

☐ Advanced liver disease
☐ Severe psychoses
☐ New cerebral vascular accident
☐ Trauma (current)
☐ Metastatic cancer/pediatric cancer
☐ Decompensating neurological conditions
☐ Complex pain management control issues
☐ Multiple chronic illnesses-uncontrolled

Utilization Triggers

☐ 6 or more ER visits in the past 12 months
☐ 2 or more readmissions to acute setting within 30 days
☐ 4 or more inpatient stays in the past 12 months
☐ On multiple medications for multiple chronic conditions
☐ Projected cost of care within a 12-month period anticipated to be >$100,000 (including high-cost medications and/or DME)

Psychosocial/Frailty Triggers

☐ Malnutrition and/or catabolic illness, loss of weight
☐ Major problems of urine/bowel retention or control
☐ Difficulty in walking/fall risk
☐ Decubitus ulcer (Stage 3, Stage 4)
☐ Social support needs (e.g., housing/food)
☐ Suspected or reported abuse of Member

Triggers for referral to Long-Term Services and Supports

☐ 65+ and at risk of placement in a Long-Term Care facility
☐ Severe and persistent mental illness
☐ Disabled, blind, or senior unable to perform activities of daily living
☐ Needs ongoing nursing monitoring and supervision at Adult Day Healthcare Center
☐ Alzheimer's or Dementia
☐ Needs a caregiver

Please return completed Form via Secure Email to ***CMReferralTeam@iehp.org*** and attach all applicable documentation.

(Please allow up to 5 business days for referral to be processed and response)

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Listed below are the items required for your Delegation Oversight Audit (DOA). We have identified when they should be available, by Department. All Desktop documents are by the date specified in the Delegation Oversight Letter.

DESKTOP	ON-SITE	DELEGATION OVERSIGHT
✓		Biographical Information
✓		Sub-Contracted Service by Facility/Agency
✓		**All sections** of the DOA tool documented with **road mapping** instructions for each element (see sample roadmap)
✓		Organizational chart(s) to include; CM, UM, Compliance and Credentialing
✓		Current job descriptions as relevant to the audit
✓		Delegation Agreements with any sub-delegated provider
✓		Ownership and Control Documentation (submitted annually)

DESKTOP	ON-SITE	QUALITY MANAGEMENT (QM) (Look back period of 07/~~20~~2021 to 06/2022)
✓		Annual Program Description (no submission required; report was submitted February 2022)
✓		Quality Improvement (QI) Committee meeting minutes from the auditing period that identify the following occurred during the meeting.
✓		- Recommendation of policy decisions
✓		- Review and evaluation of QI activities
✓		Practitioner participation in the QI program through planning, design, implementation or review
✓		Identification and follow up of needed actions
✓		Annual Work Plan
✓		Annual Program Evaluation
✓		Notification of Termination policy and evidence that Members were notified of practitioner termination
✓		Supportive documentation or materials such as studies, audits, and surveys completed during the reporting period
✓		Semi-Annual Reports for Health Plan for the last twelve (12) months;

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DESKTOP	ON-SITE	QUALITY MANAGEMENT (QM) (Look back period of 07/~~20~~2021 to 06/2022)
✓		Standards of Medical Care Access Policy and Procedure
~~✓~~		~~If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner.~~ ~~Proof of (1) member letter showing the following:~~ ~~1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.~~ ~~2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.~~
		Evidence[Teresa R1] of meeting Continued Access to Care requirements, as outlined in the Delegation Agreement.

~~Desktop~~	~~ON-SITE~~	~~Network Management (NET)~~
~~✓~~		~~Assessment of Physician Directory Accuracy Report 2022 (ASH)~~
DESKTOP	**ON-SITE**	**UTILIZATION MANAGEMENT (UM) (Look back period of 07/2021 to 06/2022)**
✓		Program, Plan and Description ~~(no submission required; reports were submitted February 2022)~~
✓		Annual Work Plan ~~(no submission required; reports were submitted February 2022)~~
✓		Annual Program Evaluation ~~(no submission required; reports were submitted February 2022)~~
✓		Policies and Procedures
✓		Committee meeting minutes from last twelve (12) months for: • Board of Directors Utilization Management Committee
✓		- ~~Board of Directors~~
✓		- ~~Utilization Management Committee~~

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✓		Subcommittee Meeting Minutes
✓		Annual Inter-rater Reliability (IRR) Audit
✓		Semi-Annual Health Plan Reports for the last twelve (12) months;
✓		Two (2) examples that demonstrate the use of Board-Certified consultants to assist with medical necessity determinations
✓		Criteria for Length of Stay and Medical Necessity used during the past two (2) years
✓		Fifteen (15) referral files to include Denials, Modifications, Cancellations and Approvals; (conducted via live Webinar)
✓		Submission of request for UM Criteria Log
✓		Referral Universe; (Required for ASH only)
✓		Utilization Management statistics from the last twelve (12) months;
✓		Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions;
✓		Evidence, other than via a denial letter, that the Providers have been notified that they may contact a Physician reviewer to discuss denial decisions;
✓		Provider communications from last twelve (12) months
✓		Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO)) and Employees (Registered Nurse (RN), Licensed Vocational Nurse (LVN)) who make UM Decisions
✓		Copies of most recent referral inventory reporting used to manage turnaround time requirements for processing of IEHP referrals.
✓		Copies of most recent mailroom policies
		Evidence of meeting Denial ~~and Appeal~~ System Controls [JV2]requirements, as outlined in the Delegation Agreement.
		Evidence of meeting Denial and Appeal System Controls Oversight requirements, as outlined in the Delegation Agreement.[JV3]

DESKTOP	~~ON-SITE~~ VIRTUAL	CARE MANAGEMENT (CM) (Look back period of 07/2021 to 06/2022)
✓		Program Plan and Description and CM applicable policies and procedures ~~if different from UM~~; **(Desk Review)***

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DESKTOP	~~ON-SITE~~ VIRTUAL	CARE MANAGEMENT (CM) (Look back period of 07/2021 to 06/2022)
~~✓~~	✓	Ten (10) SPD CM and/ or Care Coordination files;
~~✓~~	✓	Five (5) sample cases of Carve Out/ referrals to Waiver Programs; ~~(conducted via Webinar)~~
~~✓~~	✓	Five (5) sample cases of California Children's Services (CCS) identified from previously submitted logs: ~~(conducted via live Webinar)~~
~~✓~~	✓	Five (5) sample cases with documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services. ~~(conducted via live Webinar)~~

DESKTOP AUDIT[1]	VIRTUAL AUDIT[2]	CREDENTIALING
✓	~~✓~~	Credentialing Policies and Procedures
✓	~~✓~~	Committee Meeting Minutes (i.e. Credentialing Committee, Quality Management Committee, Peer Review Committee), which include the following: • Committee Date • Committee discussions for Practitioners who do not meet the organizations criteria • Attendees of voting members and their specialties to show range of practitioners
✓	~~✓~~	Committee Structure. If an MSO is contracted with multiple organizations, has one set of policies and all of the organizations use the same Credentials Committee, then only one (1) file sample across all contracts organization will be used and apply the same score for CR 3 and CR 4 elements.

[1] Desktop Audit – Audit documents are submitted at least two (2) weeks prior to the scheduled audit date for review.
[2] Virtual Audit –For all documents not submitted at least (2) weeks prior to the scheduled audit data, the Delegate will be responsible for attending and be ready to present documentation via the virtual audit (i.e. Webex, Microsoft Teams, or Zoom), on the scheduled audit day. Audit findings and results are reviewed with the delegate on the day of the scheduled Virtual Audit.

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DESKTOP AUDIT[1]	VIRTUAL AUDIT[2]	CREDENTIALING
~~✓~~	✓	Credentialing Files in the order they are listed: Forty~~Thirty~~ (43~~0~~) files selected for Delegate must include evidence of: • Current and valid license to practice • DEA/CDS or appropriate arrangements • Education and Training • Board Certification status • Work History • Malpractice Claims History • State Sanctions, restrictions on licensure and limitations on scope of practice • Medicare and Medicaid Sanctions • Application and Attestation with questions specific to: o Reasons for ~~Inability~~ inability to ~~Perform~~perform the essential functions of the position. o Lack of present illegal drug use. o History of loss of license ~~or~~ and felony convictions. o History of loss or limitation of privileges or disciplinary actions. o Current ~~Malpractice~~ malpractice ~~Insurance~~ insurance coverage. o Current and signed attestation confirming the correctness and completeness of the application. • Malpractice Insurance
~~✓~~	✓	Recredentialing Files in the order they are listed: Forty~~Thirty~~ (43~~0~~) files selected for Delegate must include evidence of: • Current and valid license to practice • DEA/CDS or appropriate arrangements • Board Certification status • Malpractice Claims History • State Sanctions, restrictions on licensure and limitations on scope of practice • Medicare and Medicaid Sanctions • Application and Attestation with questions specific to: o Reasons for ~~Inability~~ inability to ~~Perform~~perform the essential functions of the position. o Lack of present illegal drug use.

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DESKTOP AUDIT[1]	VIRTUAL AUDIT[2]	CREDENTIALING
		○ History of loss of license or felony convictions. ○ History of loss or limitation of privileges or disciplinary actions. ○ Current ~~Malpractice~~ malpractice ~~Insurance~~ insurance coverage. ○ Current and signed attestation confirming the correctness and completeness of the application. • Malpractice Insurance • Recredentialing Cycle Length
~~✓~~	✓	Credentialing and Recredentialing Files must also show evidence of: • Hospital Affiliations or Admitting privileges at a participating hospital • Review of Performance Monitoring (Recredentialing files only) • Review of OIG Exclusions • Review of Medi-Cal Suspended & Ineligible List
✓	~~✓~~	Evidence of Ongoing Monitoring of Medicaid Sanctions review: • Medi-Cal Suspended & Ineligible List • OIG Exclusions List
✓	~~✓~~	Evidence of Ongoing Monitoring of Medicare Sanctions review: • OIG Exclusions List
✓	~~✓~~	Evidence of Ongoing Monitoring of sanctions and limitations on licensure review
✓	~~✓~~	Practitioner file(s) for those who were suspended and/or terminated due to quality of care
✓	~~✓~~	Practitioner files that have an appealed ~~a~~ decision [Teresa R4]
✓	~~✓~~	Healthcare Delivery Organizational Provider Assessments via Spreadsheet/Log or Provider file, to include the following provider types: • Hospitals • Home Health Agencies • Skilled Nursing Facilities • Free-standing Surgical Centers

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DESKTOP AUDIT[1]	VIRTUAL AUDIT[2]	CREDENTIALING
		Clinical Laboratories[Teresa R5]
		Evidence of meeting Credentialing System Controls requirements, as outlined in the Delegation Agreement.
		Evidence of meeting Credentialing System Controls Oversight requirements, as outlined in the Delegation Agreement.
✓	✓	Delegation Agreement(s) for all sub-delegate arrangements, to include but not limited to: • MSO • CVO • PO • BH
✓	✓	Human Immunodeficiency Virus (HIV/AIDS) Annual Identification Process

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IEHP monitors IPA performance as it relates to their implementation of Compliance activities through the Compliance Program Effectiveness Delegation Oversight Audits. For 2022, IEHP will conduct verification audits of repeat findings resulting from the 2021 Delegation Oversight Compliance & FWA Audits.
Listed below are the items that may be required for the 2022 Delegation Oversight Compliance & FWA Validation Audit. IPAs will receive specific instructions included in IEHP's audit notice.
The IPA will be responsible for clearly displaying all policies and documented evidence during the Validation Audit webinar and for ensuring appropriate personnel are present and available during the Validation Audit Webinar.

DESKTOP	VIRTUAL	COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM
✓		**Employee and Governing Body Universe** A list of all current employees, temporary employees, volunteers/interns, and Governing Body Members who have a role or performed job duties related to IEHP's lines of business. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The list must be submitted in Microsoft Excel format, and include columns for the following: 1. Individual Last Name 2. Individual First Name 3. Employee Identification Number 4. Name of Department Individual is assigned to 5. Individual's Position Title 6. Date of Hire or Start 7. Date Access to PHI and/or PII was Obtained 8. Name of Entity the Individual is Employed, Contracted, or a Governing Body Member of The Employee and Governing Body Universe is due two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to *Employee and Governing Body Universe Template*.
✓		**Audit and Monitoring Universe** A list of all audits and monitoring activities the IPA conducted (activities performed by the IPA) of its delegated functions, including those started or completed during the audit period or a copy of the IPA's Audit and Monitoring Plan(s) for the audit period. This includes all auditing and monitoring activities of operational areas

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		which support and administer the health plan function the IPA is delegated to perform. The list must be submitted in the Microsoft Excel format, and include columns for the following: 1. Activity Name 2. Description of Activity 3. Activity Type 4. Department/Area being Reviewed 5. Activity Start Date 6. Activity Completion Date 7. Identified Deficiencies 8. Corrective Actions The Auditing and Monitoring Universe is due within two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to the *Audit & Monitoring Universe Template*.
✓		**Downstream Entity/Subcontractor Universe** A list of all Downstream Entities/Subcontractors (individuals and entities) contracted with the IPA and/or MSO during the audit period, contracted to provide health and/or administrative services to IEHP or our Members as part of the services the IPA performs on IEHP's behalf. The list must be submitted in the Microsoft Excel format, and include columns for the following: 1. Downstream Entity/Subcontractor Name 2. Description of Services Provided 3. Department Area/Responsible to Oversee Downstream Entity/Subcontractor 4. Contract Start 5. Contract End Dates (if applicable) 6. List and Description of all Oversight Activities The Downstream Entity/Subcontractor Universe is due within two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to the *Downstream Entity/Subcontractors Universe*.
	✓	**Compliance Policies and Procedures** IPA to present the Compliance policies and procedures that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.

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	✓	**Fraud, Waste, and Abuse (FWA) Policies and Procedures** IPA to present the FWA policies and procedures that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Standards/Code of Conduct** IPA to present the Code of Conduct that was updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Compliance Training Materials** IPA to present the Compliance Training materials that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Fraud, Waste, and Abuse Training Materials** IPA to present the FWA Training materials that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Compliance Committee Meeting minutes** IPA to present the committee minutes needed according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Evidence of Regulatory Exclusion Checks** A sample of ten (10) individuals will be selected from the Employee and Governing Body Universe. Sample selections will be provided to the IPA no less than two (2) business days prior to the scheduled Validation Audit Webinar. IPA will be responsible to present the following evidence for the individual sample selections: 1. Pre-hire (as applicable to the individual) exclusion check of the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and the Medi-Cal Suspended & Ineligible Provider List (S&I). 2. Monthly exclusion checks conducted of the OIG LEIE, GSA SAM, and Medi-Cal S&I. Sample month selections will be communicated to the IPA no less than two (2) business days prior to the scheduled Validation Audit Webinar.

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	✓	**Evidence of Completion of Compliance Program, FWA Training, and Distribution of Standards of Conduct** A sample of ten (10) individuals will be selected from the Employee and Governing Body Universe. IPA will be responsible to present the following evidence for the individual sample selections: 1. Evidence Compliance Program Training was completed within ninety (90) days of hire/start; 2. Evidence FWA Training was completed within ninety (90) days of hire/start; 3. Evidence the IPA's Standards/Code of Conduct was distributed to the individual within ninety (90) days of hire/start; 4. Evidence Compliance Program Training was completed annually during the audit period; 5. Evidence FWA Training was completed annually during the audit period; 6. Evidence the IPA's Standards/Code of Conduct was distributed annually within the audit period.
	✓	**Audit and Monitoring Activities** A sample of five (5) audit and/or monitoring activities will be selected from the IPA's Audit and Monitoring Universe, or from the IPA's Audit and/or Monitoring Plans submitted in lieu of the Universe. IPA will be responsible to present the following evidence of oversight activities for the sample selection: 1. Results of the activities/ Findings Reports; 2. Evidence outcomes were reported to an oversight body, senior leadership, and/or the IPA's Governing Body, and corrective actions were developed and implemented, as applicable.
	✓	**Audit and Monitoring of Downstream Entities/Subcontractors** A sample of three (3) Downstream Entities/Subcontractors will be selected from the Downstream Entity/Subcontractor Universe. IPA will be responsible to present evidence of the following: 1. Documentation audit and/or monitoring oversight activities occurred;

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		2. Evidence oversight activity outcomes were reported to an oversight body, senior leadership, and/or the IPA's Governing Body, and corrective actions, as applicable.

IEHP monitors IPA performance as it relates to their implementation of HIPAA Privacy & Security requirements through the HIPAA Privacy Delegation Oversight Audits. For 2022, IEHP will conduct verification audits of repeat findings from the 2021 Delegation Oversight HIPAA Privacy Audits. Listed below are the items that may be required for the 2022 Delegation Oversight HIPAA Privacy Validation Audit. IPAs will receive specific instructions included in IEHP's audit notice.
The IPA will be responsible for clearly displaying all policies and documented evidence during the Validation Audit Webinar and for ensuring appropriate personnel are present and available during the Validation Audit Webinar.

VIRTUAL	DESKTOP	HIPAA PRIVACY PROGRAM
✓		**Employee and Governing Body Universe** A list of all current employees, temporary employees, volunteers/interns, and Governing Body Members who have a role or performed job duties related to IEHP's lines of business. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The list must be submitted in Microsoft Excel format, and include columns for the following: 9. Individual Last Name 10. Individual First Name 11. Employee Identification Number 12. Name of Department Individual is assigned to 13. Individual's Position Title 14. Date of Hire or Start 15. Date Access to PHI and/or PII was Obtained 16. Name of Entity the Individual is Employed, Contracted, or a Governing Body Member of The Employee and Governing Body Universe is due two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to *Employee and Governing Body Universe Template*.

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		***NOTE:** If this universe was submitted in response to the Compliance & FWA Audit, an additional submission is not needed.*
✓		**Privacy Incident Universe** A list of suspected privacy incidents impacting IEHP lines of business, including reports such as but not limited to, hotline reports, walk-ins, online reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period. The list must be submitted in Microsoft Excel format, and include columns for the following: 1. Brief Description of the Suspected Incident/Breach 2. Date Incident was Reported/Received by the IPA 3. Incident Confirmed as a Breach? (Yes/No) 4. Date Report/Incident was Resolved The Privacy Incidents Universe is due within two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to the *Privacy Incidents Universe Template*.
	✓	**HIPAA Privacy Policies and Procedures** IPA to present the HIPAA Privacy policies and procedures that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**HIPPA Privacy Training Materials** IPA to present the HIPAA Privacy Training materials that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Evidence of Completion of HIPAA Privacy Training and Confidentiality Statement** A sample of ten (10) individuals will be selected from the Employee and Governing Body Universe. IPA will be responsible to present the following evidence for the individual sample selections: 1. Evidence HIPAA Privacy Training was completed prior to obtaining access to PHI and/or PII; 2. Evidence the Confidentiality Statement was completed prior to obtaining access to PHI and/or PII; 3. Evidence HIPAA Privacy Training was completed annually during the audit period; 4. Evidence the Confidentiality Statement was completed annually within the audit period.

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	✓	**Evidence of Privacy Incidents** A sample of five (5) privacy incidents will be selected from the Privacy Incident Universe. IPA will be responsible to present the following evidence for the sample selection: 3. Date incident was reported to the Privacy/Compliance Officer; 4. Completion of a Breach Risk Assessment for issue/investigation; 5. Notification sent to IEHP of discovery of a suspected breach; and 6. Corrective actions taken, if applicable.

~~DESKTOP~~	~~ON-SITE~~	~~COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 07/2020 to 06/2021)~~
~~✓~~		~~Compliance policies and procedures~~
~~✓~~		~~Fraud, Waste and Abuse policies and procedures~~
~~✓~~		~~Sanction/Exclusion Screening Process policies and procedures~~
~~✓~~		~~Standards/Code of Conduct~~
~~✓~~		~~Copies of Compliance and FWA Training provided during the audit period~~
~~✓~~		~~Compliance Committee Meeting minutes from the last 12 months to include agenda and sign in sheet (attendance)~~
~~✓~~		~~Annual Compliance Work Plan~~
~~✓~~		~~Annual Audit and Monitoring Plan~~ ~~If one does not exist, please complete Tab A- A&M Activities Universe of the Compliance and FWA Audit Tool.~~
~~✓~~		~~Annual Risk Assessment Report~~
~~✓~~		~~Employee Universe: Submit in excel a list of all current employees, including job title, department and start date who have performed job duties related to IEHP's lines of business.~~

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DESKTOP	ON-SITE	COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 07/2020 to 06/2021)
		This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The definition of employees includes full and part time employees as well as temporary employees, interns, or volunteers. Members of the Governing Body/Board of Directors should also be included. Refer to *Employee Universe* Template.
✓		Downstream Entity/Subcontractors Universe: Submit a list of all downstream entities/subcontractors contracted with the IPA and/or MSO anytime during the audit period, including Individual/Entity Name, detailed description of services provided, contract start and end dates, Refer to tab *B. Universe_ Subcontractor* of the Compliance and FWA Audit tool for required template.
✓		A sample* of ten (10) employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the Employee Universe by IEHP Auditor for which evidence of the following will be requested: 1. New Hires: a. Pre-hire exclusion check of the Office of Inspector General (OIG), List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA), System for Award Management (SAM), and Medi-Cal Suspended & Ineligible Provider List (S&I) b. Completion of Compliance, FWA, within ninety (90) days of hire or start. c. Standards/Code of Conduct distribution 2. Established Employees: a. Monthly exclusion checks performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of three consecutive months. b. Completion of Annual Compliance and FWA, training

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DESKTOP	ON-SITE	COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 07/2020 to 06/2021)
✓		A sample of five (5) audits and/or monitoring activities will be selected from the IPA's Audit and Monitoring Plan or A&M Activities Universe. Evidence of the following will be required: a. Results/Findings Reports b. Findings Activity outcomes were reported to an oversight body, senior leadership, and/or the board of directors and corrective actions were developed and implemented, as applicable.
✓		A sample of three (3) Downstream Entities /Subcontractors will be selected in tab 4. File Review_FDR Oversight. Evidence of the following will be required: a) Auditing or monitoring oversight activities; b) Activity outcome were reported to an oversight body, senior leadership, and/or the board of directors; and corrective actions, if applicable.

DESKTOP	ON-SITE	HIPAA PRIVACY PROGRAM
✓		HIPAA Privacy Program policies and procedures
✓		Copies of HIPAA Privacy Training provided during the audit period
✓		Privacy Incident Universe: Submit a list of reported suspected privacy incidents impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period. Refer to tab A. *Universe_Privacy Incidents* of the HIPAA Privacy tool for required template.

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~~DESKTOP~~	~~ON-SITE~~	~~HIPAA PRIVACY PROGRAM~~
~~✓~~		~~A sample* of 10 employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the *Employee Universe* by the IEHP Auditor for which evidence of the following will be requested:~~ ~~1. New Hires:~~ ~~a. Completion of HIPAA Privacy & Security Training upon hire/start~~ ~~b. Completion of Confidentiality Statement prior to access to PHI~~ ~~2. Established Employees:~~ ~~a. Completion of HIPAA Privacy & Security Training~~ ~~b.~~a. ~~Annual completion of Confidentiality Statement~~
~~✓~~		~~A sample of five (5) privacy incidents will be selected from the *Privacy Incidents Universe*. Evidence of the following will be required:~~ ~~a. Date incident was reported to the Privacy/Compliance Officer;~~ ~~b. Completion of a Risk Assessment for issue/investigation;~~ ~~c. Notification was sent to IEHP with HIPAA BAA Requirements of discovery of a suspected breach; and~~ ~~d. Corrective actions taken, if applicable.~~

DESKTOP	ON-SITE	IT SECURITY
✓		The name of the medical management system(s) used for the utilization management, care management, and claims functions.

DESKTOP	ON-SITE	PROVIDER DIRECTORY
✓		Report during the lookback period of the annual audit of identified/reported inaccuracies and the timeframe of the correction. (Applies to Kaiser Permanente and American Specialty Health (ASH))

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Listed below are the items required for your Delegation Oversight Audit (DOA). We have identified when they should be available, by Department.
All Desktop documents are due by the date specified in the Delegation Oversight Audit Notice.

DESKTOP	VIRTUAL~~ON-SITE~~	DELEGATION OVERSIGHT
✓		Biographical Information
✓		Sub-Contracted Service by Facility/Agency
✓		**All sections** of the DOA tool documented with **road mapping** instructions for each element (see sample roadmap)
✓		Organizational chart(s) to include; CM, UM, Compliance and Credentialing
✓		Current job descriptions as relevant to the audit
✓		Delegation Agreements with any sub-delegated provider
✓		Ownership and Control Documentation (submitted annually)

DESKTOP	VIRTUAL~~ON-SITE~~	QUALITY MANAGEMENT
✓		Program, Plan and Description (no submission required; report was submitted February 2022)
✓		Quality Improvement (QI) Committee meeting minutes from the auditing period that identify the following occurred during the meeting
✓		- Recommendation of policy
✓		- Review and evaluation of QI activities
✓		Practitioner participation in the QI program through planning, design, implementation or review
✓		Identification and follow up of needed actions
✓		Annual Work Plan
✓		Annual Program Evaluation
✓		Notification of Termination policy and evidence that Members were notified of practitioner termination
✓		Supportive documentation or materials such as studies, audits and surveys completed during the reporting period
✓		Semi-Annual Reports for Health Plan for the last twelve (12) months;

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DESKTOP	VIRTUAL~~ON-SITE~~	QUALITY MANAGEMENT
✓		Standards of Medical Care Access Policy and Procedure
✓		~~If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner.~~ ~~Proof of (1) member letter showing the following:~~ ~~1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.~~ ~~2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.~~
		Evidence of meeting Continued Access to Care requirements, as outlined in the Delegation Agreement.

DESKTOP	VIRTUAL~~ON-SITE~~	MEMBER EXPERIENCE (ME)
		Evidence of meeting ME requirements, as outlined in the Delegation Agreement.

DESKTOP	VIRTUAL~~ON-SITE~~	NETWORK MANAGEMENT (NET)
✓		Assessment of Physician Directory Accuracy Report 2022 (Kaiser & ASH)
		Evidence of meeting NET requirements, as outlined in the Delegation Agreement.

DESKTOP	VIRTUAL~~ON-SITE~~	POPULATION HEALTH MANAGEMENT (PHM)
		Evidence of meeting PHM requirements, as outlined in the Delegation Agreement.

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DESKTOP	VIRTUAL ~~ON-SITE~~	UTILIZATION MANAGEMENT
✓		Program, Plan and Description ~~(no submission required; reports were submitted February 2022)~~
✓		Annual Work Plan ~~(no submission required; reports were submitted February 2022)~~
✓		Annual Program Evaluation ~~(no submission required; reports were submitted February 2022)~~
✓		Policies and Procedures
✓		Committee meeting minutes from last twelve (12) months for:
✓		- Board of Directors
✓		- Utilization Management Committee
✓		Subcommittee Meeting Minutes
✓		Annual Inter-rater Reliability (IRR) Audit
✓		Semi-Annual Health Plan Reports for the last twelve (12) months;
✓		Two (2) examples that demonstrate the use of Board-Certified consultants to assist with determinations
✓		Criteria for Length of Stay and Medical Necessity used during the past two (2) years
✓		(Fifteen (15) referral files to include Denials, Modifications, Cancellations and Approvals; (conducted via live Webinar)
✓		Submission of request for UM Criteria Log
✓		Referral Universe
✓		Utilization Management statistics from the last twelve (12) months;
✓		Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions;
✓		Evidence, other than via a denial letter, that the providers have been notified that they may contact a physician reviewer to discuss denial decisions;

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DESKTOP	VIRTUAL ~~ON-SITE~~	UTILIZATION MANAGEMENT
✓		Provider communications from last twelve (12) months
✓		Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO) and Employees (RN, LVN) who make UM Decisions
✓		Copies of most recent referral inventory reporting used to manage turnaround time requirements for processing of IEHP referrals.
✓		Copies of most recent mailroom policies
~~✓~~		~~Policies & procedures specific to UM 12A, UM System Controls. Policies & procedures must address all seven (7) factors as outlined in the Delegation Agreement.~~
		Evidence of meeting Denial ~~and Appeal~~ System Controls requirements, as outlined in the Delegation Agreement.
		~~Evidence of meeting Denial and Appeal System Controls Oversight requirements, as outlined in the Delegation Agreement.~~

DESKTOP	~~ON-SITE~~ VIRTUAL	CARE MANAGEMENT
✓		Program Plan and Description and CM applicable policies and procedures ~~if different from UM;~~ **(Desk Review)***
~~✓~~	✓	Ten (10) SPD CM and/or Care Coordination files; ~~(conducted via live Webinar)~~
~~✓~~	✓	Five (5) sample cases of Carve Out/ Waiver Programs ~~**(Conducted via live Webinar)**~~
~~✓~~	✓	Five (5) sample cases of California Children's Services (CCS) identified from previously submitted logs: ~~(conducted via live Webinar)~~
~~✓~~	✓	Five (5) sample cases with documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services ~~(conducted via live Webinar)~~

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DESKTOP AUDIT[1]	VIRTUAL AUDIT[2]	CREDENTIALING
~~✓X~~	~~X~~	Credentialing Policies and Procedures
		Evidence of meeting Credentialing requirements, as outlined in the Delegation Agreement.
~~✓X~~	~~X~~	Committee Meeting Minutes (i.e. Credentialing Committee, Quality Management Committee, Peer Review Committee), which include the following: • Committee Date • Committee discussions for Practitioners who do not meet the organizations criteria • Attendees of voting members and their specialties to show range of practitioners
~~✓X~~		Credentialing Pull list of all practitioners credentialed and recredentialed within the designated look-back period. Applicable to: • Kaiser • American Specialty Health Plan (ASH) • MDLIVE
~~✓X~~		Evidence of NCQA Certification/Accreditation for Credentialing. • Organizations certified/accredited by NCQA will receive auto-credit for the elements they are certified/accredited.
~~✓X~~	~~X~~	Committee Structure. If an MSO is contracted with multiple organizations, has one set of policies and all of the organizations use the same Credentials Committee, then only one (1) file sample across all contracts organization will be used and apply the same score for CR 3 and CR 4 elements.

[1] Desktop Audit – Audit documents are submitted at least two (2) weeks prior to the scheduled audit date for review.
[2] Virtual Audit –For all documents not submitted at least (2) weeks prior to the scheduled audit data, the Delegate will be responsible for attending and be ready to present documentation via the virtual audit (i.e. Webex, Microsoft Teams, or Zoom), on the scheduled audit day. Audit findings and results are reviewed with the delegate on the day of the scheduled Virtual Audit.

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~~x~~	~~✓x~~	Credentialing Files in the order they are listed: Forty~~Thirty~~ (4~~3~~0) files selected for Delegate must include evidence of: • Current and valid license to practice • DEA/CDS or appropriate arrangements • Education and Training • Board Certification status • Work History • Malpractice Claims History • State Sanctions, restrictions on licensure and limitations on scope of practice • Medicare and Medicaid Sanctions • Application and Attestation with questions specific to: o Reasons for ~~Inability~~ inability to ~~Perform~~perform the essential functions of the position. o Lack of present illegal drug use. o History of loss of license ~~or~~ and felony convictions o History of loss or limitation of privileges or disciplinary actions. o Current ~~Malpractice~~ malpractice ~~Insurance~~ insurance coverage o Current and signed attestation confirming the correctness and completeness of the application. • Malpractice Insurance **Elements above are eligible for Auto-credit via NCQA Accreditation/Certification**
~~x~~	~~✓x~~	Recredentialing Files in the order they are listed: Forty~~Thirty~~ (4~~3~~0) files selected for Delegate must include evidence of: • Current and valid license to practice • DEA/CDS or appropriate arrangements • Board Certification status • Malpractice Claims History • State Sanctions, restrictions on licensure and limitations on scope of practice

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		• Medicare and Medicaid Sanctions
		• Application and Attestation with questions specific to:
		  ○ Reasons for Inability to Perform
		  ○ Lack of present illegal drug use
		  ○ History of loss of license or felony convictions
		  ○ Current Malpractice Insurance coverage
		  ○ Current and signed attestation confirming the correctness and completeness of the application.
		• Malpractice Insurance
		• Recredentialing Cycle Length
		
		Elements above are eligible for Auto-credit via NCQA Accreditation/Certification

✗	✓✗	Credentialing and Recredentialing Files must also show evidence of: • Hospital Affiliations or Admitting privileges at a participating hospital • Review of Performance Monitoring (Recredentialing files only) • Review of OIG Exclusions • Review of Medi-Cal Suspended & Ineligible List **These elements are not subject for Auto-credit via NCQA Accreditation**
✓✗	✗	Evidence of Ongoing Monitoring of Medicaid Sanctions review: • Medi-Cal Suspended & Ineligible List • OIG Exclusions List **These elements are not subject for Auto-credit via NCQA Accreditation**
✓✗	✗	Evidence of Ongoing Monitoring of Medicare Sanctions review: • OIG Exclusions List
✓✗	✗	Evidence of Ongoing Monitoring of sanctions and limitations on licensure review

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✓X	X	Practitioner file(s) for those who were suspended and/or terminated due to quality of care
✓X	X	Practitioner files that have an appealed a decision
✓X	X	Healthcare Delivery Organizational Provider Assessments via Spreadsheet/Log or Provider file, to include the following provider types: • Hospitals • Home Health Agencies • Skilled Nursing Facilities • Free-standing Surgical Centers • Clinical Laboratories Not Applicable to: • MDLive • American Specialty Health Plan (ASH)
✓X	X	Delegation Agreement(s) for all sub-delegate arrangements, to include but not limited to: • MSO • CVO • PO • BH
✓X	X	Human Immunodeficiency Virus (HIV/AIDS) Annual Identification Process Not Applicable to: • MDLive • American Specialty Health Plan (ASH)

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IEHP monitors IPA performance as it relates to their implementation of Compliance activities through the Compliance Program Effectiveness Delegation Oversight Audits. For 2022, IEHP will conduct verification audits of repeat findings resulting from the 2021 Delegation Oversight Compliance & FWA Audits.
Listed below are the items that may be required for the 2022 Delegation Oversight Compliance & FWA Validation Audit. IPAs will receive specific instructions included in IEHP's audit notice.
The IPA will be responsible for clearly displaying all policies and documented evidence during the Validation Audit webinar and for ensuring appropriate personnel are present and available during the Validation Audit Webinar

DESKTOP	VIRTUAL	COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM
✓		**Employee and Governing Body Universe** A list of all current employees, temporary employees, volunteers/interns, and Governing Body Members who have a role or performed job duties related to IEHP's lines of business. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The list must be submitted in Microsoft Excel format, and include columns for the following: 1. Individual Last Name 2. Individual First Name 3. Employee Identification Number 4. Name of Department Individual is assigned to 5. Individual's Position Title 6. Date of Hire or Start

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		7. Date Access to PHI and/or PII was Obtained 8. Name of Entity the Individual is Employed, Contracted, or a Governing Body Member of The Employee and Governing Body Universe is due two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to *Employee and Governing Body Universe Template*.
✓		**Audit and Monitoring Universe** A list of all audits and monitoring activities the IPA conducted (activities performed by the IPA) of its delegated functions, including those started or completed during the audit period or a copy of the IPA's Audit and Monitoring Plan(s) for the audit period. This includes all auditing and monitoring activities of operational areas which support and administer the health plan function the IPA is delegated to perform. The list must be submitted in the Microsoft Excel format, and include columns for the following: 1. Activity Name 2. Description of Activity 3. Activity Type 4. Department/Area being Reviewed 5. Activity Start Date 6. Activity Completion Date 7. Identified Deficiencies 8. Corrective Actions The Auditing and Monitoring Universe is due within two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to the *Audit & Monitoring Universe Template*.
✓		**Downstream Entity/Subcontractor Universe** A list of all Downstream Entities/Subcontractors (individuals and entities) contracted with the IPA and/or MSO during the audit period, contracted to provide health and/or administrative services to IEHP or our Members as part of the services the IPA performs on IEHP's behalf. The list must be submitted in the Microsoft Excel format, and include columns for the following: 1. Downstream Entity/Subcontractor Name 2. Description of Services Provided 3. Department Area/Responsible to Oversee Downstream Entity/Subcontractor 4. Contract Start 5. Contract End Dates (if applicable) 6. List and Description of all Oversight Activities

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		The Downstream Entity/Subcontractor Universe is due within two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to the *Downstream Entity/Subcontractors Universe*.
	✓	**Compliance Policies and Procedures** IPA to present the Compliance policies and procedures that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Fraud, Waste, and Abuse (FWA) Policies and Procedures** IPA to present the FWA policies and procedures that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Standards/Code of Conduct** IPA to present the Code of Conduct that was updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Compliance Training Materials** IPA to present the Compliance Training materials that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Fraud, Waste, and Abuse Training Materials** IPA to present the FWA Training materials that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Compliance Committee Meeting minutes** IPA to present the committee minutes needed according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Evidence of Regulatory Exclusion Checks** A sample of ten (10) individuals will be selected from the Employee and Governing Body Universe. Sample selections will be provided to the IPA no less than two (2) business days prior to the scheduled Validation Audit Webinar. IPA will be responsible to present the following evidence for the individual sample selections: 1. Pre-hire (as applicable to the individual) exclusion check of the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), General Services

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		Administration (GSA) System for Award Management (SAM), and the Medi-Cal Suspended & Ineligible Provider List (S&I). 2. Monthly exclusion checks conducted of the OIG LEIE, GSA SAM, and Medi-Cal S&I. Sample month selections will be communicated to the IPA no less than two (2) business days prior to the scheduled Validation Audit Webinar.
	✓	**Evidence of Completion of Compliance Program, FWA Training, and Distribution of Standards of Conduct** A sample of ten (10) individuals will be selected from the Employee and Governing Body Universe. IPA will be responsible to present the following evidence for the individual sample selections**:** 1. Evidence Compliance Program Training was completed within ninety (90) days of hire/start; 2. Evidence FWA Training was completed within ninety (90) days of hire/start; 3. Evidence the IPA's Standards/Code of Conduct was distributed to the individual within ninety (90) days of hire/start; 4. Evidence Compliance Program Training was completed annually during the audit period; 5. Evidence FWA Training was completed annually during the audit period; 6. Evidence the IPA's Standards/Code of Conduct was distributed annually within the audit period.
	✓	**Audit and Monitoring Activities** A sample of five (5) audit and/or monitoring activities will be selected from the IPA's Audit and Monitoring Universe, or from the IPA's Audit and/or Monitoring Plans submitted in lieu of the Universe. IPA will be responsible to present the following evidence of oversight activities for the sample selection: 1. Results of the activities/ Findings Reports; 2. Evidence outcomes were reported to an oversight body, senior leadership, and/or the IPA's Governing Body, and corrective actions were developed and implemented, as applicable.

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	✓	**Audit and Monitoring of Downstream Entities/Subcontractors** A sample of three (3) Downstream Entities/Subcontractors will be selected from the Downstream Entity/Subcontractor Universe. IPA will be responsible to present evidence of the following: 1. Documentation audit and/or monitoring oversight activities occurred; 2. Evidence oversight activity outcomes were reported to an oversight body, senior leadership, and/or the IPA's Governing Body, and corrective actions, as applicable.

IEHP monitors IPA performance as it relates to their implementation of HIPAA Privacy & Security requirements through the HIPAA Privacy Delegation Oversight Audits. For 2022, IEHP will conduct verification audits of repeat findings from the 2021 Delegation Oversight HIPAA Privacy Audits. Listed below are the items that may be required for the 2022 Delegation Oversight HIPAA Privacy Validation Audit. IPAs will receive specific instructions included in IEHP's audit notice.
The IPA will be responsible for clearly displaying all policies and documented evidence during the Validation Audit Webinar and for ensuring appropriate personnel are present and available during the Validation Audit Webinar.

DESKTOP	VIRTUAL	HIPAA PRIVACY PROGRAM
✓		**Employee and Governing Body Universe** A list of all current employees, temporary employees, volunteers/interns, and Governing Body Members who have a role or performed job duties related to IEHP's lines of business. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The list must be submitted in Microsoft Excel format, and include columns for the following: 9. Individual Last Name 10. Individual First Name 11. Employee Identification Number 12. Name of Department Individual is assigned to 13. Individual's Position Title 14. Date of Hire or Start 15. Date Access to PHI and/or PII was Obtained 16. Name of Entity the Individual is Employed, Contracted, or a Governing Body Member of

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		The Employee and Governing Body Universe is due two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to *Employee and Governing Body Universe Template*. ***NOTE:*** *If this universe was submitted in response to the Compliance & FWA Audit, an additional submission is not needed.*
✓		**Privacy Incident Universe** A list of suspected privacy incidents impacting IEHP lines of business, including reports such as but not limited to, hotline reports, walk-ins, online reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period. The list must be submitted in Microsoft Excel format, and include columns for the following: 1. Brief Description of the Suspected Incident/Breach 2. Date Incident was Reported/Received by the IPA 3. Incident Confirmed as a Breach? (Yes/No) 4. Date Report/Incident was Resolved The Privacy Incidents Universe is due within two (2) weeks prior to the scheduled Validation Audit Webinar. Refer to the *Privacy Incidents Universe Template*.
	✓	**HIPAA Privacy Policies and Procedures** IPA to present the HIPAA Privacy policies and procedures that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**HIPPA Privacy Training Materials** IPA to present the HIPAA Privacy Training materials that were updated according to the IPA's corrective action plan developed in response to the 2021 Delegation Oversight Audit.
	✓	**Evidence of Completion of HIPAA Privacy Training and Confidentiality Statement** A sample of ten (10) individuals will be selected from the Employee and Governing Body Universe. IPA will be responsible to present the following evidence for the individual sample selections: 1. Evidence HIPAA Privacy Training was completed prior to obtaining access to PHI and/or PII; 2. Evidence the Confidentiality Statement was completed prior to obtaining access to PHI and/or PII;

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		3. Evidence HIPAA Privacy Training was completed annually during the audit period; 4. Evidence the Confidentiality Statement was completed annually within the audit period.
	✓	**Evidence of Privacy Incidents** A sample of five (5) privacy incidents will be selected from the Privacy Incident Universe. IPA will be responsible to present the following evidence for the sample selection: 3. Date incident was reported to the Privacy/Compliance Officer; 4. Completion of a Breach Risk Assessment for issue/investigation; 5. Notification sent to IEHP of discovery of a suspected breach; and 6. Corrective actions taken, if applicable.

~~DESKTOP~~	~~ON-SITE~~	~~COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 07/2021 to 06/2022)~~
~~✓~~		~~Compliance policies and procedures~~
~~✓~~		~~Fraud, Waste and Abuse policies and procedures~~
~~✓~~		~~Sanction/Exclusion Screening Process policies and procedures~~
~~✓~~		~~Standards/Code of Conduct~~
~~✓~~		~~Copies of Compliance and FWA Training provided during the audit period~~
~~✓~~		~~Compliance Committee Meeting minutes from the last 12 months to include agenda and sign in sheet (attendance)~~
~~✓~~		~~Annual Compliance Work Plan~~
~~✓~~		~~Annual Audit and Monitoring Plan~~ ~~If one does not exist, please complete Tab A – A&M Activities Universe of the Compliance and FWA Audit Tool.~~
~~✓~~		~~Annual Risk Assessment Report~~
~~✓~~		~~Employee Universe: Submit in excel a list of all current employees, including job title, department and start date who have performed job duties related to IEHP's lines of business.~~

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		~~This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The definition of employees includes full and part time employees as well as temporary employees, interns, or volunteers. Members of the Governing Body/Board of Directors should also be included. Refer to *Employee Universe* Template.~~
~~✓~~		~~Downstream Entity/Subcontractors Universe: Submit a list of all downstream entities/subcontractors contracted with the IPA and/or MSO anytime during the audit period, including Individual/Entity Name, detailed description of services provided, contract start and end dates, Refer to tab *B. Universe _Subcontractors* of the Compliance and FWA Audit tool for required template.~~
~~✓~~		~~A sample* of ten (10) employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the Employee Universe by the IEHP Auditor for which evidence of the following will be requested:~~ ~~1. New Hires:~~ ~~a. Pre-hire exclusion check of the Office of Inspector General (OIG), List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA), System for Award Management (SAM), and Medi-Cal Suspended & Ineligible Provider List (S&I).~~ ~~b. Completion of Compliance, FWA, within ninety (90) days of hire or start.~~ ~~c. Standards/Code of Conduct distribution~~ ~~2. Establish Employees:~~ ~~a. Monthly exclusion checks performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of three (3) consecutive months.~~ ~~b.~~a. ~~Completion of Annual Compliance and FWA training~~
~~✓~~		~~A sample of five (5) audits and/or monitoring activities will be selected from the IPA's Audit and Monitoring Plan or A&M Activities Universe. Evidence of the following will be required:~~ ~~a. Result/Findings Reports~~ ~~b. Activity outcome were reported to an oversight body, senior leadership, and/or the board of directors and~~

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		~~corrective action were developed and implemented, as applicable.~~
~~✓~~		~~A sample of three (3) Downstream Entities /Subcontractors will be selected in tab 4. File Review_FDR_Oversight.~~ ~~Evidence of the following will be required:~~ ~~a. Auditing or monitoring oversight activities;~~ ~~b. Activity outcome were reported to an oversight body, senior leadership, and/or the board of directors; and corrective actions, if applicable.~~

~~DESKTOP~~	~~ON-SITE~~	~~HIPAA PRIVACY PROGRAM~~
~~✓~~		~~HIPAA Privacy Program policies and procedures~~
~~✓~~		~~Copies of HIPAA Privacy Training provided during the audit period~~
~~✓~~		~~Privacy Incident Universe: Submit a list of reported suspected privacy incidents impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period. Refer to tab A. *Universe_Privacy Incidents* of the HIPAA Privacy tool for required template.~~
~~✓~~		~~A sample* of 10 employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the *Employee Universe* by the IEHP Auditor for which evidence of the following will be requested:~~ ~~1. New Hires:~~ ~~a. Completion of HIPAA Privacy & Security Training upon hire/start~~ ~~b. Completion of Confidentiality Statement prior to access to PHI~~ ~~2. Established Employees:~~ ~~a. Completion of HIPAA Privacy & Security Training~~ ~~b.~~a. ~~Annual completion of Confidentiality Statement~~

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✓		~~A sample of five (5) privacy incidents will be selected from the *Privacy Incidents Universe*. Evidence of the following will be required:~~ ~~a. Date incident was reported to the Privacy/Compliance Officer;~~ ~~b. Completion of a Risk Assessment for issue/investigation;~~ ~~c. Notification was sent to IEHP with HIPAA BAA Requirements of discovery of a suspected breach; and~~ ~~d. Corrective actions taken, if applicable.~~

DESKTOP	VIRTUAL~~ON-SITE~~	IT SECURITY
✓		The name of the medical management system(s) used for the utilization management, care management, and claims functions.

DESKTOP	VIRTUAL~~ON-SITE~~	APPEALS (KAISER ONLY)
✓		Policy Review
✓		File Review Fifteen (15) Files; (conducted via live Webinar)

DESKTOP	VIRTUAL~~ON-SITE~~	PROVIDER DIRECTORY
✓		Report during the lookback period of the annual audit of identified/reported inaccuracies and the timeframe of the correction. (Applies to Kaiser Permanente, , and American Specialty Health (ASH))

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Listed below are the items required for your Delegation Oversight Audit (DOA). We have identified when they should be available, by Department.
All Desktop documents are due by the date specified in the Delegation Oversight Audit Notice.

DESKTOP	~~ON-SITE~~ VIRTUAL	DELEGATION OVERSIGHT
✓		Biographical Information
✓		Sub-Contracted Service by Facility/Agency
✓		**All sections** of the DOA tool documented with **road mapping** instructions for each element (see sample roadmap)
✓		Organizational chart(s) to include; UM, Compliance and Credentialing
✓		Current job descriptions as relevant to the audit
✓		Delegation Agreements with any sub-delegated provider
✓		Ownership and Control Documentation (submitted annually)

DESKTOP	VIRTUAL ~~ON-SITE~~	QUALITY MANAGEMENT
✓		Program, Plan and Description (no submission required; report was submitted February 2022~~1~~)
✓		Quality Improvement (QI) Committee meeting minutes from the auditing period that identify the following occurred during the meeting
✓		- Recommendation of policy
✓		- Review and evaluation of QI activities
✓		Practitioner participation in the QI program through planning, design, implementation or review
✓		Identification and follow up of needed actions
✓		Annual Work Plan
✓		Annual Program Evaluation
✓		Notification of Termination policy and evidence that Members were notified of practitioner termination
✓		Supportive documentation or materials such as studies, audits and surveys completed during the reporting period
✓		Semi-Annual Reports for Health Plan for the last twelve (12) months;

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DESKTOP	VIRTUAL ~~ON-SITE~~	QUALITY MANAGEMENT
✓		Standards of Medical Care Access Policy and Procedure
✓		If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner. Proof of (1) member letter showing the following: 1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

DESKTOP	VIRTUAL ~~ON-SITE~~	NETWORK MANAGEMENT (NET)
✓		Assessment of Physician Directory Accuracy Report 2022~~1~~

DESKTOP	VIRTUAL ON-SITE	UTILIZATION MANAGEMENT
✓		Program, Plan and Description (no submission required; reports were submitted February 2022~~1~~)
✓		Annual Work Plan (no submission required; reports were submitted February 2022~~1~~)
✓		Annual Program Evaluation (no submission required; reports were submitted February 2022~~1~~)
✓		Policies and Procedures
✓		Committee meeting minutes from last twelve (12) months for:
✓		- Board of Directors
✓		- Utilization Management Committee
✓		Subcommittee Meeting Minutes
✓		Annual Inter-rater Reliability (IRR) Audit
✓		Semi-Annual Health Plan Reports for the last twelve (12) months;
✓		Two (2) examples that demonstrate the use of Board-Certified consultants to assist with determinations

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DESKTOP	VIRTUAL ON-SITE	UTILIZATION MANAGEMENT
✓		Criteria for Length of Stay and Medical Necessity used during the past two (2) years
✓		(Fifteen (15) referral files to include Denials, Modifications, Cancellations and Approvals; (conducted via live Webinar)
✓		Referral Universe
✓		Utilization Management statistics from the last twelve (12) months;
✓		Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions;
✓		Evidence, other than via a denial letter, that the providers have been notified that they may contact a physician reviewer to discuss denial decisions;
✓		Provider communications from last twelve (12) months
✓		Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO) and Employees (RN, LVN) who make UM Decisions
✓		Copies of most recent referral inventory reporting used to manage turnaround time requirements for processing of IEHP referrals.
✓		Copies of most recent mailroom policies
~~✓~~		~~Policies & procedures specific to UM 12A, UM System Controls. Policies & procedures must address all seven (7) factors as outlined in the Delegation Agreement~~
		Evidence of meeting Denial and Appeal System Controls requirements according to NCQA (National Committee for Quality Assurance) standards, as outlined in the Delegation Agreement.
		Evidence of meeting Denial and Appeal System Controls Oversight requirements according to NCQA standards, as outlined in the Delegation Agreement.

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DESKTOP AUDIT[1]	VIRTUAL AUDIT[2]	CREDENTIALING
~~X~~ ✓	~~X~~	Credentialing Policies and Procedures
~~X~~✓	~~X~~	Committee Meeting Minutes (i.e. Credentialing Committee, Quality Management Committee, Peer Review Committee), which include the following: • Committee Date • Committee discussions for Practitioners who do not meet the organizations criteria • Attendees of voting members and their specialties to show range of practitioners
~~X~~✓		Credentialing Pull list of all practitioners credentialed and recredentialed within the designated look-back period. Applicable to: • Kaiser • American Specialty Health Plan (ASH) • MDLIVE
~~X~~ ✓		Evidence of NCQA Certification/Accreditation for Credentialing. • Organizations[Teresa R1] certified/accredited by NCQA ~~will~~ may receive auto-credit for the elements they are certified/accredited.
~~X~~✓	~~X~~	Committee Structure. If an MSO is contracted with multiple organizations, has one set of policies and all of the organizations use the same Credentials Committee, then only one (1) file sample across all contracts organization will be used and apply the same score for CR 3 and CR 4 elements.

[1] Desktop Audit – Audit documents are submitted at least two (2) weeks prior to the scheduled audit date for review.
[2] Virtual Audit –For all documents not submitted at least (2) weeks prior to the scheduled audit data, the Delegate will be responsible for attending and be ready to present documentation via the virtual audit (i.e. Webex, Microsoft Teams, or Zoom), on the scheduled audit day. Audit findings and results are reviewed with the delegate on the day of the scheduled Virtual Audit.

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~~X~~	~~X~~ ✓	Credentialing Files in the order they are listed: ~~Thirty~~ Forty(40~~30~~) files selected for Delegate must include evidence of:
		• Current and valid license to practice
		• DEA/CDS or appropriate arrangements
		• Education and Training
		• Board Certification status
		• Work History
		• Malpractice Claims History
		• State Sanctions, restrictions on licensure and limitations on scope of practice
		• Medicare and Medicaid Sanctions
		• Application and Attestation with questions specific to:
		  ○ Reasons for Inability to Perform
		  ○ Lack of present illegal drug use
		  ○ History of loss of license or felony convictions
		  ○ Current Malpractice Insurance coverage
		  ○ Current and signed attestation confirming the correctness and completeness of the application.
		• Malpractice Insurance
		
		Elements above are eligible for Auto-credit via NCQA Accreditation/Certification

~~X~~	~~X~~ ✓	Recredentialing Files in the order they are listed: Forty ~~Thirty~~ (4~~3~~0) files selected for Delegate must include evidence of: • Current and valid license to practice • DEA/CDS or appropriate arrangements • Board Certification status • Malpractice Claims History • State Sanctions, restrictions on licensure and limitations on scope of practice • Medicare and Medicaid Sanctions • Application and Attestation with questions specific to: ○ Reasons for ~~Inability~~ inability to ~~Perform~~perform the essential functions of the position.

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		○ Lack of present illegal drug use. ○ History of loss of license ~~or~~ and felony convictions. ○ History of loss or limitation of privileges or disciplinary actions. ○ Current ~~Malpractice~~ malpractice ~~Insurance~~ insurance coverage ○ Current and signed attestation confirming the correctness and completeness of the application. • Malpractice Insurance • Recredentialing Cycle Length **Elements above are eligible for Auto-credit via NCQA Accreditation/Certification**
~~X~~	~~X~~✓	Credentialing and Recredentialing Files must also show evidence of: • Hospital Affiliations or Admitting privileges at a participating hospital • Review of Performance Monitoring (Recredentialing files only) • Review of OIG Exclusions • Review of Medi-Cal Suspended & Ineligible List **These elements are not subject for Auto-credit via NCQA Accreditation**
~~X~~✓	~~X~~	Evidence of Ongoing Monitoring of Medicaid Sanctions review: • Medi-Cal Suspended & Ineligible List • OIG Exclusions List **These elements are not subject for Auto-credit via NCQA Accreditation**
~~X~~✓	~~X~~	Evidence of Ongoing Monitoring of Medicare Sanctions review: • OIG Exclusions List
~~X~~✓	~~X~~	Evidence of Ongoing Monitoring of sanctions and limitations on licensure review

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~~X~~✓	~~X~~	Practitioner file(s) for those who were suspended and/or terminated due to quality of care
~~X~~✓	~~X~~	Practitioner files that have an appealed a decision
~~X~~	~~X~~	Delegation Agreement(s) for all sub-delegate arrangements, to include but not limited to: • MSO • CVO • PO • BH

~~DESKTOP~~	~~ON-SITE~~	~~COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 07/202 to 06/202)~~
~~✓~~		~~Compliance policies and procedures~~
~~✓~~		~~Fraud, Waste and Abuse policies and procedures~~
~~✓~~		~~Sanction/Exclusion Screening Process policies and procedures~~
~~✓~~		~~Standards/Code of Conduct~~
~~✓~~		~~Copies of Compliance and FWA Training provided during the audit period~~
~~✓~~		~~Compliance Committee Meeting minutes from the last 12 months to include agenda and sign in sheet (attendance)~~
~~✓~~		~~Annual Compliance Work Plan~~
~~✓~~		~~Annual Audit and Monitoring Plan~~ ~~If one does not exist, please complete Tab A – A&M Activities Universe of the Compliance and FWA Audit Tool.~~
~~✓~~		~~Annual Risk Assessment Report~~
~~✓~~		~~Employee Universe: Submit a list of all current employees who have performed job duties related to IEHP's lines of business. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The definition of employees includes full and part time employees as well as temporary employees, interns, or volunteers. Members of the Governing Body/Board of Directors should also be included. Refer to *Employee Universe* Template.~~

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✓		~~Downstream Entity/Subcontractors Universe: Submit a list of all downstream entities/subcontractors contracted with the IPA and/or MSO anytime during the audit period, including Individual/Entity Name, detailed description of services provided, contract start and end dates, Refer to tab *B. Universe _Subcontractors* of the Compliance and FWA Audit tool for required template.~~
✓		~~A sample* of ten (10) employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the Employee Universe by the IEHP Auditor for which evidence of the following will be requested:~~ ~~1. New Hires:~~ ~~a. Pre-hire exclusion check of the Office of Inspector General (OIG), List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA), System for Award Management (SAM), and Medi-Cal Suspended & Ineligible Provider List (S&I).~~ ~~b. Completion of Compliance, FWA, within ninety (90) days of hire or start.~~ ~~c. Standards/Code of Conduct distribution~~ ~~2. Establish Employees:~~ ~~a. Monthly exclusion checks performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of three (3) consecutive months.~~ ~~b. Completion of Annual Compliance and FWA training~~
✓		~~A sample of five (5) audits and/or monitoring activities will be selected from the IPA's Audit and Monitoring Plan or A&M Activities Universe. Evidence of the following will be required:~~ ~~a. Result/Findings Reports~~ ~~b. Activity outcome were reported to an oversight body, senior leadership, and/or the board of directors and corrective action were developed and implemented, as applicable.~~
✓		~~A sample of three (3) Downstream Entities /Subcontractors will be selected in tab 4. File Review_FDR_Oversight.~~ ~~Evidence of the following will be required:~~ ~~a. Auditing or monitoring oversight activities;~~ ~~b. Activity outcome were reported to an oversight body,~~

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		~~senior leadership, and/or the board of directors; and corrective actions, if applicable.~~

~~DESKTOP~~	~~ON-SITE~~	~~HIPAA PRIVACY PROGRAM~~
~~✓~~		~~HIPAA Privacy Program policies and procedures~~
~~✓~~		~~Copies of HIPAA Privacy Training provided during the audit period~~
~~✓~~		~~Privacy Incident Universe: Submit a list of reported suspected privacy incidents impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period. Refer to tab A. *Universe_Privacy Incidents* of the HIPAA Privacy tool for required template.~~
~~✓~~		~~A sample* of 10 employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the *Employee Universe* by the IEHP Auditor for which evidence of the following will be requested:~~ ~~1. New Hires:~~ ~~a. Completion of HIPAA Privacy & Security Training upon hire/start~~ ~~b. Completion of Confidentiality Statement prior to access to PHI~~ ~~2. Established Employees:~~ ~~a. Completion of HIPAA Privacy & Security Training~~ ~~b. Annual completion of Confidentiality Statement~~

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~~✓~~		~~A sample of five (5) privacy incidents will be selected from the *Privacy Incidents Universe*. Evidence of the following will be required:~~ ~~a. Date incident was reported to the Privacy/Compliance Officer;~~ ~~b. Completion of a Risk Assessment for issue/investigation;~~ ~~c. Notification was sent to IEHP with HIPAA BAA Requirements of discovery of a suspected breach; and~~ ~~d. Corrective actions taken, if applicable.~~

DESKTOP	VIRTUAL ~~ON-SITE~~	IT SECURITY
✓		The name of the medical management system(s) used for the utilization management, care management, and claims functions.

DESKTOP	VIRTUAL ~~ON-SITE~~	PROVIDER DIRECTORY
✓		Report during the lookback period of the annual audit of identified/reported inaccuracies and the timeframe of the correction.

TERMINATIONS
2023

IPA NAME	INITIAL DATE	RECRED DATE	CRED EXPIRES	LICENSE#	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	SPECIALTY(1)	SPECIALTY(2)	TERMED DATE	REASON FOR TERMINATION	DUE TO QUALITY OF CARE (YES OR NO)

RECREDENTIALING ACTIVITIES
2023

IPA NAME	PREVIOUS CRED DATE	RECRED DATE	LICENSE#	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	SPECIALTY(1)	SPECIALTY(2)

CREDENTIALING ACTIVITIES
2023

IPA NAME	INITIAL DATE	CRED EXPIRES	LICENSE#	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	SPECIALTY(1)	SPECIALTY(2)

2023 Credentialing Activities Report Instructions for Credentialing Delegates

Delegates are strongly encouraged to print and thoroughly review these instructions before preparing the lists according to the instructions below.

To ensure that IEHP can accurately review the credentialing activities reported by the Delegate, Delegates are required to submit the lists of practitioners exactly as indicated below.

Credentialing lists submitted in a format inconsistent with the specifications below will be returned to the organization for correction and resubmission, which may result in a delay in timeliness reporting by the Delegate to IEHP.

- Please compile three (3) lists
  - **Credentialing Activities:** All practitioners initially credentialed within the one (1) month look back period
  - **Recredenitaling Activities:** All practitioners recredentialed within the one (1) month look back period
  - **Terminations:** All practitioners terminated within the one (1) month look back period

If the MSO has multiple IPAs, the Delegate may submit one (1) report, however, the report must list the pracititioner by IPA affiliation, by having each IPA affiliation listed on a separate row.

CREDENTIALING ACTIVITIES DATA DICTIONARY	
IPA NAME	Name of Delegate
INITIAL DATE	Initial Credentialing Decision Date
CRED EXPIRES	Credentialing Expiration Date
LICENSE#	License# as listed on License
TYPE	Provider Type: Primary Care Provider (PCP), Specialist Care Provider (SCP), Mid Level (ML) i.e. Physician Assistants (PAs);
LAST NAME	Last Name as listed on License
FIRST NAME	First Name as listed on License
M.I.	M.I. as listed on License
SUFFIX	Suffix as listed on License
DEGREE	Degree e.g., MD, DO, PA, NP etc.,)
SPECIALTY(1)	Primary Specialty as Credentialed
SPECIALTY(2)	Secondary Specialty as Credentialed

If there are no activities report, please state "None to Report" on the CREDENTIALING ACTIVITIES tab

2023 Credentialing Activities Report Instructions for Credentialing Delegates

RECREDENTIALING ACTIVITIES DATA DICTIONARY	
IPA NAME	Name of Delegate
PREVIOUS CRED DATE	Previous Credentialing decision date to calculate the 36 month look back period
RECRED DATE	Recredentialing Decision Date
LICENSE#	License# as listed on License
TYPE	Provider Type: Primary Care Provider (PCP), Specialist Care Provider (SCP), Mid Level (ML) i.e. Physician Assistants (PAs);
LAST NAME	Last Name as listed on License
FIRST NAME	First Name as listed on License
M.I.	M.I. as listed on License
SUFFIX	Suffix as listed on License
DEGREE	Degree e.g., MD, DO, PA, NP etc.,)
SPECIALTY(1)	Primary Specialty as Credentialed
SPECIALTY(2)	Secondary Specialty as Credentialed

If there are no activities report, please state "None to Report" on the RECREDENTIALING ACTIVITIES tab

TERMINATIONS DATA DICTIONARY	
IPA NAME	Name of Delegate
INITIAL DATE	Initial Credentialing Decision Date
RECRED DATE	Recredentialing Decision Date
CRED EXPIRES	Credentialing Expiration Date
LICENSE#	License# as listed on License
TYPE	Provider Type: Primary Care Provider (PCP), Specialist Care Provider (SCP), Mid Level (ML) i.e. Physician Assistants (PAs);
LAST NAME	Last Name as listed on License
FIRST NAME	First Name as listed on License
M.I.	M.I. as listed on License
SUFFIX	Suffix as listed on License
DEGREE	Degree e.g., MD, DO, PA, NP etc.,)
SPECIALTY(1)	Primary Specialty as Credentialed
SPECIALTY(2)	Secondary Specialty as Credentialed
TERMED DATE	Effective date of the Termination
REASON FOR TERMINATION	Reason for Termination
DUE TO QUALITY OF CARE (YES OR NO)	Yes or No (if the Practitioner was terminated due to Quality of Care)

If there are no activities report, please state "None to Report" on the TERMINATIONS tab

2023 Credentialing Activities Report Instructions for Credentialing Delegates

Delegates are strongly encouraged to print and thoroughly review these instructions before preparing the lists according to the instructions below.

To ensure that IEHP can accurately review the credentialing activities reported by the Delegate, Delegates are required to submit the lists of practitioners exactly as indicated below.

Credentialing lists submitted in a format inconsistent with the specifications below will be returned to the organization for correction and resubmission, which may result in a delay in timeliness reporting by the Delegate to IEHP.

- Please compile three (3) lists
  - **Credentialing Activities:** All practitioners initially credentialed within the one (1) month look back period
  - **Recredentialing Activities:** All practitioners recredentialed within the one (1) month look back period
  - **Terminations:** All practitioners terminated within the one (1) month look back period

CREDENTIALING ACTIVITIES DATA DICTIONARY	
DELEGATE NAME	Name of Delegate
INITIAL DATE	Initial Credentialing Decision Date
CRED EXPIRES	Credentialing Expiration Date
LICENSE#	License# as listed on License
D.O.B.	Practitioners Date of Birth
SSN	Practitioners Social Security Number
NPI	Practitioners Individual NPI
TYPE	Provider Type: Primary Care Provider (PCP), Specialist Care Provider (SCP), Mid Level (ML) i.e. Physician Assistants (PAs);
LAST NAME	Last Name as listed on License
FIRST NAME	First Name as listed on License
M.I.	M.I. as listed on License
SUFFIX	Suffix as listed on License
DEGREE	Degree e.g., MD, DO, PA, NP etc.,)
SPECIALTY(1)	Primary Specialty as Credentialed
SPECIALTY(2)	Secondary Specialty as Credentialed

If there are no activities report, please state "None to Report" on the CREDENTIALING ACTIVITIES tab

2023 Credentialing Activities Report Instructions for Credentialing Delegates

RECREDENTIALING ACTIVITIES DATA DICTIONARY	
IPA NAME	Name of Delegate
PREVIOUS CRED DATE	Previous Credentialing decision date to calculate the 36 month look back period
RECRED DATE	Recredentialing Decision Date
LICENSE#	License# as listed on License
D.O.B.	Practitioners Date of Birth
SSN	Practitioners Social Security Number
NPI	Practitioners Individual NPI
TYPE	Provider Type: Primary Care Provider (PCP), Specialist Care Provider (SCP), Mid Level (ML) i.e. Physician Assistants (PAs);
LAST NAME	Last Name as listed on License
FIRST NAME	First Name as listed on License
M.I.	M.I. as listed on License
SUFFIX	Suffix as listed on License
DEGREE	Degree e.g., MD, DO, PA, NP etc.,)
SPECIALTY(1)	Primary Specialty as Credentialed
SPECIALTY(2)	Secondary Specialty as Credentialed

If there are no activities report, please state "None to Report" on the RECREDENTIALING ACTIVITIES tab

TERMINATIONS DATA DICTIONARY	
IPA NAME	Name of Delegate
INITIAL DATE	Initial Credentialing Decision Date
RECRED DATE	Recredentialing Decision Date
CRED EXPIRES	Credentialing Expiration Date
LICENSE#	License# as listed on License
D.O.B.	Practitioners Date of Birth
SSN	Practitioners Social Security Number
NPI	Practitioners Individual NPI
TYPE	Provider Type: Primary Care Provider (PCP), Specialist Care Provider (SCP), Mid Level (ML) i.e. Physician Assistants (PAs);
LAST NAME	Last Name as listed on License
FIRST NAME	First Name as listed on License
M.I.	M.I. as listed on License
SUFFIX	Suffix as listed on License
DEGREE	Degree e.g., MD, DO, PA, NP etc.,)
SPECIALTY(1)	Primary Specialty as Credentialed
SPECIALTY(2)	Secondary Specialty as Credentialed
TERMED DATE	Effective date of the Termination
REASON FOR TERMINATION	Reason for Termination
DUE TO QUALITY OF CARE (YES OR NO)	Yes or No (if the Practitioner was terminated due to Quality of Care)

If there are no activities report, please state "None to Report" on the TERMINATIONS tab

CREDENTIALING ACTIVITIES
2023

DELEGATE NAME	INITIAL DATE	CRED EXPIRES	LICENSE#	D.O.B.	SSN	NPI	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	SPECIALTY(1)	SPECIALTY(2)

TERMINATIONS
2023

DELEGATE NAME	INITIAL DATE	RECRED DATE	CRED EXPIRES	LICENSE#	D.O.B.	SSN	NPI	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	SPECIALTY(1)	SPECIALTY(2)	TERMED DATE	REASON FOR TERMINATION	DUE TO QUALITY OF CARE (YES OR NO)

RECREDENTIALING ACTIVITIES
2023

DELEGATE NAME	PREVIOUS CRED DATE	RECRED DATE	LICENSE#	D.O.B.	SSN	NPI	TYPE	LAST NAME	FIRST NAME	M.I.	SUFFIX	DEGREE	SPECIALTY(1)	SPECIALTY(2)

Delegated IPA California Children's Services Review Tool
Medi-Cal

IPA:			
Reviewer:			
Service Year:	2021	Service Month:	
Review Year:	2020	Review Month:	

Overall Score:

	File Review: #1	Comments:	File Review: #2	Comments:	File Review: #3	Comments:	File Review: #4	Comments:	File Review: #5	Comments:
Member Full Name										
Member ID#										
File Type										
IEHP Enrollment Date										
IPA Eligibility Date										
CCS Referral Date										
CCS Status										
Date Case Closed										
Reason for Closure										
Identification of Potential CCS eligible conditions										
Documentation of a referral to CCS program										
Submission of supportive medical documentation to CCS										
Documentation of CCS status										
Care Coordination Facilitation										
Notification to PCP/ Specialist upon Member transitioning out of CCS										
Individual Score										
File Summary										

Inland Empire Health Plan

IEHP Care Management Delegation Oversight: California Children's Services File Review - Data Dictionary

Element Letter	Element Description	Regulatory Criteria/ Citation/ Policy	Methodology	Benchmark	Look-back Period	Data Source	Frequency	Sample Size
A	Identification of Potential CCS eligible conditions	IEHP Provider Policy and Procedure Manual Medi-Cal MC_12B	Review of clinical documentation to ensure that Members with CCS eligible diagnosis or condition is assessed for potential CCS program enrollment.	≥ 90%	9 Months	Care Management Clinical Documentation	Monthly	5 Cases
D	Documentation of a referral to CCS program	DHCS Contract. Exhibit A. Attachment 11 Case Management and Coordination of Care. 9. California Children's Services (CCS) IEHP Provider Policy and Procedure Manual Medi-Cal MC_12B IEHP Provider Policy and Procedure Manual Medi-Cal MC_25C2	Review of clinical documentation to ensure Member was referred to CCS for program enrollment via telephone, same day mail, or fax. CCS form to be reviewed if applicable.	≥ 90%	9 Months	Care Management Clinical Documentation	Monthly	5 Cases
E	Submission of supportive medical documentation to CCS	DHCS Contract. Exhibit A. Attachment 11 Case Management and Coordination of Care. 9. California Children's Services (CCS) IEHP Provider Policy and Procedure Manual Medi-Cal MC_25C2	Review of evidence to ensure all medical documentation pertinent to Members medical condition is submitted to CCS for program enrollment.	> 90%	9 Months	Care Management Clinical Documentation	Monthly	5 Cases
F	Documentation of CCS status	IEHP Provider Policy and Procedure Manual Medi-Cal MC_25C2	Review of documented evidence indicating timely follow up to assess status of CCS referral 1. Approved 2. Pending 3. Denied 4. Closed	≥ 90%	9 Months	Care Management Clinical Documentation	Monthly	5 Cases
G	Care Coordination Facilitation	APL 20-012: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 DHCS Contract. Exhibit A. Attachment 11 Case Management and Coordination of Care. 9. California Children's Services (CCS) A. 5 IEHP Provider Policy and Procedure Manual Medi-Cal MC_25C2	Review of clinical documentation to ensure that care coordination needs were facilitated between Member, PCP/Specialist and family/caregiver in coordinating available services. This includes the review of documentation demonstrating care is established with an adult PCP when the Member is turning 21 years of age and transitioning out of CCS.	≥ 90%	9 Months	Care Management Clinical Documentation	Monthly	5 Cases
L	Notification to PCP/ Specialist upon Member transitioning out of CCS	IEHP Provider Policy and Procedure Manual Medi-Cal MC_12A.2 IEHP Provider Policy and Procedure Manual Medi-Cal MC_25C2	Review of documented evidence that the IPA notified Members PCP of CCS services ending due to Member turning 21 years of age	≥ 90%	9 Months	Care Management Clinical Documentation	Monthly	5 Cases

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Denial Review Tool

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

Overall Score	N/A
Overall Points Possible	
Overall Points Received	

		File #1	File #2	File #3	File #4	File #5	File #6	File #7	File #8
(a)	Denial Tracking #								
(b)	File Type Requested								
(c)	Referral Received Date / Time								
(d)	Referral Decision Date / Time								
(e)	Opportunity to Discuss								
(f)	Physician Reviewed								
(g)	Clinical Documentation								
(h)	Alternative Direction								
(i)	Provider/Member Outreach								
(j)	Denial Language								
(k)	Appropriate use of Criteria								
(l)	Correct Template								
(m)	Points Received								
(n)	Points Possible								
(o)	Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Comments								

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Denial Review Tool

Timeliness*	
Total Denials	###
Notification Timely	%
Decisioned Timely	%

**Details Provided by IEHP HCI Dept*

		File #9	File #10	File #11	File #12	File #13	File #14	File #15
(a)	Denial Tracking #							
(b)	File Type Requested							
(c)	Referral Received Date / Time							
(d)	Referral Decision Date / Time							
(e)	Opportunity to Discuss							
(f)	Physician Reviewed							
(g)	Clinical Documentation							
(h)	Alternative Direction							
(i)	Provider/Member Outreach							
(j)	Denial Language							
(k)	Appropriate use of Criteria							
(l)	Correct Template							
(m)	Points Received							
(n)	Points Possible							
(o)	Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Comments							

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Denial Review Tool

		File #16	File #17	File #18	File #19	File #20	File #21	File #22	File #23
(a)	Denial Tracking #								
(b)	File Type Requested								
(c)	Referral Received Date / Time								
(d)	Referral Decision Date / Time								
(e)	Opportunity to Discuss								
(f)	Physician Reviewed								
(g)	Clinical Documentation								
(h)	Alternative Direction								
(i)	Provider/Member Outreach								
(j)	Denial Language								
(k)	Appropriate use of Criteria								
(l)	Correct Template								
(m)	Points Received								
(n)	Points Possible								
(o)	Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments									

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Denial Review Tool

		File #24	File #25	File #26	File #27	File #28	File #29	File #30	Elemental Score
(a)	Denial Tracking #								
(b)	File Type Requested								
(c)	Referral Received Date / Time								
(d)	Referral Decision Date / Time								
(e)	Opportunity to Discuss								
(f)	Physician Reviewed								
(g)	Clinical Documentation								
(h)	Alternative Direction								
(i)	Provider/Member Outreach								
(j)	Denial Language								
(k)	Appropriate use of Criteria								
(l)	Correct Template								
(m)	Points Received								
(n)	Points Possible								
(o)	Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Comments								

Inland Empire Health Plan
Delegated IPA Delegation Oversight Audit Tool
Sub-Contracted Facility/Agency Services and Delegated Functions

This form is to be completed for all ancillary services where the IPA/MSO has established a contract directly with a facility or agency.

Directions:
1. Mark yes or no (Y or N) for each Service listed where your IPA/MSO has established a contract.
2. In the CONTRACTED FACILITY/AGENCY list the name of each contracting facility or agency.
3. In the ACCREDITED BY column, indicate if the facility or agency is accredited and by whom. In the DELEGATED FUNCTION column mark X in each row where your IPA/MSO has delegated any functions.

ANCILLARY SERVICE REVIEW								
Service	Y	N	Capitated Services	Contracted Facility/Agency	Accredited by	Date Accreditation Expiration	**Delegated Function**	**Date License Expiration**
1. Alcohol/Substance Abuse								
2. Home Health Agency								
3. DME, Orthotics, Prosthesis								
4. Mental Health								
5. Short-term Rehabilitation; P.T./O.T.								
6. Short-term Rehabilitation; Speech								
7. Hospice								
8. Infusion Center								
9. Renal Dialysis								
10. Family Planning								
11. Chiropractor								
12. Skilled Nursing Facilities								
13. Tertiary Care Facility								
14. X-ray								
15. Ultrasound MRI/CT								
16. Laboratory								
17. Surgi-Centers								
18. Urgent Care Centers								
19. Transportation (ambulance, ambi-vans)								

Note: The Delegated Credentialing function is evaluated separately

Inland Empire Health Plan

INLAND EMPIRE HEALTH PLAN
SECOND OPINION TRACKING LOG

IPA Name: _____ Date Submitted: _____

Report for Month of: _____ Submitted by: _____

Member Name and IEHP ID #	Name of the Requesting Practitioner or Member	Diagnosis	Reason for Second Opinion *(use codes below)*	Request Date	Decision Date	Decision Code (circle one)	Second Opinion to be provided by (name):	Date of Appoint.	Date Consult Report Received	*See Legend Below For Member Type
						Approved Modified Denied				
						Approved Modified Denied				
						Approved Modified Denied				
						Approved Modified Denied				

Second Opinion Reason Codes:

Reason 1: The Member questions the reasonableness or necessity of recommended surgical procedures.

Reason 2: The Member questions a diagnosis or plan or care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment including but not limited to a serious chronic condition.

Reason 3: If clinical indications are not clear or are complex and confusing, a diagnosis is questionable due to conflicting test results, or the treating PCP/Specialist is unable to diagnose the condition and the Member requests an additional diagnosis.

Reason 4: If the treatment plan in progress is not improving the medical condition of the Member within an appropriate time period given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment.

Reason 5: The Member has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care

Legend: MC = IEHP Medi-Cal
CMC = IEHP DualChoice Cal MediConnect

<Date>

<Name>
<Address>
<Address>

RE: Request for Utilization Management (UM) Criteria

Dear <Name>:

Attached is the clinical guideline or criteria used for determining health care services specific for the procedure or condition requested.

The materials provided to you are guidelines used by the Delegate to authorize, modify, or deny services for Members with a similar illness or condition. Specific care and treatment may vary depending on individual needs and the benefits covered under your health plan.

Sincerely,

<Utilization Management Department>

INLAND EMPIRE HEALTH PLAN

INLAND EMPIRE HEALTH PLAN
REQUEST FOR UM CRITERIA LOG

IPA Name: _____ Log for Year: _____

Date Requested	Date Sent	Sent via: F = fax EM = email GM =ground mail	Name of the Requesting Practitioner or Member	Member Name and IEHP ID #	Line of Business (MC, CMC)	Criteria Requested (i.e. InterQual-MRI Brain)	Reason for Request

Legend: F = Fax EM = email GM = Ground MC = Medi-Cal CMC = IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

Referral Universe (Include all medical prior authorization requests)		
Column ID	**Field Name**	**Description**
A	IPA Auth/Tracking #	Enter IPA's Authorization or tracking number
B	Member Name	Enter Member's name (LAST NAME, FIRST NAME)
C	IEHP Member ID#	Enter the IEHP identifier used to identify the Member.
D	Member Date of Birth	Enter the Member's date of birth (MM/DD/YY)
E	Priority of Referral	Enter the appropriate priority: Routine, Urgent, Concurrent, Post-Service/Retrospective
F	Date Request Received	Enter the date when the request was received from the Provider. (MM/DD/YY)
G	Time Request Received	Enter the time the request was received (For Urgent Requests only)
H	Requesting Provider	Enter the name of the requesting provider (LAST NAME, FIRST NAME)
I	Requested Provider	Enter the name of the requested provider (LAST NAME, FIRST NAME)
J	Requested Provider Specialty	Enter the requested provider's specialty
K	Service Requested	Provide a description of the service or item requested, including all CPT codes
L	Service category	Enter the service category: DME, Dermatology, Home Health, Physical Therapy, etc.
M	Diagnosis	Provide all of the Member's diagnosis/diagnoses ICD-10 codes related to the request.
N	Was a timeframe extension taken?	Yes/No indicator of whether the IPA extended the timeframe to make a decision
O	If an extension was taken, date the Notice of Delay was issued to the Member and Provider	If an extension was taken, enter the date the Notice of Delay was mailed to the Member and Provider (MM/DD/YY). Answer NA if no extension was taken.
P	Referral Disposition/Decision	Enter determination: Approved, Denied, Modified/Partial Approval or Cancelled
Q	If denied, modified or cancelled - reason for denial, modification or cancellation	For denied, modified, and cancelled requests, provide an explanation of why the prior authorization request was denied, modified or cancelled.
R	Decision Date	Enter the date of the IPA decision (MM/DD/YY).
S	Decision Time	Enter the time of the IPA decision (For Urgent Requests Only)
T	Date notice mailed to member	Enter the date the notice was mailed to the Member. (MM/DD/YY)
U	Date provider notified	Enter the date the notice was sent to the Provider. (MM/DD/YY)
V	Date effectuated	Enter the date the approved authorization was entered in to the IPA's Claims system (MM/DD/YY). **(Only for approved/partially approved services)**

Inland Empire Health Plan

Referral Universe

MONTH: _____ **LOB:** _____ **IPA:** _____

IPA Auth/Tracking number	Member Name	IEHP ID Number	Member Date of Birth	Priority of Referral*	Date Request Received	Time Request Received (urgent requests)	Requesting/ Referring Provider	Requested Provider	Requested Provider Specialty	Service Requested	Service Category	Diagnosis	Was a timeframe extension taken?	If an extension was taken, date the Notice of Delay was issued to the Member and Provider	Referral Disposition/ Decision**	Reason for Denial/Modification/ Cancellation***	Decision date	Decision time (Urgent requests)	Date notice mailed to Member	Date Provider Notified	Date Effectuated****

* Priority of Referral: Urgent, Routine, Concurrent, Post-Service/Retrospective
** Referral Disposition/Decision: Approved, Modified/ Partially Approved, Denied, Cancelled
***Reason for denial/modification Not medically necessary, not a covered benefit, carve out, out of network, etc.
**** Date Effectuated Date of effectuation / when was the authorization available in the claims system

M-C/CM 1: Care Management Process

Element A: Policy and Procedure

	The Care Management Program and/or policy and procedure must include a written description of the process to coordinate services and help Members access needed resources (Provider Manual Section 12) and 25:	0	1	NA	Completed by the IPA Supporting Documentation (Include page and section numbers)	Completed by IEHP Comment /Guidance
1	Evidence used to develop the Care Management Program					
2	Criteria for identifying members who are eligible for the program					
3	Process for stratifying levels for the CM program					
4	Frequency of Case Management contact for each stratification level					
5	Process for referring members meeting complex case management criteria to IEHP CM.					
6	Process for care coordination to community resources					
7	Defined program goals					
8	SPD requirements					
9	Coordinate care with the PCP and/or Specialist					

Total Requirements Element A		0		Score
Requirement Met	0	0	0	#DIV/0!
Average		####		

Element B: Staff Responsibilities

	There must be a description that defines the roles and responsibilities for:	0	1	NA	Supporting Documentation (Include page and section numbers where applicable)	Comment /Guidance
1	Care Managers (licensed clinical staff, such as RN / LVN/LCSW).					
2	Practitioners / IPA Medical Director.					
3	Ancillary Personnel (Nutritionist, Social Worker, etc.) (May be n/a if IPA does not employee ancillary staff for CM).					
	COMMENTS:					

Total Requirements Element B		0		Score
Requirement Met	0	0	0	#DIV/0!
Average		####		

Element C: Evidence of Care Management Process (FILE REVIEW)

		0	1	NA	Supporting Documentation (Include page and section numbers where applicable)	Comment /Guidance
1	Care Management file review must demonstrate the care management process, including use of Evidenced-based guidelines (e.g. CMSA guidelines). • Targeted pull of 10 Care Management files • 100% - 90% = full score of 1 Less then 90% = score of 0					
	COMMENTS: (see file review Work Sheet for details)					

Total Requirements Element C		0		Score
Requirement Met	0	0	0	#DIV/0!
Average		####		

M-C/CM 2: California Children's Services (CCS)

Element A: Policy and Procedure

	The policy and procedure for CCS must include a written description of the process to (Provider Manual 12B):	0	1	NA	Supporting Documentation (Include page and section numbers where applicable)	Comment /Guidance
1	Identify actual and potential cases.					
2	Refer potential cases, appropriately and timely, to CCS (Provider Manual 12B).					
3	Coordinate care with the PCP and/or SCP (whether eligible or not).					
4	Follow cases through the outpatient treatment process and assist with COC.					
5	Continue all medically necessary care within the IPA network when not eligible for CCS.					
	COMMENTS:					

Total Requirements Element A		0		Score
Requirement Met	0	0	0	#DIV/0!
Average		####		

M-C/CM 3: High Risk OB Care (HROB)

Element A: Policy and Procedure

	Alignment with IEHP Provider Policy MC_10D1	0	1	NA	Supporting Documentation (Include page and section numbers where applicable)	Comment /Guidance
1	IPA policies indicate that Members at high risk of a poor pregnancy outcome must be referred to appropriate Specialists - including perinatologists - and, with proper referrals, have access to genetic screening. High Risk OB Members must be referred for evaluation and care if beyond the scope of practice of the initial prenatal Practitioner.		x			
	COMMENTS:					

Total Requirements Element A		1		Score
Requirement Met	0	1	0	100%
Average		100%		

M-C/CM 4: Carve-Out / Waiver Programs / Transition of Care

Element A: Policy and Procedure

		0	1	NA	Supporting Documentation (Include page and section numbers where applicable)	Comment /Guidance
	The written policy and procedure for cases meeting the criteria must include the process used to: (Provider Manual 12 – see below):					
1	Identify cases.					
2	Refer timely.					
3	Coordinate care (CM must ensure COC into appropriate program).					
4	Waiver Programs: {Home & Community Based Services (HCBS).					
5	Department of Developmental Services (Provider Manual 12M).					
6	Multipurpose Senior Services (MSSP) (Provider Manual 12I.2).					
7	AIDS/ARC Waiver (Provider Manual 12Q).					
8	In-Home Supportive Services					
	Carve-Out(s):					
9	Dental (Provider Manual 12J) – incorporate modified benefits (<21 only).					
10	Vision (Provider Manual 12L) – incorporate modified benefits.					
	COMMENTS:					

Total Requirements Element A		0		Score
Requirement Met	0	0	0	#DIV/0!
Average		####		

Element B: Implementation (FILE REVIEW)

	There is evidence of care coordination between the IPA, Member, provider, practitioner, and Health Plan, which must include:	0	1	NA	Supporting Documentation (Include page and section numbers where applicable)	Comment /Guidance
	Carve-Out / Waiver Programs:					
1	Appropriate and timely referrals for potential cases.					
2	Appropriate notification for accepted or denied cases.					
3	Documentation information sent to Health Plan.					
	Transition of Care:					
	COMMENTS:					

Total Requirements Element B		0		Score
Requirement Met	0	0	0	#DIV/0!
Average		####		

M-C/CM 5: Community and/or Public Health Services

Element A: Policy and Procedure

	The written description regarding Community and/or Public Health Services must include the process used to:	0	1	NA	Supporting Documentation (Include page and section numbers where applicable)	Comment /Guidance
1	Identify cases.					
2	Refer timely.					
3	Coordinate care.					
	The scope of services includes, but is not limited to, the specific agencies funded by the county, state and/or federal funds:					
4	Early & Periodic Screening, Dx, Tx (EPSDT) (Provider Manual 12D).					
5	Early Start Services and Referrals (Provider Manual 12C).					
6	Tuberculosis Services (Provider Manual 10J).					
7	Immunizations Services (Provider Manual 10C.3).					
8	Developmental Disabilities / Regional Centers (Provider Manual 12M).					
9	WIC Program (Provider Manual 10E)					
10	Genetically Handicapped Persons (GHPP) (Provider Manual 12E).					
11	Reporting Potential Abuse (Provider Manual 12A.5).					
	COMMENTS: Community and Public Service Programs Policy					

Total Requirements Element A		0		Score
Requirement Met	0	0	0	#DIV/0!
Average		####		

CM Total Score:
#DIV/0!

Delegate: _____
Reviewed by: _____

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

Delegate: _____
Reviewed by: _____

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

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

Delegate: _____
Reviewed by: _____

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

Delegate: _____
Reviewed by: _____

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

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

Delegate: _____
Reviewed by: _____

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

Delegate: _____
Reviewed by: _____

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

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

Delegate: _____
Reviewed by: _____

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

Delegate: _____
Reviewed by: _____

	POINTS RECEIVED	POINTS POSSIBLE	COMPLIANCE	Delegate #4		
CR 8. CMS Requirements/MediCal (DHCS)/CMC Delegation Agreement Requirements						
Criteria				**Compliance 1/0/N/A**	**Delegation Agreement (Page / Section)**	**Comments**
1. Documentation in the agreement showing that sub-delegates must adhere to CMS regulations.	0	0	N/A			
2. The written delegation agreement must require at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			
3. Review of at least quarterly reporting of the delegated entity to the organization.	0	0	N/A			

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

2023 CR.7. OP TOOL

Delegate: _____ **Review Date:** _____

Reviewed by: _____

					7.A1	7.A1	7.A2-A3	CMS					
File #	Facility Name	Type of Organization	Cred "C"/Recred "R" [Recred files >36 months, all elements are our of compliance	Date of Completion or Cred Committee	License	OIG Query	Accreditation or Site Visit	CMS Certification # (Medicare only)	Actual File Score	Possible Score	% Compliant per File	File Pass 1 =>90% 0=<89%	Comments
1				05/01/22					0	0	N/A	N/A	
2									0	0	N/A	N/A	
3									0	0	N/A	N/A	
4									0	0	N/A	N/A	
5									0	0	N/A	N/A	
6									0	0	N/A	N/A	
7									0	0	N/A	N/A	
8									0	0	N/A	N/A	
9									0	0	N/A	N/A	
10									0	0	N/A	N/A	
11									0	0	N/A	N/A	
12									0	0	N/A	N/A	
13									0	0	N/A	N/A	
14									0	0	N/A	N/A	
15									0	0	N/A	N/A	
16									0	0	N/A	N/A	
17									0	0	N/A	N/A	
18									0	0	N/A	N/A	
19									0	0	N/A	N/A	
20									0	0	N/A	N/A	

CODING	
PRESENT	1
ABSENT	0
ELEMENT NOT APPLICABLE	N/A

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

2022 CR 3-4 FILE REVIEW TOOL

Delegate: _____
Reviewed by: _____

Review Date: _____

								3.A1	3.A1	3.A2	3.A3	3.A4	3.A5	3.A6	3.B1	3.B2	3.D1	3.D2	3.C1	3.C2	3.C3	3.C4	3.C5	3.C6	3.D3	3.D4	3.D6	4.A	
File No.	Name	Specialty	License Type	IEHP Decision Date	Decision Date	Previous Decision Date	180 calendar days Prior (Queries must be dated after this date)	License to Practice (Present)	License to Practice (Current)	DEA/CDS Certification	Education/Training	Board Certification	Work History	Malpractice History	State Sanctions, Restrictions on Licensure/Practice	Sanction Activity by Medicare and Medicaid	Sanction Activity by Medicare and Medicaid (CMS)	Medi-Cal Suspended & Ineligible List	Reasons for Inability to perform	Lack of present illegal drug use	History of Loss of License and felony convictions	History of loss or limitations of privileges	Current Malpractice Insurance Coverage	Current and signed Attestation	Hospital Admitting Privileges	Monitoring Physicians who have Opted Out	Review of Performance Information	Recredentialing Cycle	Comments
	POINTS RECEIVED							0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	POINTS POSSIBLE							0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	PERCENT COMPLIANT							#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
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2022 CR 3-4 FILE REVIEW TOOL

Delegate: _____
Reviewed by: _____

Review Date: _____

								3.A1	3.A1	3.A2	3.A3	3.A4	3.A5	3.A6	3.B1	3.B2	3.D1	3.D2	3.C1	3.C2	3.C3	3.C4	3.C5	3.C6	3.D3	3.D4	3.D6	4.A	
File No.	Name	Specialty	License Type	IEHP Decision Date	Decision Date	Previous Decision Date	180 calendar days Prior (Queries must be dated after this date)	License to Practice (Present)	License to Practice (Current)	DEA/CDS Certification	Education/Training	Board Certification	Work History	Malpractice History	State Sanctions, Restrictions on Licensure/Practice	Sanction Activity by Medicare and Medicaid	Sanction Activity by Medicare and Medicaid (CMS)	Medi-Cal Suspended & Ineligible List	Reasons for Inability to perform	Lack of present illegal drug use	History of Loss of License and felony convictions	History of loss or limitations of privileges	Current Malpractice Insurance Coverage	Current and signed Attestation	Hospital Admitting Privileges	Monitoring Physicians who have Opted Out	Review of Performance Information	Recredentialing Cycle	Comments
	POINTS RECEIVED							0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	POINTS POSSIBLE							0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	PERCENT COMPLIANT							#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
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CR 1 D. CREDENTIALING SYSTEM CONTROLS OVERSIGHT	
DELEGATE INFORMATION	
DELEGATE NAME:	
PERSON/TITLE WHO CONDUCTED OVERSIGHT:	
DATE OF OVERSIGHT:	
TIME PERIOD OF OVERSIGHT:	

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

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

OVERSIGHT OF IDENTIFIED NON COMPLIANT MODIFICATIONS

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

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

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

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

OVERSIGHT OF IDENTIFIED NON COMPLIANT MODIFICATIONS

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

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

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

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

OVERSIGHT OF IDENTIFIED NON COMPLIANT MODIFICATIONS

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____
Reviewed by: _____

Review Date: _____

CR 1: Credentialing Policies

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

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

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

Source: NCQA

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____
Review Date: _____
Reviewed by: _____

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

***MUST PASS ELEMENT**

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

D	Credentialing System Controls Oversight (NEW)	0		
	(applies to paper and electronic proceses)			
	At least annually, the organization demonstrates that it monitors compliance with its CR controls, as described in Elemet C, Factor 5 by:			
1	Identifying all modifications that did not meet the policies and procedures	*		
2	Analyzing all modifications that did not meet the policies and procedures	*		
3	Acting on all findings	*		

***MUST PASS ELEMENT**

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

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

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

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

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date: _____**

Reviewed by: _____

CR 2: Credentialing Committee

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

Document Location: Credentialing Committee Minutes

Policy and Evidence Required for all Elements

Source: NCQA/CMS

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date:** _____

Reviewed by: _____

CR 3: Credentialing Verification

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

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

Scores pull from the CR 3 File Review Tool Tab

Source: NCQA

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

***MUST PASS ELEMENT**

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

***MUST PASS ELEMENT**

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

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

***MUST PASS ELEMENT**

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____
Reviewed by: _____

Review Date: _____

Scores pull from the CR C3 Credentialing Files tab

Source: CMS; DHCS; DMHC

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date: _____**

Reviewed by: _____

CR 4: Recredentialing Cycle Length

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

Document Location: Practitioner Recredentialing files

Scores pull from the CR 3 File Review Tool

Source: NCQA

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

***MUST PASS ELEMENT**

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____
Review Date: _____
Reviewed by: _____

SV: Practitioner Office Site Quality

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

IEHP does not delegate the responsibility of Practitoner Office Site Quality

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

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date: _____**

Reviewed by: _____

CR 5: Ongoing Monitoring and Interventions

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

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

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

Source: NCQA

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

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

Policy and Evidence Required for all Elements

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____
Reviewed by: _____

Review Date: _____

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

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

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date: _____**

Reviewed by: _____

CR 6: Notification to Authorities and Practitioner Appeal Rights

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

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

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

Source: NCQA

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

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____
Review Date: _____
Reviewed by: _____

CR 7: Assessment of Organizational Providers

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

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

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

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

C	**Includes behavioral health facilities providing mental health or substances abuse services in the following settings:**			
1	Inpatient			IEHP does not delegate this element
2	Residential			IEHP does not delegate this element
3	Ambulatory			IEHP does not delegate this element
D	**Assessing Medical Providers**	**0**		
1	Has documentation that it assessed contracted medical health care providers for at least three years thereafter. (The organization assesses contracted medical health care providers against the requirements and within the time frame in Element A.)	*		Review spreadsheet and note compliance. If files are reviewed complete the CR.7. Organizational Providers Tool and note the score in Column C.

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____ **Review Date: _____**

Reviewed by: _____

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

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

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____
Reviewed by: _____

Review Date: _____

CR 8: Delegation of Credentialing

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

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

Scores pull from the CR.8. DELEGATION tab

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

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

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____

Review Date: _____

Reviewed by: _____

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

2023 CREDENTIALING AUDIT TOOL

Delegate: _____
Review Date: _____
Reviewed by: _____

CA 9: Identification of HIV/AIDS Specialists

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

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

Source: DMHC/DHCS

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

Attachment 25 - Credentialing DOA Audit Tool

2023 AUDIT RESULTS

Review Date: _____

Delegate: _____

Reviewed by: _____

NCQA	POINTS RECEIVED	POINTS POSSIBLE	A	B	C	D	E
CR 1: Credentialing Policies	0	4	0	0	0	0	
CR 2: Credentialing Committee	0	1	0				
CR 3: Credentialing Verification	0	0	*	*	*		
CR 4: Recredentialing Cycle Length	#DIV/0!	0	#####				
CR 5: Ongoing Monitoring and Interventions	0	1	0				
CR 6: Notification to Authorities and Practitioner Appeal Rights	0	1	0				
CR 7: Assessment of Organizational Providers	0	3	0	0	N/A	0	N/A
CR 8: Delegation of CR	1	3	0	N/A	0	1	
TOTAL	#DIV/0!	13	#####				

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

MEDI-CAL AUDIT SCORE #DIV/0!

MEDICARE AUDIT SCORE #DIV/0!

Credentialing		10%
Actual	1	
Possibile	10	

File Review		#DIV/0!
Actual	#####	
Possible	0	

HDO Review		0%
Actual	0	
Possible	3	

MUST PASS ELEMENTS

2023 Credentialing Activities Report Instructions for Credentialing Delegates

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

AUDIT INSTRUCTIONS:
POLICIES AND PROCEDURES

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

CREDENTIALING SYSTEM CONTROLS OVERSIGHT

- This element appies to both paper and electronic cedentialing processes
- IEHP will review Delegates Credentialing System Control Report, which may be scanned and provided as an attachment.
- Delegate may also provide their audit findings on the CR 1D SYSTEMS CONTROLS OVERSIGHT tab.

CREDENTIALING & RECREDENTIALING FILE REVIEWS

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

ONGOING MONITORING AND INTERVENTIONS

- IEHP reviews the organization's policies and procedures, monitoring reports and documentation of interventions throughout the look-back period.

ORGANIZATIONAL PROVIDER FILE REVIEWS

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

DELEGATION AGREEMENTS

- Delegates are required to submit a copy of Delegation Agreement of all sub-delegation arrangements.

- Delegates are required to provide evidence of Delegation Activities for all sub-delegation arrangements.

IDENTIFICATION OF HIV/AIDS SPECIALISTS

- IEHP will review evidence that the Delegate identifies HIV/AIDS specialists on an annual basis, which includes review of the current and previous year's survey/spreadsheet/credentialing attestation/logs.

- IEHP will review the list of identified qualifying physicians is provided to the department responsible for authorizing standing referrals.
- Distribution of findings must be communicated within thirty (30) calendar days from the completion of the screening/survey assessment.

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Denial Review Tool

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

Overall Score	N/A
Overall Points Possible	
Overall Points Received	

		File #1	File #2	File #3	File #4	File #5	File #6	File #7	File #8
(a)	Denial Tracking #								
(b)	File Type Requested								
(c)	Referral Received Date / Time								
(d)	Referral Decision Date / Time								
(e)	Opportunity to Discuss								
(f)	Physician Reviewed								
(g)	Clinical Documentation								
(h)	Alternative Direction								
(i)	Provider/Member Outreach								
(j)	Denial Language								
(k)	Appropriate use of Criteria								
(l)	Correct Template								
(m)	Points Received								
(n)	Points Possible								
(o)	Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Comments								

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Denial Review Tool

Timeliness*	
Total Denials	###
Notification Timely	%
Decisioned Timely	%

**Details Provided by IEHP HCI Dept*

		File #9	File #10	File #11	File #12	File #13	File #14	File #15
(a)	Denial Tracking #							
(b)	File Type Requested							
(c)	Referral Received Date / Time							
(d)	Referral Decision Date / Time							
(e)	Opportunity to Discuss							
(f)	Physician Reviewed							
(g)	Clinical Documentation							
(h)	Alternative Direction							
(i)	Provider/Member Outreach							
(j)	Denial Language							
(k)	Appropriate use of Criteria							
(l)	Correct Template							
(m)	Points Received							
(n)	Points Possible							
(o)	Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Comments							

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Denial Review Tool

		File #16	File #17	File #18	File #19	File #20	File #21	File #22	File #23
(a)	Denial Tracking #								
(b)	File Type Requested								
(c)	Referral Received Date / Time								
(d)	Referral Decision Date / Time								
(e)	Opportunity to Discuss								
(f)	Physician Reviewed								
(g)	Clinical Documentation								
(h)	Alternative Direction								
(i)	Provider/Member Outreach								
(j)	Denial Language								
(k)	Appropriate use of Criteria								
(l)	Correct Template								
(m)	Points Received								
(n)	Points Possible								
(o)	Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments									

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Denial Review Tool

		File #24	File #25	File #26	File #27	File #28	File #29	File #30	Elemental Score
(a)	Denial Tracking #								
(b)	File Type Requested								
(c)	Referral Received Date / Time								
(d)	Referral Decision Date / Time								
(e)	Opportunity to Discuss								
(f)	Physician Reviewed								
(g)	Clinical Documentation								
(h)	Alternative Direction								
(i)	Provider/Member Outreach								
(j)	Denial Language								
(k)	Appropriate use of Criteria								
(l)	Correct Template								
(m)	Points Received								
(n)	Points Possible								
(o)	Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	Comments								

IEHP Utilization Management Delegation Oversight
LOB: Medi-Cal
Approval Review Tool - Instructions and Data Dictionary

File Review Instructions:

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

Data Dictionary

Element Letter	*Element Description*	*Methodology*	*Regulatory Criteria/ Citation/ Policy*
(a)	Approval Tracking #	*Element Not Scored:* The authorization reference number located on the referral form for tracking purposes.	IEHP Provider Policy and Procedure - Medi-Cal MC_25E1: *Utilization Management - Delegation Oversight & Monitoring*
(b)	File Type requested	*Element Not Scored:* The authorization type: Pre-Service Routine , Pre-Service Expedited, Post Service Retrospective Review, Concurrent Standard, Concurrent Expedited.	
(c)	Authorization Received Date / Time	*Element Not Scored:* The date the authorization request was received.	
(d)	Authorization Decision Date / Time	*Element Not Scored:* The date the authorization request was approved.	
(e)	Member/Provider Language	*Scored Element:* Review of the authorization approval letter sent to the Member/Provider must be written in a manner, format, and language that can be easily understood.	IEHP Provider Policy and Procedure - Medi-Cal MC_25E1: *Utilization Management - Delegation Oversight & Monitoring*
(f)	Notification of Letter Sent	*Scored Element:* Review of documentation must demonstrate evidence that an approved authorization letter was sent to the Member/Provider.	
(g)	Clinical Documentation	*Scored Element:* Review of supportive clinical information must demonstrate the application of the criteria utilized to determine decision. Element excludes automated authorization approvals.	
(h)	Provider Outreach	*Scored Element:* In the event initial request submitted by Provider does not include information reasonably necessary to make a determination of the authorization, evidence must demonstrate IPA outreach to the requesting Provider for additional clinical information.	
(i)	Correct Template	*Scored Element:* Review of the authorization letter demonstrates the use of IEHP approved template and attachments - Correct template with attachments can be found on the IEHP website at: iehp.org. Member authorization letter must be mailed in the Member's appropriate threshold language.	
(j)	Points Received	Each file reviewed has a maximum score of 5 possible points. Total points earned from letters (e)-(i) above.	N/A
(k)	Points Possible	Each file reviewed has a maximum score of 5 possible points. Total points possible from letters (e)-(i) above, excluding non applicable elements.	
(l)	Individual File Score	Total points earned from letters (e)-(i) above divided by total points possible from letters (e)-(i) above, excluding non applicable elements for each file reviewed.	

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Approval Review Tool

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

Overall Score	N/A
Overall Points Possible	
Overall Points Received	

		File #1	File #2	File #3	File #4	File #5	File #6
(a)	Approval Tracking #						
(b)	File Type Requested						
(c)	Authorization Received Date / Time						
(d)	Authorization Decision Date / Time						
(e)	Member/Provider Language						
(f)	Notification of Letter Sent						
(g)	Clinical Documentation						
(h)	Provider Outreach						
(i)	Correct Template						
(j)	Points Received						
(k)	Points Possible						
(l)	Individual File Score	N/A	N/A	N/A	N/A	N/A	N/A
	Comments						

IEHP Utilization Management Delegation Oversight

LOB: Medi-Cal

Approval Review Tool

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

**Details Provided by IEHP HCI Dept*

		File #7	File #8	File #9	File #10	Elemental Score
(a)	Approval Tracking #					
(b)	File Type Requested					
(c)	Authorization Received Date / Time					
(d)	Authorization Decision Date / Time					
(e)	Member/Provider Language					
(f)	Notification of Letter Sent					
(g)	Clinical Documentation					
(h)	Provider Outreach					
(i)	Correct Template					
(j)	Points Received					
(k)	Points Possible					
(l)	Individual File Score	N/A	N/A	N/A	N/A	
	Comments					

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight-Monthly Referral Universe	Monthly	1/1-1/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Referral_Tracking_Log_MM_2023	IPA Oversight / Year/ Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
IPA Oversight-Monthly Second Opinion Log	Monthly	1/1-1/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Second Opinion Log_MM_2023	IPA Oversight / Year/ Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
IPA Oversight-Monthly Denial Files	Monthly	1/1-1/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Den Files_MM_2023	IPA Oversight / Year/ Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Care Management Log	Monthly	1/1-1/31	February 15, 2023	MC 25C3- Care Management Requirements - Reporting Requirements	CM	IPACode_CM_Log_MM_2023	IPA Oversight / Year/Month	Guidelines for Care Management
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
California Children Services (CCS) Log	Monthly	1/1-1/31	February 15, 2023	MC 25C3- Care Management Requirements - Reporting Requirements	CM	IPACode_CCS_Log_MM_2023	IPA Oversight / Year/Month	Guidelines for Care Management
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
IPA Oversight- Monthly CM File Review	Monthly	1/1-1/31	February 15, 2023	MC 12A3 - Coordination of Care - CM Reporting Requirements	CM	IPACode_CM File Review_MM_2023	IPA Oversight / Year/ Month	Guidelines for Care Management
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight- Monthly Approval File Review	Monthly	1/1-1/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Approval File Review_MM_2023	IPA Oversight / Year/ Month	FDR Oversight
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Encounter Data	Monthly	See Encounter Data Schedule	See Encounter Data Schedule'	MC 21A - Encounter Data Submission Requirements IEHP Provider EDI Manual- IV-4	EDI	See IEHP Provider EDI Manual for File Naming Conventions	837 Version 5010 / Encounters	Encounter Data Submission Requirement

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Claims Timeliness Reports- MCL	Monthly	1/1-1/31	February 15, 2023	MC 20G - Claims and Provider Dispute Resolution Reporting	Financial Compliance	IPAName_MCL_MTR_MM_2023	Claims Timeliness/Year/Month	28 CCR 1300.71 Section (e)(3)
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Claims & PDR Detail Reports	Monthly	7/1-7/31	February 15, 2023	MC 20G - Claims and Provider Dispute Resolution Reporting	Financial Compliance	IPAName_MCL_Claims & PDR Detail_MM_2023	Claims Timeliness/Year/Month	FDR Oversight
			March 15, 2023					
			April 15, 2023					
			May 15, 2023					
			June 15, 2023					
			July 15, 2023					
			August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		12/1-12/31	January 15, 2024					
Other Healthcare Coverage Post Payment Recovery Report	Monthly	13 month or older	5th of every month	MC 20F - Claims Processing Coordination of Benefits	Financial Compliance	MCPPR.[Assigned Code]_[YYYY_MM]_[FileNumber].xlsx	/OHC/Post Payment Recovery	APL 21-002
Discovery of Other Healthcare Coverage	As needed	1/31-12/31	Within (2) days of discovery	MC_14A3 - Other Health Care Coverage	UM	MCOHC.(IPA Code)_YYYY_MM_FileNumber.xslx	/OHC/Discovery of OHC	APL 21-002
Other Healthcare Coverage Overpayment Recovery Report	Monthly	Up to 12 months	5th of every month	MC 20F - Claims Processing Coordination of Benefits	Financial Compliance	MCPPR.[Assigned Code]_[YYYY_MM]_[FileNumber]_13M.xlsx	/OHC/Post Payment Recovery	APL 21-002
Monthly CCS File Review	Monthly	1/1-1/31	February 15, 2023	MC 25C1 - Care Management Requirements - Delegation and Monitoring	CM	IPACode_CCS File Review_MM_2023	IPA Oversight / Year/ Month	Guidelines for Care Management
		2/1-2/28	March 15, 2023					
		3/1-3/31	April 15, 2023					
		4/1-4/30	May 15, 2023					
		5/1-5/31	June 15, 2023					
		6/1-6/30	July 15, 2023					
		7/1-7/31	August 15, 2023					
		8/1-8/31	September 15, 2023					
		9/1-9/30	October 15, 2023					
		10/1-10/31	November 15, 2023					
		11/1-11/30	December 15, 2023					
		10/1-12/31	January 15, 2024					
Quarterly Provider Payment Dispute Resolution	Quarterly	1/1-3/31	April 30, 2023	MC 20G - Claims and Provider Dispute Resolution Reporting	Financial Compliance	IPAName_Quarterly PDR_LOB_Q1_2023	Claims Timeliness	28 CCR 1300.71 Section (e)(3)
		4/1-6/30	July 31, 2023			IPAName_Quarterly PDR_LOB_Q2_2023		
		7/1-9/30	October 31, 2023			IPAName_Quarterly PDR_LOB_Q3_2023		
		10/1-12/31	January 31, 2024			IPAName_Quarterly PDR_LOB_Q4_2023		
Quarterly Statement of Deficiencies Report	Quarterly	1/1-3/31	April 30, 2023	MC 20G - Claims and Provider Dispute Resolution Reporting	Financial Compliance	IPAName_Month of Report_LOB_Q1_2023	Claims Timeliness	28 CCR 1300.71 Section (q)(1)
		4/1-6/30	July 31, 2023			IPAName_Month of Report_LOB_Q2_2023		
		7/1-9/30	October 31, 2023			IPAName_Month of Report_LOB_Q3_2023		
		10/1-12/31	January 31, 2024			IPAName_Month of Report_LOB_Q4_2023		
Balance Sheet, Income Statement, Cash flow Statement, Supporting Worksheets for IBNR	Quarterly	1/1-3/31	May 15, 2023	MC 19A - Financial Viability	Financial Compliance	IPAName_Quarterly IBNR_LOB_Q1_2023	Financial Statements	California Code of Regulations: 1300.75.4.2
		4/1-6/30	August 15, 2023			IPAName_Quarterly IBNR_LOB_Q2_2023		
		7/1-9/30	November 15, 2023			IPAName_Quarterly IBNR_LOB_Q3_2023		
		10/1-12/31	February 15, 2024			IPAName_Quarterly IBNR_LOB_Q4_2023		

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Organizational Informational Disclosures	Quarterly	1/1-3/31	May 15, 2023	MC 19A - Financial Viability	Financial Compliance	IPAName_Quarterly Financial Info Disc_LOB_Q1_2023	Financial Statements	California Code of Regulations: 1300.75.4.2
		4/1-6/30	August 15, 2023			IPAName_Quarterly Financial Info Disc_LOB_Q2_2023		
		7/1-9/30	November 15, 2023			IPAName_Quarterly Financial Info Disc_LOB_Q3_2023		
		10/1-12/31	February 15, 2024			IPAName_Quarterly Financial Info Disc_LOB_Q4_2023		
IPA Oversight-Quarterly UM Program Evaluation / HICE Report	Quarterly	1/1-3/31	May 15, 2023	MC 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_UM Program Evaluation_HICE_Q1_2023	IPA Oversight / Year/ Quarterly	FDR Oversight
		4/1-6/30	August 15, 2023			IPACode_UM Program Evaluation_HICE_Q2_2023		
		7/1-9/30	November 15, 2023			IPACode_UM Program Evaluation_HICE_Q3_2023		
		10/1-12/31	February 15, 2024			IPACode_UM Program Evaluation_HICE_Q4_2023		
IPA Oversight-Quarterly UM Workplan Update /Evaluation / HICE Report	Quarterly	1/1-3/31	May 15, 2023	MC 25E2 - Utilization Management - Reporting Requirements	UM	IPACode_UM Program Evaluation_HICE_Q1_2023	IPA Oversight / Year/ Quarterly	FDR Oversight
		4/1-6/30	August 15, 2023			IPACode_UM Program Evaluation_HICE_Q2_2023		
		7/1-9/30	November 15, 2023			IPACode_UM Program Evaluation_HICE_Q3_2023		
		10/1-12/31	February 15, 2024			IPACode_UM Program Evaluation_HICE_Q4_2023		
IPA Oversight-Annual UM Program Description	Annual	1/1-12/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_UM Program Description_2023	IPA Oversight / Year / Annual	FDR Oversight

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
IPA Oversight-Annual UM Work plan / Initial / HICE Report	Annual	1/1-12/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_Initial UM Workplan_HICE Report_2023	IPA Oversight / Year / Annual	FDR Oversight
IPA Oversight-Annual UM Program Evaluation	Annual	1/1-12/31	February 15, 2023	MC 25E2 - Utilization Management Reporting Requirements	UM	IPACode_UM Program Evaluation_2023	IPA Oversight / Year / Annual	FDR Oversight
IPA Oversight- Semi-Annual UM System Controls Reports	Semi-Annual	1/1/2022-6/30/2022	As required for Annual DOA	MC 25D - Quality Management Reporting Requirements	QM	IPACode_UM System Controls_Q1-Q2_2022	IPA Oversight / Year / Semi-Annual	FDR Oversight
IPA Oversight- Semi-Annual UM System Controls Reports	Semi-Annual	7/1/2022-12/31/2022	February 15, 2023	MC 25D - Quality Management Reporting Requirements	QM	IPACode_UM System Controls_Q3-Q4_2022	IPA Oversight / Year / Semi-Annual	FDR Oversight
IPA Oversight- Semi-Annual Credentialing (CR) System Controls Reports	Semi-Annual	1/1/2022-6/30/2022	As required for Annual DOA	MC 25D - Quality Management Reporting Requirements	QM	IPACode_CR System Controls_Q1-Q2_2022	IPA Oversight / Year / Semi-Annual	FDR Oversight
IPA Oversight- Semi-Annual Credentialing (CR) System Controls Reports	Semi-Annual	7/1/2022-12/31/2022	February 15, 2023	MC 25D - Quality Management Reporting Requirements	QM	IPACode_CR System Controls_Q3-Q4_2022	IPA Oversight / Year / Semi-Annual	FDR Oversight
Annual QM GQP4P Workplan	Annual	1/1-12/31	As designated by P4P Program	MC 25D - Quality Management Reporting Requirements	QM	As designated by P4P Program	IPA Oversight / Year / Annual	P4P Program
Compliance-Compliance Program Description	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	MMCM Chapter 21
Compliance- FWA Program Description	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24D FWA Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, Part 422 and 423; Code of Federal Regulations, Title 42, §438.608 and §455.2; Federal False Claims Act, US Code, Title 31; Health & Safety Code §1348; Welfare & Institutions Code, §14043.1; CMS 2007 MA-PDP Contract H5640, Attachment A

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Compliance- HIPAA Privacy Policies and Procedures	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 23B HIPAA Privacy and Security	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 45, Part 160, 162, and 164; U.S. Dept. of Health and Human Services (DHHS), section 13402(h)(2) of Public Law 111-5 (HITECH ACT).
Compliance - Standards/Code of Conduct	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(1)(i)
Compliance - Copies of Compliance, FWA, and Privacy Trainings	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description MC 24D FWA Program Description MC 23B HIPAA Privacy and Security	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(iv)
Compliance - Compliance Committee or Subcommittee Minutes & Sign Ins	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(iii)
Compliance - Annual Compliance Workplan	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42 §§422.503(b)(4)(vi)(F) & 423.504(b)(4)(vi)(F)
Compliance - Annual Audit Plan	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(vi)
Compliance - Annual Risk Assessment	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §438.608(a)(vi)
Compliance - Sanction/Exclsion Screening Process policies and procedures	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	Code of Federal Regulations, Title 42, §10011901).
Compliance - List of Downstream Entity/ Subcontractors	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description MC 24D FWA Program Description	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Confidentiality Statement policies and procedures	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 23B HIPAA Privacy and Security	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Employee Universe List	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24E Compliance Program Description	Compliance	N/A	IPA Oversight / Compliance	
Compliance - List of Privacy Incidents	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 23B HIPAA Privacy and Security	Compliance	N/A	IPA Oversight / Compliance	
Compliance - List of FWA cases	Annual	7/1/2022-6/30/2023	As required for Annual DOA	MC 24D FWA Program Description	Compliance	N/A	IPA Oversight / Compliance	

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
Compliance - Data Integrity Controls and Access Safeguards policies and procedures	Annual	1/1-12/31	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Medical management systems used for UM, CM, and Claims functions	Annual	1/1-12/31	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - System administration/IT rep for user access to medical management systems used for UM, CM, and Claims functions	Annual	1/1-12/31	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Walkthrough of medical management systems: data interity controls and access safeguards validation	Annual	1/1-12/31	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - User Types Universe	Annual	1/1-12/32	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Compliance - Active Users Universe	Annual	1/1-12/33	As required for Annual DOA	MC 23D HIPAA Protected Health Info (PHI)	Compliance	N/A	IPA Oversight / Compliance	
Annual Claims Payment and Dispute Resolution Mechanism Report	Annual	10/01/2022 – 09/30/2023	11/30/2023	MC_20G Claims and Provider Dispute Reporting	Financial Analysis	IPACode_Annual Claims PDR Resolution_2023	Claims Timeliness	28 CCR 1300.71 Section (q)(2) and (q)(A).
Annual Audited Financial Statements, Including IBNR Certification Financial Statements, Including IBNR Certification	Annual	Fiscal Year	5 Months after end of your IPA's Fiscal Year	MC 19A - Financial Viability	Financial Analysis	IPACode_Annual Financial Statement_2023	Financial Statements	California Code of Regulations: 1300.75.4.2
~~Credentialing and Recredentialing Report~~	~~Monthly~~	~~1/1-1/31~~	~~February 15, 2023~~	~~MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates~~	~~Credentialing (CR)~~	~~IPACode - YYYY-MM - Credentialing and Recredentialing Report~~	~~./Credentialing/ and Email to CredentialingProfileSubmission@iehp.org~~	~~Per most current IEHP, NCQA, State and regulatory guidelines~~
		~~2/1-2/28~~	~~March 15, 2023~~					
		~~3/1-3/31~~	~~April 15, 2023~~					
		~~4/1-4/30~~	~~May 15, 2023~~					
		~~5/1-5/31~~	~~June 15, 2023~~					
		~~6/1-6/30~~	~~July 15, 2023~~					
		~~7/1-7/31~~	~~August 15, 2023~~					
		~~8/1-8/31~~	~~September 15, 2023~~					
		~~9/1-9/30~~	~~October 15, 2023~~					
		~~10/1-10/31~~	~~November 15, 2023~~					
		~~11/1-11/30~~	~~December 15, 2023~~					
		~~12/1-12/31~~	~~January 15, 2024~~					
Credentialing and Recredentialing Report	Quarterly	1/1-3/31	May 15, 2023	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPACode - YYYY-Q1 - Credentialing and Recredentialing Activities Report	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
		4/1-6/30	August 15, 2023			IPACode - YYYY-Q2 - Credentialing and Recredentialing Activities Report		
		7/1-9/30	November 15, 2023			IPACode - YYYY-Q3 - Credentialing and Recredentialing Activities Report		

INLAND EMPIRE HEALTH PLAN

Medi-Cal Provider Reporting Requirements Schedule

IPA Medi-Cal Calendar Year Reporting Period 2023

IPA Deliverable	Report Frequency	CY 2023 Reporting Period	Date Due to IEHP	Policy Number (s)	Department(s)	File Naming Convention	SFTP Folder	Regulatory Measure(s)
		10/1-12/31	February 15, 2024			IPACode - YYYY-Q4 - Credentialing and Recredentialing Activities Report		
~~Review of Recred Report provided by IEHP (by the 5th of each month)~~	~~Monthly~~	~~1/1-1/31~~	~~February 15, 2023~~	~~MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates~~	~~Credentialing (CR)~~	~~IPA - YYYY-MM - Recredentialing Report (IEHP to IPA Code)~~	~~/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org~~	~~Per most current IEHP, NCQA, State and regulatory guidelines~~
		~~2/1-2/28~~	~~March 15, 2023~~					
		~~3/1-3/31~~	~~April 15, 2023~~					
		~~4/1-4/30~~	~~May 15, 2023~~					
		~~5/1-5/31~~	~~June 15, 2023~~					
		~~6/1-6/30~~	~~July 15, 2023~~					
		~~7/1-7/31~~	~~August 15, 2023~~					
		~~8/1-8/31~~	~~September 15, 2023~~					
		~~9/1-9/30~~	~~October 15, 2023~~					
		~~10/1-10/31~~	~~November 15, 2023~~					
		~~11/1-11/30~~	~~December 15, 2023~~					
		~~12/1-12/31~~	~~January 15, 2024~~					
Review of Recred Report provided by IEHP (by the 5th of each month)	Quarterly	1/1-3/31	May 15, 2023	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPA - YYYY-Q1 - Recredentialing Report (IEHP to IPA Code)	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
		4/1-6/30	August 15, 2023			IPA - YYYY-Q2 - Recredentialing Report (IEHP to IPA Code)		
		7/1-9/30	November 15, 2023			IPA - YYYY-Q3 - Recredentialing Report (IEHP to IPA Code)		
		10/1-12/31	February 15, 2024			IPA - YYYY-Q4 - Recredentialing Report (IEHP to IPA Code)		
Current Profile, Contract and W-9 (to include any applicable attachments i.e. Attachment I, Practice Agreements, Standardized Procedures, Applicable Contract Addendums)	As needed	Not Applicable	As required for Initial Credentialing Applications	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPA Code_Last Name, First Name_YYYY_MM_DD (YYYY_MM-DD = Date submitted to IEHP)	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
Provider Submission via Excel Spreadsheet	As needed	Not Applicable	As required for Initial Credentialing Applications	MC 25B10 - Credentialing Standards, Credentialing Quality Oversight of Delegates	Credentialing (CR)	IPA_Code_Provider Profile Additions_YYYY_MM_DD (YYYY_MM-DD = Date submitted to IEHP)	/Credentialing/ and Email to CredentialingProfileSubmission@iehp.org	Per most current IEHP, NCQA, State and regulatory guidelines
Written and approved Credentialing, Recredentialing, Peer Review Policies and Procedures	As needed	01/31 - 12/31	Within (30) days following Credentialing Committee approval and prior to on-site and/or desktop audit	MC05A8 - Credentialing Standards - Delegation of Credentialing	Credentialing (CR)	N/A	IPA Oversight/Credentialing	

IPA NAME:			IPA CODE:		00A	
	FUNCTIONAL AREA	Pts Poss	Raw Score	Pts Score	IEHP Expectation	IEHP Scoring
I	CLAIMS				Total possible points: 20	
1	Claims Audit – 01/22 - 12/22 (9 points)					
	A	Audit Type:_____ Audit Date: _____ Number of CARs. (If an Annual Audit and Verification Audit are performed in the same year, only the Annual Audit Score will apply.	3			Annual Audits: No CARs are received. All Verification Audits must pass.	Annual Audit: No CARs =3 1-3 CARs = 2, 4-7 CARs =1,>7 CARs =0, Verification Audit: Pass= 2, Fail=0, ≥2 Verification Audits: Pass=1, Fail=0
	B	Were all Claims Universes submitted timely, accurately and completed in their entirety?	1			Provides complete and accurate Claims Universe by due date	YES=1; NO=0
	C	Were all Claims Audit documents submitted timely, accurately and completed in their entirety?	1			Provides complete and accurate Audit Documents by due date	YES=1; NO=0
	D	If IPA was required to submit a CAP resulting from the Annual Audit, was it accepted on the first submission? For Verification Audits, was the CAP implemented?	1			Annual Audits: CAP is accepted upon first submission. Verification Audit: CAP is implemented.	0-1 CAP=1 >1 CAP=0
	E	Were CAPs submitted timely for the Annual Audit?	1			Provides CAP by due date	YES=1; NO=0
	F	Was a Verification Audit required at any time during the year as a result of the audit performed in section A?	1			No Verification Audit required during timeframe	NO=1; YES=0
	G	Was a Focused Audit performed at any time during the year?	1			No Focused Audit required during timeframe	NO=1; YES=0
2	Claims Reports – 01/22 - 12/22 (5 points)					
	A	How many months were the MTRs submitted timely, accurately and completed in their entirety?	2			Complete and Accurate reports submitted by the 15th of each month	10-12 Months=2; 7-9 Months=1; Under 7 Months=0
	B	Were all quarterly reports and the annual report submitted timely, accurately and completed in their entirety?	1			Complete and Accurate reports are submitted by the last day of the month following end of QTR.	YES=1; NO=0
	C	How many extensions were granted over the year?	1			Extensions are requested before the reporting deadline, for extenuating circumstances only	0-3 Extensions= 1; 4 or more Extensions= 0
	D	Did the IPA report whether or not they had any deficiencies through out the year?	1			The IPA must report even if they had no deficiencies	YES=1; NO=0
3	Claims Appeals – 01/22 - 12/22 (4 points)					
	A	Did the IPA have any appealed claims?	4			No appealed claims; if appealed claims proceed to 3B.	0 appeals=4; Go to Question 4; Appealed claims=Go to Question 3B
	B	If Provider had appealed claims:					
	a	What percentage of IPA claims did the IPA fail to respond to IEHP's written request for claims payment or denial information which lead to IEHP having to pay the claim and deduct from the IPA's capitation?	3			Score is equal or less than 24%	100%-75% =0; 74%-50%=1; 49%-25%=2; <25%=3
	b	What percentage of all IPA denials were overturned and paid by IEHP?	1			Score less than or equal to 10%	0-10%=1; >10%=0
4	Member Claim Bills Activity (Bills received by Members for non-payment or balance due for underpayment) - 01/22 - 12/22 (2 points)					
	A	Did the IPA have any Member Claim Bill activities?	2			No Member Bills	0 Member Bills=2; Member Bill activity=Go to Question 4Ba
	B	If IPA had Member Claim Bill activities:					
	a	What percentage of Member Claim Bill cases received did IEHP have to pay and deduct from the IPA's capitation?	2			Score less than or equal to 25%	0-25% =2: <25%=0
		CLAIMS POINTS SCORED:	20				

							IEHP Scoring
II	**COMMUNICATION**				Total possible points: 11		
1	Communication of PCP Changes – 01/22 - 12/22 (4 points)						
	A	Does IPA communicate changes in its PCP network in a timely manner and include required information as stated in policy 18.C?	4			Provides 60-day advance notification for all changes	100%-75%=4; 74%-50%=2; <50%=0
2	Bi-annual Review of Specialty and Ancillary Network - 01/22 - 12/22 (2 points)						
	A	Does IPA complete the online Specialist and Ancillary network on a bi-annual basis in timely, complete manner and including all required information as stated in policy 18.F?	2			Verified network review completed by due date specified in bi-annual request	Complete and Timely Semi-Annual Submission (First Round for CY - Winter) - 1 point; Complete and Timely Semi-Annnual Submission (Second Round for CY - Summer) - 1 point. Timely = Complete Submission Provided to IEHP by Deadline Provided by IEHP
3	Monthly Review of Admitter/Hospitalist Report - 01/22 - 12/22 (2 points)						
	A	Does the IPA respond to Admitter/Hospitalist monthly review emails within 10 days of receipt with corrections or confirmation that information is current and accurate?	2			IPA Admitter/Hospitalist report is emailed to designated contact on the 15th day of each month. Corrections and/or confirmation is received by IEHP within 10 days of receipt.	100-80% = 2; 79-50% = 1; < 50% = 0
4	Submission of Complete Specialist Term Collateral- 01/22-12/22 (3 points)						
	A	Does the IPA submit all required collateral for Specialist Terminations in policy 18.D.2?	3			Complete Collateral is submitted for all specialist terms. Scoring based on complete collateral submitted for each specialist termination submitted to IEHP. The written notification from the IPA to IEHP must include a list of all the Members who have seen the Specialist two (2) or more times in the preceding twelve (12) month period, are currently under on-going care, or have an open referral, as well as a copy of the notification letter sent to Members, including the date the letter was issued to Members.	100-90%=3; 89-80%=2 ; 79-70%=1 < 70%=0
COMMUNICATION POINTS SCORED:			11				

		FUNCTIONAL AREA	Pts Poss	Raw Score	Pts Score	IEHP Expectation	IEHP Scoring
III		**ENCOUNTER DATA**				Total possible points: 8	
1		Monthly Data Submission – 2022 (8 points)					
	A	Are IPA submissions meeting IEHP validity requirements?	4			See standards outlined in Policy 21A	100%-97%=4 96%-75%=3; 74%-50%=1; <50%=0
	B	Are IPA submissions meeting IEHP adequacy requirements?	4			See standards outlined in Policy 21A	100%-97%=4 96%-75%=3; 74%-50%=1; <50%=0
		ENCOUNTER DATA POINTS SCORED:	8				

		FUNCTIONAL AREA	Pts Poss	Raw Score	Pts Score	IEHP Expectation	IEHP Scoring
IV		**FINANCE**				Total possible points: 10	
1		Financial Viability – Calendar Year 2022 Submissions (10 points)					
	A	Does the IPA submit their quarterly financial reports within the required timeframe?	1			Reports submitted to IEHP by the 15th of the month due	100%=1; <100%=0
	B	Did the IPA always pass IEHP's quarterly financial viability test the first time?	1			Passed quarterly financial viability test each quarter; no corrective action needed	PASS=1, FAIL=0
	C	Did the IPA pass DMHC's quarterly financial viability test each quarter?	2			Passed quarterly financial viability test each quarter; no corrective action needed	PASS=2, FAIL=0
	D	Did the IPA submit the current Audited Annual Financial Statement within the required timeframe?	2			Provided as requested by IEHP	YES=2; NO=0
	E	Did the IPA pass the Audited Annual Financial Viability Test?	2			Passed quarterly financial viability test each quarter; no corrective action needed	PASS=2, FAIL=0
	F	Did the IPA secure the required Letter of Credit (LOC)?	2			Provided as requested by IEHP	YES=2; NO=0
		FINANCE POINTS SCORED:	10				

		FUNCTIONAL AREA	Pts Poss	Raw Score	Pts Score	IEHP Expectation	IEHP Scoring
V		**GRIEVANCES**				Total possible points: 6	
1		Member Grievances (Rec'd by IPA) – 01/22 - 12/22 (3 points)					
	A	1. Grievances responses received timely from the IPA? 2. CAP Issued?	3			1. Timeliness/Grievance Response; >90% received within 14 days 2. Corrective action plan (CAP) was not issued during the 2022 reporting period; <1 CAP issued per calendar year	3 points – 1. Timeliness/Grievance Response 90% or above 2. Corrective Action Plan (CAP) issued: 0 per calendar year 2 points - 1. Timeliness/Grievance Response from 80% - 89% 2. CAPs issued: ≤1 CAP issued per calendar year 0 point – 1. Timeliness/Grievance Response less than 80% 2. CAPs issued: ≥2 per calendar year
2		Member Appeals : 01/22 - 12/22 (3 points)					
	A	1. Appeals Reported 2. Over Turn Appeals 3. CAP issued	3			1. Appeals Reported; <10 Appeals reported 2. Corrective action plan (CAP) was not issued; <1 CAP issued per calendar year	3 points – 1. ≤10 Appeals reported; with 0 CAPS issued (OT rate is null) and/or; 2. ≥11 Appeals reported with 0 CAPS, Annual overturn rate ≤25% 2 points – 1. ≥12 Appeals reported 2. OT appeals at ≤26% - 35% annual rate 3. ≤1 CAP issued per calendar year 0 points – 1. ≥11 Appeals reported 2. ≥36% OT appeal annual rate 3. ≥2 or more CAPs issued per calendar year
		GRIEVANCES POINTS SCORED:	6				

		FUNCTIONAL AREA	Pts Poss	Raw Score	Pts Score	IEHP Expectation	IEHP Scoring
VI		**DELEGATION OVERSIGHT AUDIT RESULTS -2022**				Total possible points: 13	
1		Quality Management (1 points)					
	A	Delegation Oversight Audit score:	1			Must score a minimum of 90% to pass audit. Score based upon initial audit score	100-90%=1; < 90%=0
2		Utilization Management (1 points)					
	A	Delegation Oversight Audit score:	1			Must score a minimum of 90% to pass audit. Score based upon initial audit score	100-90%=1; < 90%=0
3		Credentialing (1 points)					
	A	Delegation Oversight Audit score:	1			Must score a minimum of 90% to pass audit. Score based upon initial audit score	100-90%=1; < 90%=0
4		Credential File Review (2 points)					
	A	Delegation Oversight Audit score:	2			Must score a minimum of 90% to pass audit. Score based upon initial audit score	100-96%=2; 95-80%=1; < 80%=0
5		Recredential File Review (2 points)					
	A	Delegation Oversight Audit score:	2			Must score a minimum of 90% to pass audit. Score based upon initial audit score	100-96%=2; 95-80%=1; < 80%=0
6		HDO File Review (2 points)					
	A	Delegation Oversight Audit score:	2			Must score a minimum of 90% to pass audit. Score based upon initial audit score	100-96%=2; 95-80%=1; < 80%=0
7		Care Management (1 Points)					
	A	Delegation Oversight Audit Score:	1			Must score a minimum of 90% to pass audit. Score based upon initial audit score	100-90%=1; < 90%=0
8		Compliance (1 Points)					
	A	Delegation Oversight Audit Score:	1			Must score a minimum of 90% to pass audit. Score based upon initial audit score	100-90%=1; < 90%=0
9		Tool Roadmapped (1 Points)					
	A	DOA Tool Completely Roadmapped and available at time of the IPAs Audit	1			Entire DOA Tool needs to be completed	Complete Tool=1; Incomplete/None=0
10		Documents Submitted Timely (1 Points)					
	A	Was all DOA document request submitted timely, accurately and completed in their entirety?	1			All DOA documentation requests submitted by due date	YES=1; NO=0
		DELEGATION OVERSIGHT AUDIT RESULTS PTS SCORED:	13				

		FUNCTIONAL AREA	Pts Poss	Raw Score	Pts Score	IEHP Expectation	IEHP Scoring
VII		**DELEGATE REPORTING AND MEMBER ACCESS AUDIT**				Total possible points: 32	
1		Monthly Reports – 01/22 - 12/22 (20 points)					
	A	Is the Delegate denial decision turnaround time compliant with guidelines?	4			Compliant with IEHP turn around timeframes 90% of the time.	100-90% = 4; 89-75% = 2; < 75% = 0
	B	Does the Delegate utilize the correct denial letter templates?	4			Delegate utilizes IEHP approved denial letter templates with correct attachments.	100-90% = 4; 89-75% = 2; < 75% = 0
	C	Is the Delegate compliant with all denial guidelines?	4			Complaint with IEHP overall Denial process 90% of the time.	100-90% = 4; 89-75% = 2; < 75% = 0
	D	Is the Delegate compliant with all approval guidelines?	4			Complaint with IEHP overall approval process 80% of the time.	100-90% = 4; 89-75% = 2; < 75% = 0
	E	Does Delegate submit monthly Care Management logs that are comprehensive and adhere to IEHP guidelines?	4			Reports adhere to IEHP policy 12.A.3. and reference all elements.	100-90% = 4; 89-75% = 2; < 75% = 0
2		Reports - 01/22 - 12/22 (4 points)					
	A	Does the Delegate submit Monthly, Semi-Annual and Annual Reports that are timely, comprehensive and adhere to IEHP guidelines?	4			Received by IEHP: Monthly by 15th of every month, Semi Annual by August 15th (Jan 1- June 30) & Annual by February 15th (July 1- Dec 31)	100-90% = 4; 89-75% = 2; < 75% = 0
3		Member Access 01/22 - 12/22 (8 points)					
	A	What percentage of Delegate's PCPs passed the Routine (visit within 10 days) appointment access audit?	2			Score is ≥ to 75%	100%-75%=2; 74%-50%=1; <50%=0
	B	What percentage of Delegate's PCP passed the Urgent (visit within 48 hours) appointment availability audit?	2			Score is ≥ to 75%	100%-75%=2; 74%-50%=1; <50%=0
	C	What percentage of Delegate's Specialist passed the Routine (visit within 15 days) appointment access audit?	2			Score is ≥ to 75%	100%-75%=2; 74%-50%=1; <50%=0
	D	What percentage of Delegate's Specialist passed the Urgent (visit within 48 hours) appointment availability audit?	2			Score is ≥ to 75%	100%-75%=2; 74%-50%=1; <50%=0
		SCORED:	32				

	SCORING SUMMARY*		
		TOTAL POINTS SCORED	**TOTAL POINTS POSSIBLE**
I	CLAIMS	0	20
II	COMMUNICATION	0	11
III	ENCOUNTER DATA	0	8
IV	FINANCE	0	10
V	GRIEVANCES	0	6
VI	DELEGATION OVERSIGHT AUDIT RESULTS	0	13
VII	DELEGATE REPORTING AND MEMBER ACCESS AUDIT	0	32
TOTAL POINTS		0	100
TOTAL PERCENTAGE		**0%**	**100%**

 # CONTRACT YEARS AWARDED

Providers achieving the following percentages:	Are awarded a contract term of:
95% or above	3 years
85% to 94.99%	2 years
80% to 84.99%	1 year
Less than 80%	Non-renewal

Any functional area not reviewed in the PET timeframe will not be included as part of the total score

IEHP
INLAND EMPIRE HEALTH PLAN

Corrective Action Plan (CAP) Form

COMPLETION INSTRUCTIONS
Please complete the below form. Fields that are BOLD are required. (Root Cause Analysis, Action Plan and Monitoring Plan)
E-Sign at the "X" by double-clicking or right-clicking with your mouse in the space provided below.
*If E-signature is not available, you may submit a signed and dated PDF copy along with this Microsoft Word version of this form.
This CAP is due to IEHP within 30 days from the date of request.
If you have any questions regarding this CAP, please contact Juan Ortega at Ortega-J2@iehp.org.

IPA: Choose an IPA
Original Date Sent to IPA: Click here to enter a date
CAP DUE DATE: Click here to enter a date

Finding #	File Month/Year	Type	Findings (As identified by IEHP audit)	Response Number (Initial response row #1, secondary response row #2)	**Completed by IPA: Root Cause Analysis (Examples: policy, process, vendor, technology, reporting, staffing, training, etc. Was an Impact Analysis conducted on providers or impacted members? If so, provide those results.)**	**Completed by IPA: Action Plan (Clearly define the plan to remediate all deficiencies including impacted departments, required system updates, policy updates, staff training, member outreach, follow up or transition plans, implementation due dates, Committee Approvals or Board updates, Provider Updates, and monitoring plan)**	**Completed by IPA: Monitoring Plan (Identify what policy and work process updates will be put in place to monitor performance going forward. Include what actions will be taken to report deficiencies or trigger actions to address potential compliance risks.)**	CAP received from IPA	CAP Status	Decision/ Notification Date	Additional Documents Required / Comments
1				1							
				2							
				3							
				4							
2				1							
				2							
				3							
				4							
3				1							
				2							
				3							
				4							

CAP Attestation:

By signing below, I attest that the information in this Corrective Action Plan (CAP) including the Root Cause Analysis, Action Plan and Monitoring Plan will be implemented as stated in this form. **Please sign and date with each CAP submission.**

First CAP Response:	
Printed Name of Signing Individual	**Title of Signing Individual**
Signature	**Date**

Second CAP Response:	
Printed Name of Signing Individual	**Title of Signing Individual**
Signature	**Date**

Third CAP Response:	
Printed Name of Signing Individual	**Title of Signing Individual**
Signature	**Date**

CAP Attestation Instructions:

Please sign and date the form with each CAP submission, until the CAP form has been accepted. Initial Response, secondary response, etc.
Signature line: IPA to sign document using a scanned image with an approved document signer.
The CAP form will be returned if it is received without an approved signature for each response submission (see provided example).