25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

1. Delegated Activities

APPLIES TO:

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

POLICY:

A. IEHP evaluates and audits contracted Delegates in accordance with current applicable National Committee for Quality Assurance (NCQA) accreditation standards, Centers for Medicare and Medicaid Services (CMS) regulatory requirements, Department of Managed Health Care (DMHC) 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.[1]

DEFINITION:

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

PROCEDURES:

A. IEHP performs an initial, monthly, and annual audits of the following delegated activities:
   1. Quality Management and Improvement;
   2. Utilization Management;
   3. Encounter Data;
   4. Credentialing and Re-credentialing;
   5. Care Management; and
   6. Claims Process and Payment.

B. IEHP performs initial, monthly annual and as needed audits of the following regulatory requirements:
   1. Compliance (Fraud, Waste, and Abuse Program);
   2. Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security; and

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

3. Financial Viability.

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

1. For each activity, IEHP has identified its expectations and reporting requirements to be achieved (See, "IPA Delegation Agreement – IEHP DualChoice" and "Medicare Provider Reporting Requirements Schedule" found on IEHP website[2]).

D. IEHP provides each Delegate with the results of audit and monitoring activities and deficiencies in their delegated activities within 30 calendar days of the scheduled audit date.

E. Delegates identified to be deficient in a delegated activity are required to submit a Corrective Action Plan (CAP). See Policy 25A3, "Delegation Oversight – Corrective Action Plan Requirements.

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

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

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[2] https://www.iehp.org/en/providers/provider-resources?target=forms

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
2. Delegation Oversight Audit

APPLIES TO:

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

POLICY:

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

B. IEHP does not delegate Quality Management and Improvement (QI), QI Health Equity Transformation Program, 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 Delegation Oversight Audits are conducted by IEHP functional departments (Provider Services, Compliance, Credentialing, Quality Management, Utilization Management, and Care Management (CM) to ensure that Delegates' are complying with IEHP requirements and maintain their ability to perform delegated functions in QI, UM, Credentialing/Re-credentialing, Compliance and Fraud, Waste and Abuse (FWA) Programs, HIPAA Privacy & Security Program, CM, Claims and related activities on an annual basis.[1]

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

DEFINITION:

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

PROCEDURES:

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

B. To coordinate and schedule audits, IEHP must provide written notice to the Delegate's staff at least 60 business days in advance of the scheduled audit. The Delegate receives audit preparation instructions (See "Delegation Oversight Audit Preparation Instructions – IEHP

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

DualChoice" on the IEHP website[2]) 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.[3]

C. In preparation for the audit the Delegate should:

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

D. At the time of the audit, the Delegate must have:

1. All requested documents ready; and
2. Have appropriate staff available for each functional area that is being audited.
3. Credentialing Must Pass Elements. If the Delegate does not score "MET" in a Must Pass Element, they must submit a corrective action plan (CAP) within thirty (30) calendar days following receipt of final report, which may require a re-survey. The following credentialing requirements are "MUST-PASS" Elements:
   a. CR 1: Credentialing Policies
      1) Element C: Credentialing System Controls
      2) Element D: Credentialing System Controls Oversight
   b. insurance, are kept current.

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

F. Delegation Oversight Annual Audit of Care Management activities will be an aggregated score of the case reviews conducted with IEHP review team and Delegates monthly throughout each calendar year.

G. The Delegate receives an exit interview with the IEHP review team at the completion of each session of the Delegation Oversight Audit. This interview identifies areas found to be deficient giving the Delegate an opportunity to provide additional information to clear the deficiency within two (2) business days. If the deficiency is not remediated, opportunities for improvements will be addressed through the Corrective Action Plan (CAP) process.

H. Within 30 calendar days of the audit, the Delegate receives written notification of the results. The written notification includes a cover letter and completed audit tools noting any

[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] Title 42 Code of Federal Regulations (CFR) § 438.230

deficiencies found during the audit. The cover letter notes the timeframes for corrective action, and any other pertinent information.

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

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

J. 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.

K. All Delegates that score 90% or greater pass that section of the audit. A CAP is required for all scores that fall below 90%. However, a CAP may be issued at the discretion of IEHP, regardless of the score, even if the score is 90% or above. Failure to meet the minimum threshold for any must- pass elements for Credentialing, will result in a CAP response to be submitted to IEHP within 30 calendar days after the receipt of the Delegation Audit Results and must meet IEHP approval. All CAPs submitted to IEHP must meet the Corrective Action Plan Requirements noted in Policy 25D3, "Quality Management - Corrective Action Plan Requirements."

L. 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.

M. 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.

N. 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 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.

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

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
2. Delegation Oversight Audit

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

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

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25. DELEGATION AND OVERSIGHT

A. Delegation Oversight

3. Corrective Action Plan Requirements

APPLIES TO:

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

POLICY:

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

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

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

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

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

DEFINITION:

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

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

PROCEDURES:

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

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
3. Corrective Action Plan Requirements

Delegation Oversight Audit CAP

A. IEHP monitors Delegate compliance with requirements set forth by IEHP, Centers for Medicare and Medicaid Services (CMS), Department of Managed Health Care (DMHC), 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, HIPAA, 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. Compliance;
    d. HIPAA Security;
    e. Credentialing & Recredentialing; and
    f. 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 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. 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.

8. 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 15 calendar days to IEHP.

9. 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 30 calendar days to adequately correct the deficiencies.

CAP Timeline

A. Upon receipt of the initial CAP, IEHP reviews the CAP and either approves or denies the CAP in writing within seven (7) calendar days of receipt. If the CAP is denied:

   1. IEHP will communicate all remaining deficiencies to the Delegate, with a written request for additional documentation.

   2. The Delegate is required to submit additional documentation within 15 calendar days to IEHP.

   3. IEHP reviews and either approves or denies the CAP in writing within seven (7) calendar days of receipt. If the additional documentation is approved, the CAP is accepted.

ICAP Timeline

A. Upon receipt of the initial ICAP, IEHP reviews the ICAP and either approves or denies in writing within 72 hours of receipt. If the ICAP is denied:

1. IEHP will communicate all remaining deficiencies to the Delegate, with a written request for additional documentation.
2. The Delegate is required to submit additional documentation within 72 hours of receipt to IEHP.
3. If the additional documentation is approved, the ICAP is accepted.

B. IEHP monitors for subsequent Delegate deficiencies through review of grievances, assessment of reports, and results of activities related to each area addressed by the ICAP.

C. If the Delegate fails to demonstrate sustained improvement depending on the nature of the findings and the severity of the deficiencies. IEHP may elect to take any of the following actions:

1. Conduct a validation audit;
2. Placement on concurrent review;
3. Increased monitoring and reporting;
4. Delegate is frozen to new Member enrollment;
5. Financial Sanction;
6. Request for cure under contract compliance;
7. De-delegation of specified functions;
8. Contract non-renewal; or
9. Contract termination.

Appeal of CAPs and ICAPs

A. 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 30 calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.

B. 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.

Failure to submit a CAP

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

1. Delegates are frozen to new Member assignment;
2. Financial Sanction;

3. Request for cure under contract compliance;
4. Requirement to subcontract out the deficient activities within Management Services Organization (MSO) or Delegates;
5. De-delegation of specified functions;
6. Contract non-renewal; or
7. Contract termination.
8. Upon receipt of the Corrective Action Plan, IEHPs will review for compliance and:
    a. May elect to keep the CAP open while the Delegates performance is monitored for sustained improvements; or
    b. Complete a validation audit following the implementation of the audit (as needed).

Failure to Implement Corrective Action Plan

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

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. 24 hour access studies;
    7. Language competency audits;

8. Clinical audits (including asthma, diabetes, etc.);
9. Specific quality studies;
10. Focused audits;
11. Pharmacy audits;
12. Audits determined necessary by the Delegation Oversight Committee;
13. Follow up audits; and /or
14. Universe and Log Data Quality and Validation Audits.

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

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

1. Delegated Entities are evaluated and monitored for performance on an ongoing basis through the various sources, to include but not limited to:
    a. Pre-Delegation Audits
    b. Annual Audits
    c. Focused Audits
    d. Clinical Audits
    e. Delegate Reporting

D. Within 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). The cover letter defines the timeframes for corrective action, and any other pertinent information.

1. The Delegates must submit a complete and comprehensive CAP response to IEHP that adequately addresses all deficiencies for each section within the CAP/ICAP.
2. The Delegates are responsible for coordination of their CAP response with each of its internal departments responsible for addressing audit deficiencies.
3. IEHP does not accept CAPs for multiple deficiencies when received in individual sections. These are returned to the Delegates and considered delinquent until a complete and all-inclusive CAP is received.
4. Each section of the CAP response must be clearly identified with supporting documentation attached and clearly labeled.

5. The ICAP form findings must be submitted to IEHP within 72 hours of the issuance of the written notification. The standard CAP form must be submitted within 30 calendar days of written notification by IEHP of the audit results.
    a. The Audit or Study score received for each section;
    b. A listing of the deficiencies as identified by IEHP;
    c. CAPs must identify the root cause analysis for the deficiency;
    d. CAPs must specifically state how the deficiency is corrected along with supporting documentation, including policies and procedures, training agenda, training materials, and sign in sheets when applicable;
    e. Completion dates for each of the corrective actions;
    f. Identification and signature of the person responsible for completing the corrective action; and
    g. Follow-up or monitoring plan to ensure that the corrective action plan is successful.
6. If the CAP is incomplete:
    a. IEHP will communicate all remaining deficiencies to the Delegates with a written request for an updated CAP including request for additional documentation and/ or any other documents as part of the CAP response.
    b. For standard CAP findings, the Delegates are required to resubmit an updated CAP response within 15 calendar days 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.

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

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

25. DELEGATION AND OVERSIGHT

A. Delegation Oversight
   3. Corrective Action Plan Requirements

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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards

1. Credentialing Policies

APPLIES TO:

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

POLICY:

A. IEHPs Delegates must 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 90 days prior of any such changes.

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

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

PURPOSE:

A. IEHP promulgates credentialing and recredentialing decision guidelines for Practitioners credentialed and contracted by IEHP's Delegates to perform these activities. Delegates are expected to use these guidelines for recommended education and/or training for PCPs and Specialists, patient age ranges for Practitioners, hospital arrangements, and recommendations for review of malpractice or other adverse history when making credentialing and recredentialing decisions.

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

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

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

and appropriate state-licensing agency.

DEFINITION:

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

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

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

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

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

F. Delegate: If the organization 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]

[2] 42 CFR § 422.204

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 Member to see a specific practitioner or group of Practitioners, including all Practitioners whom Member can select as Primary Care Provider (PCP).
    c. Practitioners who provide care to Members under the organization's medical benefits.
    d. The criteria listed above apply to Practitioners in the following settings:
        1) Individual or group practices
        2) Facilities
        3) Telemedicine
    e. Delegates are required to contract with and credential all their Practitioners defined as PCPs, Specialists, Non-Physician Practitioners, and Physician Admitters, including employed Physicians participating on the Provider panel and published in external directories who provide care to Members. At minimum, the Credentialing policies and procedures include the following types of Practitioners and describes which Providers the Delegate credentials:
        1) Doctor of Medicine (M.D.)
        2) Doctor of Osteopathic Medicine (D.O.)
        3) Doctor of Podiatric Medicine (D.P.M.)
        4) Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), who provide medical services only
        5) Occupational Therapists (O.T.)
        6) Physical Therapy (P.T.)
        7) Physician Assistants (P.A.) or Physician Assistants Certified (P.A.-C)
        8) Certified Nurse Midwives (C.N.M.)[4]
        9) Nurse Practitioners (N.P.)

[3] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 1, Element A, Factor 1
[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

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

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

1) Doctor of Chiropractic (D.C.)
2) Licensed Acupuncturists (L.Ac.)

[5] DHCS APL 18-022

3) Optometrists (O.D.)
4) Psychiatrists (M.D.)
5) 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)[6]

2. Delegates' credentialing policies and procedures describe the sources the organization uses to verify credentialing information. The policy must describe the sources used to verify credentialing information of each of the following criterion listed below. All verification sources must be included in policy to ensure compliance with IEHP.[7]

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

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

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

[6] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3.
[7] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 2

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: 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) American Medical Association (AMA) Physician Master File

3) American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File

4) Delegates 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.

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

c. Education and Training (VTL: Prior to the Credentialing Decision) Delegates 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. Delegates must:

- Obtain written confirmation of primary source verification from the primary source, at least annually; or

- Provide 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

- Provide 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.
    - Delegates must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.

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

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

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

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

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

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

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

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

1) For all Practitioner types

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

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

- ABMS or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
    - The ABMS "Is your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
- AMA Physician Master File.
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
- Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards perform primary source verification of completion of education and training.

3) For other health care professionals

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

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

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

5) For Nurse Practitioners (N.P.)

- American Association of Nurse Practitioners (AANP).
- American Nurses Credentialing Center (ANCC).

- 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: 180 calendar days prior to Credentialing decision date) Delegates 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: 180 calendar days prior to Credentialing decision date). Delegates will obtain confirmation of the past seven (7) years of malpractice settlements through one of the following sources:

1) Malpractice Insurance Carrier;

2) National Practitioner Data Bank Query; or

3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within 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: Delegates must verify that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating Hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be confirmed with the Hospital, in writing, via approved website or verbally.

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

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

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

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

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

i. State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: 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 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 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.[8]

2) The Medi-Cal Suspended and Ineligible list must be one (1) of the verification source for Medicaid sanctions, to ensure compliance with DHCS.[9]

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.[10]

3. Delegates' policies require credentialing of Practitioners before they provide care to Members. IEHP does not allow provisional credentialing. Policies must define the criteria required to reach a credentialing decision and must be designed to assess the Practitioner's ability to deliver care. This criterion is used to determine which

[8] DHCS APL 22-013
[9] Ibid.
[10] Ibid.

Practitioners may participate in its network, which may include, but are not limited to:[11]

a. Verification of Credentials

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

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

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

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

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

- If the Practitioner is not board certified in the subspecialty in which he/she is applying, there must be evidence of verification of residency and training in the subspecialty (e.g. Fellowship in Cardiology, Rheumatology, Pediatric Endocrinology, etc.), as relevant to the credentialed specialty, and meet the training requirements as set forth by ABMS or AOA.

IEHP designated specialty requirements:

- Bariatric Surgery requirements effective January 1, 2019. Meet the

[11] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 3

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 "Bariatric Surgeon Case Volume Attestation" found on the IEHP website[12]) to indicate volume of the following:
  - Volume of applicant's proctored cases; and
  - Volume of cases where applicant was the primary surgeon.
    - IEHP requires a minimum of 15 cases where applicant was the primary surgeon.[13]
- 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)**

[12] https://www.iehp.org/en/providers?target=forms
[13] American Society for Metabolic and Bariatric Surgery Standard Manual, https://www.facs.org/~/media/files/quality%20programs/bariatric/mbsaqip%20standardsmanual.ashx

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 28 weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
  - The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted hospital linked with that IPA network.

- **Family Practice 2: Family Practice that includes full OB services and delivery)** must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:
  - Have and maintain full delivery privileges at an IEHP contracted hospital.
  - Provide a written agreement for an available OB back up Provider is required.
    - The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP hospital linked with the Family Practice Provider; and
    - Provide a protocol for identifying and transferring high risk members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc).
- Effective August 1, 2023, Internal Medicine practitioners may not expand their age range to all ages unless they have board eligibility or board certification in Pediatrics.
- Effective August 1, 2023, Pediatric Practitioners may not expand their age range to all ages unless they have board eligibility or board certification in Internal Medicine.
- **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:
  - Documentation of primary care practice in the United States;
  - 25 Continuing Medical Education (CME) units for most recent three (3) year period, of which must be in primary care related areas;

- Applicants must provide two (2) letters of recommendation from a physician coworker (i.e. Primary Care Providers with work experience associated with the applicant in the preceding 24 months); and
  - The physician coworkers must hold an active board certification in a Primary Care Specialty (i.e. board certified in Internal Medicine, Family Practice or Pediatrics).
- In lieu of having full Hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc), must be available for consultations, as needed and that the OB will provide prenatal care after 28 weeks gestation including delivery. (See "Patient Transfer Agreement" found on the IEHP website[14]).
  - The Agreement must include back-up physician's full delivery privileges at IEHP network hospital, in the same network as the non-admitting OB Provider.
  - The OB Provider must be credentialed and contracted within the same network.

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

- **Specialties not recognized by either board (ABMS or AOA) are subject to Medical Director, Chief Medical Officer Review.** Further review may be completed by the Credentialing Subcommittee or Peer Review Subcommittee, who will either approve or deny.
- **Urgent Care Providers** must:
  - Meet the education and training requirements set forth by ABMS or AOA for at least one (1) of the following Specialty boards:
    - American Board of Pediatrics
    - American Board of Family Practice
    - American Board of Internal Medicine

[14] https://www.iehp.org/en/providers?target=forms

- American Board of Emergency Medicine
- Osteopathic Board of Pediatrics
- Osteopathic Board of Family Physicians
- Osteopathic Board of Internal Medicine
- 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 for review by Chief Medical Officer (CMO) or an IEHP Medical Director as designated by the CMO. Further review may be completed by the Peer Review Subcommittee. For their review and consideration, the following documents must be submitted:
  - ❖ Provide evidence of 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 25 CME units in Adult Primary Care completed within the last three (3) years if the Provider is requesting to treat adult patients; and
  - ❖ Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding twenty-four (24) months). The physician coworkers must hold an active board certification in Pediatrics, Family Practice or Internal Medicine

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

5) Work History. Delegates 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. Delegates must obtain 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.
- Trends in cases - Practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).

7) Hospital Admitting Privileges. Practitioner must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation(s) or admitting privileges at a participating hospital. Practitioners must have appropriate admitting privileges or arrangements with IEHP's contracted Hospitals, if applicable See Policy 5B, "Hospital Privileges" and See "Hospital Admitting Privileges Reference by Specialty" found on the IEHP website[15]).

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

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

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

9) Grievance History

- Lower than average grievance rate
- Absence of grievance trends

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

b. Sanction Information

[15] https://www.iehp.org/en/providers?target=forms
[16] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3

1) State Sanctions, restrictions on licensure and limitations on scope of practice:
   - Any actions, restrictions or limitations on scope of practice, are presented for review of and discussion to the Credentialing Subcommittee and/or Peer Review Subcommittee.
2) Medicare and Medicaid Sanctions
   - Medi-Cal Suspended & Ineligible List Providers are deemed suspended and ineligible from Medi-Cal will be terminated or not be credentialed and contracted with for Medi-Cal line of business. IEHP does not allow Medi-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 identified on the Medicare Opt-Out will not be contracted for Medicare line of business. IEHP does not allow Medicare Opt-Out Providers to participate in Medicare line(s) business.
   - Preclusions List, Providers identified on the preclusions list will be terminated or not be credentialed and contracted with.[18]

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

1) Attestation to:
   - Reasons for inability to perform the essential functions of the position;
   - Lack of present illegal drug use;
   - History of loss of license and felony convictions;
   - History of loss or limitation of privileges or disciplinary actions;
   - Current Malpractice Insurance coverage; and
   - Malpractice Insurance Coverage: Must have current and adequate malpractice insurance coverage that meets the following criteria:
     - Minimum $1 million per claim/$3 million per aggregate.

[17] DHCS APL 22-013
[18] Centers for Medicare & Medicaid Services, "Preclusion List Requirements", 11/02/2018

- 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. NPs, Nurse Midwives, or PAs)
   - Age Limitations
   - Practitioner Office Hours
   - Practitioner's written plan for continuity of care if they do not have Hospital privileges
   - Languages spoken by Physician
   - Languages spoken by staff

4) Addendum B, used for Professional Liability Action explanation(s).

5) Addendum C, used to confirm Practitioner's status as a:
   - Certified Workers Compensation Provider
   - Reservist

6) Addendum D, Notice to Practitioners of Credentialing Rights/Responsibilities

7) Addendum E, applicable to General Practice and Obstetrics/Gynecology providers who are PCP's.

8) Verification of Qualifications for HIV/AIDS Physician Specialist form (See "Verification of Qualifications for HIV/AIDS Physician Specialist" found on the IEHP website[20]) required for Practitioners who would like to be designated as an HIV/AIDS Specialist.

[19] NCQA, 2023 HP Standards and Guidelines, CR1, Element C, Factor 5
[20] https://www.iehp.org/en/providers?target=forms

9) Transgender Questionnaire (See "Transgender Questionnaire" found on the IEHP website[21]) are required for all Practitioners who are or would like to be designated as a Transgender Competent Provider. At minimum, the Practitioner must meet and provide evidence of the following for consideration:

- Demonstrate 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

10) Licensed Midwife Attestation: Plan for Consultation, Emergency Transfer, & Transport (See "Licensed Midwife Attestation" found on the IEHP website[22]) required for all Licensed Midwife practitioners.

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

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

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

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

- IEHP requires all Advanced Practice Practitioners to practice at the same

[21] https://www.iehp.org/en/providers?target=forms
[22] Ibid.

site as their Supervising Physician.

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

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

- PAs must provide one (1) of the following:
  - Delegation of Services Agreement and Supervising Physician Form[23] (See "Delegation of Services Agreement and Supervising Physician Form" found on the IEHP website[24]).
  - Practice Agreement, effective January 1, 2020,[25] the writing, developed through collaboration among one or more Physicians and Surgeons and one or more PAs, that defines the medical services the PA is authorized to perform[26] and that grants approval for Physicians and Surgeons on the staff of an organized health care system to supervise one or more PAs in the organized health care system. Any reference to a Delegation of Services Agreement relating to PAs in any other law shall have the same meaning as a practice agreement. [27]
- NPs and CNMs are required to have Standardized Procedures. Standardized Procedures must be on-site site specific and:
  - To meet the requirements, reference textbooks and other written sources, which must include:[28]
    (i) Book (specify edition) or article title, page numbers and sections.
  - NP and/or CNM must be practicing at a site assigned to their supervising Physician; and
  - Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the documents must include:
    - Table of Contents of the Standardized Procedures used, between the NP and/or CNM and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
    - Evidence that the Standards of Care established by the sources

[23] Title 16 California Code of Regulations (CCR) § 1399.540(b)
[24] https://www.iehp.org/en/providers?target=forms
[25] Senate Bill 697
[26] Business & Professions Code § 3502
[27] California Code, Unemployment Insurance Code (UIC) § 2708
[28] 16 CCR § 1474 (3)

were reviewed and authorized by the NP, Physician and administrator in the practice setting (i.e., signature page that includes all parties involved).

- Standardized Procedures written using the Practice Agreement or PAs Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.[29,30,31]

d. Adverse History Guidelines: IEHP must carefully review the oversight process for the Delegates' review of all Practitioners with evidence of adverse history are presented to Credentialing Committee for review and documented in the meeting minutes, that may include, but is not limited to Providers who have:

1) Restrictions on licensure
2) Restrictions on DEA
3) Loss of Clinical privileges or negative privilege actions
4) Sanction Other negative actions may include, but are not limited to:

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

e. Provider Network

1) Advanced Practice Practitioners are allowed to increase only one (1) supervising PCP's enrollment capacity per location with a maximum of two (2) unique locations allowed.
2) Advanced Practice Practitioners must practice at a site assigned to their supervising Physician.
3) Patient age ranges for PCP must be specifically delineated as part of the Delegated credentialing process. The age range for DualChoice line of business are Ages 21 and above.

   Guidelines for age ranges for Non-Physician Practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Licensed Midwives (LM), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Opticians, Optometrists

[29] NCQA, 2023 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, California Code of Regulations (CCR) § 1474 (3)

(OD), Chiropractors (DC), Dieticians and Nutritionists are as applicable to the training and certification of the Non-Physician Practitioner.

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

4. Delegates' policies must define the process used and the criteria required to reach credentialing decisions that are designed to assess the Practitioner's ability to deliver care. At a minimum:[32]
   a. The Credentialing Committee must receive and review the credentials of the Practitioners who do not meet the Delegates established criteria.
   b. Policy must identify what is considered acceptable to be determined as a clean file, if the Delegate utilized a clean file process.
   c. If retrospective review by IEHPs Credentialing Department reveals that a Practitioner approved by a Delegate does not meet the above requirements, IEHP can submit the Practitioner to IEHPs Peer Review Subcommittee for review.
5. Delegates may designate to their Medical Director the authority to determine and sign off on a credentialing and recredentialing file that meets the Delegate standards as complete, clean, and approved. Delegates may assign an associate medical director or other qualified medical staff member as the designated medical director if the individual has equal qualifications as the medical director and is responsible for credentialing, as applicable. The Delegate's Credentialing Committee must review the credentials of all Practitioners being credentialed or recredentialed who do not meet the Delegates established criteria, and to provide advice and expertise for credentialing decisions.[33]
   a. If the Medical Director or equally qualified Practitioner signs off on clean files, the sign off date is the Committee date.
   b. If the Delegate decides not to use the Medical Director or equally qualified Practitioner, the Delegate can continue to send "clean files" to the Credentialing Committee.
6. Delegates' policies must describe the process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.[34,35]
   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

[32] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 4
[33] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 5
[34] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 6
[35] 42 CFR § 422.205

credentialing/recredentialing processes.

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

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

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

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

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

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

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

7. Delegates' policies and procedures must describe the process for notifying Practitioners when credentialing information obtained from other sources varies substantially from that provided. A statement that Practitioners are notified of discrepancies does not meet the requirement.[36]

8. Delegates' policies and procedures must describe the process for notifying Practitioners the credentialing and recredentialing decisions within 60 calendar days of the Committee's decision.[37]

9. Delegates' policies must describe the medical director or other designated Practitioner's overall responsibility and participation in the credentialing process.[38]

[36] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 7
[37] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 8
[38] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 9

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 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:[39]
    a. Confidentiality statements are signed by Committees and Credentialing staff;
    b. Practitioner files are maintained in locked file cabinets are only accessible by authorized personnel, if applicable; and
    c. Security for database systems is maintained through passwords or other means to limit access to Practitioner information to authorized staff only.
11. Delegates' policies and procedures describe the Delegates' process for ensuring that information provided to IEHP for Member materials and Practitioner directories is consistent with the information obtained during the credentialing and recredentialing process. At minimum, policy should demonstrate that the information collected during the credentialing and recredentialing process and requests received in between cycles, is entered, maintained, and submitted to IEHP by the Credentialing Department to ensure consistency.[40]

B. Delegates' policies and procedures describe how the following three (3) factors are met and how the Practitioners are notified (e.g. application, contact, Provider manual, other information distributed to Practitioners, website, letter to Practitioners):[41]
    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.

[39] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 10
[40] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 11
[41] NCQA, 2023 HP Standards and Guidelines, CR 1, Element B, Factor 1-3

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

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

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

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

- Change passwords periodically
- Changing or withdrawing passwords, including alerting appropriate staff 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.[42]

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

E. Delegates' recredentialing policies and procedures require information from quality improvement activities and Member complaints in the recredentialing decision making process.[43,44]

F. Delegates' policies and procedures must ensure that it only contracts with Physicians who have not opted out.

[42] NCQA, 2023 HP Standards and Guidelines, CR 1, Element C, Factors 1-5
[43] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.3
[44] DHCS APL 22-013

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.[45]

G. Delegates must have policies and procedures that prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report).

1. Providers identified on the OIG report, will not be credentialed or contacted, and terminated from our network if they are existing Providers.[46]

H. Delegates must have policies and procedures that they do not contract with Practitioners who are precluded from receiving payment for Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries.

1. IEHP does not allow Practitioners identified on the preclusions list to participate in the IEHP network.

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	☐ DMHC	☐ NCQA
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[45] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Chapter 6 § 60.2
[46] DHCS APL 22-013

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
2. Credentialing Committee

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice (HMO D-SNP) Providers.

POLICY:

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

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

   1. Assessment of Timeliness - IEHP uses the Credentialing Committee or medical director decision date to assess timeliness in the file review elements, even if a review board or governing body reviews decisions made by the Credentialing Committee or Medical Director.

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

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

PURPOSE:

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

DEFINITION:

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

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

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

      b. If information is gathered from a company website and the Delegate staff is pulling

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 180 calendar days of the credentials committee decision.

PROCEDURES:

A. Participating Practitioners are external to the organization and are part of the organization's network, as noted by NCQA.[3]

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

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

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

   At a minimum, the policy and procedures must include:

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

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

[1] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, Glossary
[2] NCQA, 2023 HP Standards and Guidelines, Glossary
[3] NCQA, 2023 HP Standards and Guidelines, CR 2, Element A, Factor 1

network;

2) If the Credentialing Committee is comprised of Primary Care Providers (PCPs) only, the policy must state that Specialists are consulted, when necessary and appropriate. Evidence may include, but is not limited to:
   - There is evidence through their Committee minutes that a Specialist was consulted, when applicable; and
   - There is a listing that indicates what Specialists were used (if applicable).
3) Quorum requirements of Committee (minimum of three (3));
   - Meetings should include a quorum of Practitioners for each meeting.
4) Identity of voting Members;
5) Identity of who has authority to make final credentialing decisions and the relationship to the Governing Board (if applicable);
6) Frequency of Committee meeting (at minimum, quarterly);
7) Process to document, review and approve delegate credentialing policies and procedures by the Committee on an annual basis; [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 180 days old at the time of the Committee decision.

B. Delegates Credentialing Committee policies must describe how the Credentialing Committee receives and reviews the credentials of Practitioners who do not meet the Delegates criteria for participation in the network. The Credentialing Committee must give thoughtful consideration of the credentialing information. IEHP will review Credentialing Committee meeting minutes from three (3) different meetings, each in separate quarter, 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-

[4] NCQA, 2023 HP Standards and Guidelines, CR 2, Element A, Factor 3
[5] NCQA, 2023 HP Standards and Guidelines, CR 2, Element A, Factor 2

time virtual meetings (e.g. through video conferencing or WebEx conferment with audio).

a. All meetings, including ad hoc, may not be conducted only through email.

b. Meetings should include a quorum of Practitioners for each meeting, as established in the Delegates policy.

c. Minutes should be signed by the Credentialing Committee Chairperson and dated within one (1) month or by the date of the next meeting.

d. Ad hoc Credentialing Committee meeting minutes must be documented at the time of the ad hoc meeting and must be presented at the next formal meeting.

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

1. Submit all Practitioner files to the Credentialing Committee for review; or
2. Has a process for medical director or quality physician review and approve clean files.

a. Evidence of review is a handwritten signature, handwritten initials, or unique electronic identifier, if the organization has appropriate controls for ensuring that only the designated medical director or qualified physician can enter the electronic signature.

b. An individual signature is not required in each Practitioner file if there is one report with a signature that lists all required credentials for all Practitioners with clean files.

3. If the Delegate presents all files (including clean files) to the Credentialing Committee, this factor is met.

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[6] NCQA, 2023 HP Standards and Guidelines, CR 2, Element A, Factor 3

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
3. Credentialing Verifications

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice (HMO D-SNP) Providers.

POLICY:

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

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

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

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

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

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

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

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

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

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

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

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

PURPOSE:

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

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

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

1. Credentialing documents signed (or initialed) and dated by the verifier.
2. A checklist that includes for each verification:
    a. The source used.
    b. The date of verification.
    c. The signature or initials of the person who verified the information.
    d. The report date, if applicable.
3. A checklist with a single signature and a date for all the verifications that has a statement confirming that the signatory verified all of the credentials on that date and that includes for each verification.
    a. The source used.
    b. The report date, if applicable.
    c. If the checklist does not include checklist requirements listed above appropriate 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 Delegate may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.

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

DEFINITION:

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

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

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

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

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

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

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

1. Currently revoked from Medicare:

2. Under an active re-enrollment bar; or

3. CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.

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

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

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

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

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

I. Types of Signatures:

1. Wet signature - created when a person physically marks a document.

2. Faxed signature – the “copy” or “duplication” of your signature (no matter the method, system or medium you choose) is referred to as a facsimile signature.

3. Digital signature - type of electronic signature that encrypts documents with digital codes that particularly difficult to duplicate. It includes a certificate of authority, such as a Windows certificate, to ensure the validity of the signatory (the signature’s author and owner).

4. Electronic signature - symbols or other data in digital form attached to an electronically transmitted document as verification of the sender’s intent to sign the document.

5. Scanned signature - a written signature that’s been scanned into an electronic format, like a PDF.

6. Photocopied signature - a signature reproduced provided that the copy must be of an original document containing an original handwritten signature.

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

PROCEDURES:

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

1. A current and valid license to practice in California (Verification Time Limit (VTL): 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

[1] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 3, Element A, Factor 1

(CDS) certificate, if applicable (VTL: 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) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision; or

c. Any Practitioner with a DEA with an "EXEMPT" Fee or status, the DEA is only valid at the exempting institution and any affiliate Hospital or Clinic rotations within the scope of training. The Delegate must confirm the Practitioner's practice and exempting institutions relationship and document their findings in the Provider file, if the address on the DEA does not match the Providers practice location. If a Practitioner is practicing outside of the exempting institution and/or its affiliates, the Practitioner must obtain a "Paid" status DEA.

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

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

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

      - Practitioner's statement. I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I

refer the patient to their PCP or to another practitioner for evaluation and management, example provided by NCQA.

f. Failure to maintain an active DEA, may result in an administrative termination of the Practitioner.[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 to be credentialed and contracted. The Delegate verifies the highest of the following three (3) levels of education and training obtained by the Practitioner, as appropriate. i.e., Board Certification, Residency or Graduation from medical or professional school. An expired board certification may be used for verification of education/training.

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

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

   a. The primary source from the Medical School.

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

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

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

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

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

         - Delegates must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.

[2] [2]NCQA, 2023 HP Standards and Guidelines, CR 3, Element A, Factor 2

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

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

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

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

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

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

1) Primary source from the institution where the postgraduate medical training was completed.

2) AMA Physician Master File.

3) AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.

4) Federation Credentials Verification Service (FCVS) for closed residency programs.

- NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.[3]

4. Board certification status, if applicable (VTL: 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.

[3] NCQA, 2023 HP Standards and Guidelines, CR 3, Element A, Factor 3

2) If board certification has expired it may be used as verification of education and training.

3) Verification must be performed through a letter directly from the board or an online query of the appropriate board as long as the board states that they verify education and training with primary sources, is an acceptable source by NCQA, and indicate that this information is correct. Below are the acceptable sources to verify board certification:

- For all Practitioner types
  - The primary source (appropriate specialty board).
  - The state licensing agency if the primary source verifies board certification.
- For Physicians (M.D., D.O.)
  - American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
    - The ABMS "Is your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
  - AMA Physician Master File.
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - Boards in the United States that are not members of the ABMS or AOA if the Delegate documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.
- For other health care professionals
  - Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.
- 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: 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: 180 calendar days prior to Credentialing decision date)

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

      1) Malpractice Insurance Carrier

      2) National Practitioner Data Bank Query

      3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within 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 verifies the following sanction information for credentialing:

   1. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: 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] NCQA, 2023 HP Standards and Guidelines, CR 3, Element A, Factor 5
[5] NCQA, 2023 HP Standards and Guidelines, CR 3, Element A, Factor 6

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

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

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

- Evidence of current enrollment must be provided.
- Report must be reviewed within 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: 180 calendar days prior to Credentialing decision).

a. Verification Sources for Medicare/Medicaid Sanctions:

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

2) Medicare intermediary

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

- OIG must be one (1) of the verification sources for Medicare sanctions, to ensure compliance with CMS.
    - Date of query and staff initials must be evident on a checklist or the OIG page must be in the file.

4) Medicare Exclusions Database.

5) The Federal Employees Health Benefits (FEHB) Program Department Record, published by the Office of Personnel Management, OIG.

6) AMA Physician Master File

7) NPDB

- For Delegate's using the Continuous Query (formerly Proactive Disclosure Service (PDS)). Continuous Query must be reviewed within 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 include the following:

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

[7] NCQA, 2023 HP Standards and Guidelines, CR 3, Element C, Factor 1
[8] NCQA, 2023 HP Standards and Guidelines, CR 3, Element C, Factor 2
[9] NCQA, 2023 HP Standards and Guidelines, CR 3, Element C, Factor 3
[10] NCQA, 2023 HP Standards and Guidelines, CR 3, Element C, Factor 4

verified with the insurance carrier or through the Practitioner via a copy of the policy and the signed attestation completed by the Practitioner. The copy of the Practitioner's certificate must be initialed, and date stamped to show receipt prior to the credentialing decision and to show it was effective at the time of the credentialing decision.

2) Must include coverage for the specialty the Practitioner is being credentialed for and for all locations the Practitioner will be treating IEHP patients.

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

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

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

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

- Failure to maintain current malpractice coverage for the specialty the Provider is being credentialed for and for all locations the Practitioner will be treating IEHP patients, will result in an administrative termination of the Practitioner.[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 180 calendar-day time frame is based on the date the Practitioner signed the application.

- If the signature or attestation exceeds 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

[11] NCQA, 2023 HP Standards and Guidelines, CR 3, Element C, Factor 5

Practitioner; dating and initialing is not acceptable.

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

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

1) If a question is answered incorrectly, Delegate is responsible for notifying the Practitioner to have them review the question.

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

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

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

1. Confirmed with the Hospital, in writing, via approved website or verbally, and must include:

a. The date of appointment;

b. Scope of privileges, restrictions (if any i.e. restricted, unrestricted) and recommendations.

c. Confirmation Provider has admitting privileges in the specialty the Provider is credentialed and contracted for.

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

e. Practitioner must meet the requirements for Hospital Privileges as required by IEHP. (See Policy 5B, "Hospital Privileges"), i.e. if an admitter or hospitalist arrangement is used, a written agreement that meets IEHP admitter requirements, confirming coverage for all inpatient work covering the entire age range of the Practitioner must be included in the Practitioner's credentialing file.

1) These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider profile, admitter report or attachment.

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

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

2. If the Practitioner does not have clinical privileges, the Delegate must have a written statement delineating the inpatient coverage arrangement. (See Policy 5B, "Hospital Privileges"). For Specialties that are required to have clinical privileges or admitting privileges at a Participating hospital, See "Hospital Admitting Privileges Reference by Specialty" found on the IEHP website[12].

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 "Hospital Admitting Privileges Reference by Specialty" found on the IEHP website[13]).

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

[12] https://www.iehp.org/en/providers?target=forms
[13] Ibid.

fully credentialed and approved by the IPA or IEHP directly. CNM Providers must meet the following criteria:

a. In lieu of having full hospital delivery privileges, provide a written agreement with an Obstetrician (OB) Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed.

- The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the CNM Provider.
- The OB Provider must be credentialed and contracted within the same practice and network.

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

a. Member transfers will take place within the first 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 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 "Licensed Midwife Attestation" found on the IEHP website[14]) 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.[15,16,17]

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

1. Reviewing and obtaining the information via had 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.[18]

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;

[14] https://www.iehp.org/en/providers?target=forms
[15] Medicare Managed Care Manual, Relationships with Providers", Section 60.3
[16] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013 Supersedes APL 19-004, "Provider Credentialing/Recredentialing and Screening/Enrollment
[17] California Code of Regulations (CCR) § 1300.51(d)(H)(iii)
[18] 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.

b. Pages of the CMS.gov listing report showing where the providers name would have been listed in alpha order. Must have the following to be compliant:

1) Staff initials/signature;

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

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

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

1. Quality activities include, but are not limited to:
   a. Adverse events
   b. Medical record review
   c. Data from Quality Improvement Activities
   d. Performance Information, may include but is not limited to:
      1) Utilization Management Data
      2) Enrollee satisfaction surveys
      3) Other activities of the Delegate
   e. Not all quality activities need to be present
2. Grievance/complaints[19,20]

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

1. Verified through the NPPES website;
2. Active while in the IEHP network;
3. Current at all times (i.e. Primary Practice Address must be registered to an address within California).
   a. Telehealth Providers are not required to have an NPI registered to an address within California.

[19] Medicare Managed Care Manual, Relationships with Providers", Section 60.3
[20] DHCS APL 22-013

4. Practitioners that have a group NPI number may submit that information to IEHP, in addition to the mandatory individual NPI number.[21]

H. Delegate ensures all Primary Care Provider's (PCP) and Urgent Care's (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring"). All PCPs and UCs must pass an IEHP facility on-site review at the time of initials credentialing and every three (3) years thereafter, for Medi-Cal Programs.[22]

1. Delegates are note 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.

[21] DHCS APL 22-013
[22] Medicare Managed Care Manual, Relationships with Providers", Section 60.3

4. If a Practitioners' SSN is correctly stated but the name and Date of Birth (DOB) does not, the Delegate must request for:
   a. A copy of the Social Security Card;
   b. A photo ID;
   c. A signed attestation from the Practitioner confirming they are who they say they are; and
   d. The Provider to contact the Social Security Administration's Death Master File (SSADMF) to correct the issue.[23]

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

K. Delegates must ensure all Practitioners are within the appropriate age range guidelines, as appropriate. IEHP DualChoice Member age ranges are ages 21 and above.
   1. Specialists Member age ranges are specific to the specialty involved, training, and education of the Physician.
   2. Non-Physician Practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Opticians, Optometrists (OD), Chiropractors (DC), Dieticians and Nutritionists are as applicable to the training and certification of the non-physician Practitioner.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☒ NCQA
Original Effective Date:	January 1, 2020	
Revision Effective Date:	January 1, 2024	

[23] DHCS APL 22-013

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 DualChoice (HMO D-SNP) Providers.

POLICY:

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

PURPOSE:

A. To describe the guidelines for Delegates recredentialing and ensures recredentialing is conducted in a timely manner.[3]

DEFINITION:

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

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

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

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

[1] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 4, Element A
[2] Title 42 Code of Federal Regulations (CFR) § 422.204(b)(2)(ii)
[3] Medicare Managed Care Manual, "Relationships with Providers", Section 60.3

PROCEDURES:[4]

A. The length of the recredentialing cycle is within the required 36 month time frame and is a must-pass element for NCQA. Files that fail to meet the 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 36 month recredentialing cycle begins on the date of the previous credentialing decision. The 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 12 months.

            - IEHP will document in comments the total number of Practitioners that appear on the spreadsheet that have not been recredentialed within the last 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 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.

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

1. Verify that the Practitioner has a valid license to practice before the Practitioner resumes seeing patients.

2. Within 60 calendar days of when the Practitioner resumes practice, the Delegate must

[4] NCQA, 2023 HP Standards and Guidelines, CR 4, Element A

complete the recredentialing cycle. Delegates must document this and recredentials the Practitioner within 60 calendar days of the Practitioners return to practice.

a. If there is a termination of 30 calendar days, the Delegate can initially credential the Practitioner before rejoining the Delegates network.

C. Delegates failure to recredential within 36 months. The Delegate will be scored down if it missed the 36 month timeframe for recredentialing a Practitioner but did not terminate the Practitioner.

1. If the Delegate does not have the necessary information for recredentialing, the Delegate must:

   a. Inform the Practitioner that this information is needed at least 30 calendar days before the recredentialing deadline and that without this information, the Practitioner will be administratively terminated.

      1) The Delegate must include this notification in the Practitioner's credentialing file.

      2) If the practitioner is subsequently terminated for lack of information, the termination notice must be in the Practitioner's file.

2. Delegates may recredential the Practitioner within 30 calendar days of missing the deadline.

   a. If recredentialing is not completed within 30 calendar days, Delegates must initial credential the Practitioner.

3. If the Delegates terminates a Practitioner for administrative reasons (e.g. the Practitioner failed to provide complete credentialing information) and not for quality reasons, it may reinstate the Practitioner within 30 calendar days of termination and is not required to perform initial credentialing.

   a. Delegates must perform initial credentialing if reinstatement is more than 30calendar days after termination.

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Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☒ NCQA
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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 IEHP DualChoice (HMO D-SNP) Providers.

POLICY:

A. Delegate must develop and implement policies and procedures for ongoing monitoring of Practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against Practitioners when it identifies occurrences of poor quality.[1]

B. Delegate maintains a documented process for monitoring whether network Providers have opted out of participating in the Medicare Program, may not participate in Medicare lines of business.[2,3]

C. Delegate will verify that their contracted Providers have not been terminated as Medi-Cal Providers or have not been placed on the Suspended and Ineligible Provider List.[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 Medicare Program Final Rule.[5]

E. IEHP maintains a documented process for monitoring Practitioners identified on the Restricted Provider Database, for Practitioners directly credentialed with IEHP and those credentialed through a Delegated Network.[6]

F. IEHP maintains a documented process that includes the System for Award Management (SAM) in their list of database checks, for Practitioners directly credentialed with IEHP and those credentialed through a Delegated Network.[7]

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

[1] National Committee for Quality Assurance (NCQA), 2023 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) 22-013 Supersedes APL 19-004 "Provider Credentialing/Recredentialing and Screening/Enrollment"
[4] Ibid.
[5] Centers for Medicare & Medicaid Services (CMS), Policy CMS-4182 Final Rule
[6] DHCS APL 22-013
[7] Ibid.

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]

DEFINITIONS:

A. Adverse event – An injury that occurs while a Member is receiving healthcare service 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 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.

[8] DHCS APL 22-013
[9] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 1-5
[10] NCQA, 2023 HP Standards and Guidelines, Glossary

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]

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 30 calendar days of its release.[13,14]

        1) Delegate may develop a tracking log to include the report run date, review date, initials of person reviewing report, the list reviewed, and the web link used; or

        2) Delegate can print the entire list. The report must be dated and initialed

            - Practitioners identified on the Health & Human Services (HHS)-Office of Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.

                o Members will be reassigned to new Practitioners.

                o 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.

[11] NCQA, 2023 HP Standards and Guidelines, Glossary
[12] Ibid.
[13] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 5
[14] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 1-2

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.[15]

   a. Physicians. Sanction and limitation on licensure verifications must be verified through:

      1) BreEZe Online services online or directly with the licensing board via phone or mail:

         - Medical Board of California (M.D.)
         - Osteopathic Medical Board of California (D.O.)

      2) Federation of State Medical Boards (FSMB)

      3) National Practitioner Data Bank (NPDB). For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a process for reviewing sanction alerts within 30 calendar days of their release. The Delegate must:

         - Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within 30 calendar day of its release.
         - Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
            - Documentation can be kept electronically or via an electronic or paper/log checklist.

   b. Chiropractors. Sanction and limitation on licensure verifications must be verified through:

      1) BreEZe Online services online or directly with the licensing board via phone or mail:

         - California Board of Chiropractic Examiners (D.C.)

      2) Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD)

      3) National Practitioner Data Bank (NPDB) . For Delegates using the Continuous Query, the Continuous Query, the Delegate must provide evidence of practitioner's continuous enrollment in the Continuous Query and must have a

[15] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 2

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

- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within 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 30 calendar days of their release. The Delegate must:

- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within 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 30 calendar days of their release. The Delegate must:

- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within 30 calendar day of its release.
- Document or note that no reports were received during the monthly look-back period, if no reports were received for ongoing monitoring.
    - Documentation can be kept electronically or via an electronic or paper/log checklist.

e. Nonphysician healthcare Practitioners. Sanction and limitation on licensure verifications must be verified through:

1) BreEZe Online services online or directly with the licensing board via phone or mail:

- Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C)
- Board of Psychology (Ph.D., Psy.D.)
- California Board of Occupational Therapy (O.T.)
- California State Board of Optometry (O.D.)
- Physical Therapy Board of California (P.T.)
- Physician Assistant Committee (P.A., P.A.-C)
- California Board of Registered Nursing (C.N.M., N.P.)
- Speech-Language Pathology & Audiology Board (S.P., Au)
- Acupuncture Board (L.Ac.)[16]

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 30 calendar days of their release. The Delegate must:

- Provide evidence of the annual enrollment listing of providers enrolled and review of alerts within 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.

[16] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 2

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

[17] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 3
[18] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 4
[19] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 5

direction;

2) Immediately suspend the Practitioner from participation with IEHP with referral to the next IEHP Peer Review Subcommittee meeting; or

3) Any other action as appropriate, given the circumstances and severity of the situation.

B. Delegates maintains a documented process for monitoring whether network physicians have opted out of participating in the Medicare Program using one of the CMS.gov Opt-Out sites.

1. Delegate must review the Opt-Out Report from one of the CMS.gov sites on a quarterly basis, within 30 days of its release.

   a. The report must be dated and initialed

   b. A checklist may be used to document the date of the electronic file download. The checklist must contain:

      1) The date of the download and signature of the Delegate personnel who verified it.

      2) Delegates must review quarterly Opt-Out reports even if they employ their Practitioners.

C. Delegates must use the Medi-Cal Suspended & Ineligible List, published monthly by the Department of Health Care Services (DHCS), as the verification source for Medicaid Sanctions. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance. Delegate must review the Suspended & Ineligible List on a monthly basis, within 30 days of its release.

1. Delegate may develop a tracking log to include the report run date, review date, initials of person reviewing report, the list reviewed, and the web link used;

2. Delegate may print the parts of the list that are applicable; or

3. Delegate can print the entire list

   a. The report must be dated and initialed

      1) All Members assigned to suspended Practitioners will be reassigned to new Practitioners.

      2) The Suspended Practitioner will be presented to the Peer Review Subcommittee as an administrative termination and for further review, discussion.

         - Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings to include any additional prior

quality of care issues and Member complaints for the Provider.[20]

D. Delegated maintains a documented process for monitoring whether its Practitioners are included in the CMS Preclusions List, to ensure compliance with the Medicare Program Final Rule. In order for Providers (including entities) to receive payment from Medicare Plan (Part C and D), they must not be included in the CMS Preclusions List. Name of Board/Entity, date of query, date of report and signature/initials of staff must be included as documentation for compliance. [21]

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 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 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).[22] 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.[23]

[20] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013 Supersedes APL 19-004 "Provider Credentialing/Recredentialing and Screening/Enrollment"
[21] Centers for Medicare & Medicaid Services (CMS), Policy CMS-4182 Final Rule
[22] DHCS APL 22-013
[23] DHCS APL 21-003 Supersedes APL 16-001 "Medi-Cal Network Provider and Subcontractor Terminations"

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.[24]

F. IEHP maintains a documented process that includes the System for Award Management (SAM) in their list of database checks. IEHP uses OIG Compliance Now as the vendor to collect data and alert services, to include but is not limited to the System for Award Management (SAM) in their scope of review.

1. The OIG LEIE includes all healthcare providers and suppliers that are excluded from participation in federal health care programs, including those health care providers and suppliers that might also be on the SAM (previously EPLS). In addition to health care providers (that are also included on the OIG LEIE) the EPLS includes non-health care contracts[25], 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 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

[24] APL 21-003
[25] Medicare Managed Care Manual, Chapter 21 "OIG/GSA Exclusion", Section 50.6.8

- Date of report
- Signature(s)/initials of Delegate personnel who reviewed it.

2) If the reporting entity does not publish sanction information on a set schedule, the delegates:

- Documents that the reporting entity does not release information on a set schedule.
- Queries for this information for at least six (6) months.

3) If the reporting entity does not release sanction information reports, the delegate must conduct individual queries of credentialed Practitioners every 12to 18 months after the last credentialing cycle.

d. Delegates that subscribe to a sanctions alert service reviews the information within 30 calendar days of a new alert. The delegate must:

1) Show evidence of its subscription to the sanctions alert service during the look-back period and reviews the information within 30 calendar days of a new release.

H. IEHP notifies Delegates of any adverse actions it becomes aware of through sources other than the Delegate. In addition, IEHP shares with all Delegates the results of performing monitoring through quality improvement studies, Member complaints and Member satisfaction surveys, as applicable. IEHP reviews the history of each Delegate's credentialed and approved Practitioners. Delegate is responsible for notifying IEHP of:

1. Any findings and the actions decided by the Credentialing Committee within 30days 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 "IEHP Peer Review Level I and Credentialing Appeal" and "IEHP Peer Review Process and Level II Appeal" found on the IEHP website[26]).

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 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 30 days of the change. The notification must include:
   a. Date the Delegate was notified;

[26] https://www.iehp.org/en/providers?target=forms

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 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 "Death Master File Identity Attestation" found on the IEHP website[27]) from the Practitioner confirming their identity; and

      4) Request for the practitioner to contact the SSADMF to correct the issue.

   b. Confirms their SSN is correctly stated but the name and Date of Birth (DOB) does not, IEHP will request for the following:

      1) A copy of the Social Security Card.

      2) A Photo ID.

      3) A signed attestation (See "Death Master File Identity Attestation" found on the

[27] https://www.iehp.org/en/providers?target=forms

IEHP website[28]) from the Practitioner confirming their identity; and

4) Request for the practitioner to contact the SSADMF to correct the issue.

3. Upon receipt of the required documents, the Credentialing designee will provide the attestation and supporting documentation to our Compliance Department for review and repository.[29]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☒ NCQA
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[28] https://www.iehp.org/en/providers?target=forms
[29] DHCS APL 22-013

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 DualChoice (HMO D-SNP) 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].and inform Practitioners of the appeal process.[2]

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

PURPOSE:

A. Delegates must use objective evidence and patient-care considerations when deciding on a course of action for dealing with a Practitioner who does not meet its quality standards. [3]

B. Notification applies to Physicians and nonphysicians for suspensions and terminations for quality reasons.[4]

C. Delegates must provide evidence that it followed its appeal process if it altered the conditions of a Practitioner's participation based on quality of care or service reasons.[5]

D. Practitioners must appeal directly to their contracted IPA for adverse credentialing decisions rendered by the Delegated IPA.

E. Reporting to appropriate authorities is not applicable in the following circumstances:

1. If there are no instances of suspension, termination, restriction or revocation to report for quality reasons.

[1] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 6, Element A, Factor 1
[2] NCQA, 2023 HP Standards and Guidelines, CR 6, Element A, Factor 2
[3] NCQA, 2023 HP Standards and Guidelines, CR 6, Element A, Factor 1-2
[4] Title 42 Code of Federal Regulations (CFR) § 422.202
[5] Ibid.

2. For automatic administrative terminations based on the Practitioners not meeting specific contractual obligations for participation in the network.

F. All credentialing records and proceeds are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.[6]

DEFINITION:[7]

A. "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates.

1. The Medical Board of California is the agency for the following Practitioner types:

   a. Physicians and Surgeons (MDs)

   b. Doctors of Podiatric Medicine (DPMs)

   c. Licensed Midwives (LMs)

   d. Physician Assistants (PAs)

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

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

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

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

D. "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

E. "Licentiate" means a Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, or physician's assistant. Licentiate also includes a person authorized

[6] California Evidence Code § 1157
[7] Business and Professions Code (Bus. & Prof. Code) § 805

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

F. "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to the patient's safety or to the delivery of patient care.

G. "Peer" is an appropriately trained and licensed Physician in a practice similar to that of the affected Physician.

H. "Staff privileges" means any arrangements under which a licentiate can to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

PROCEDURES:

A. Delegates has policies and procedures for:

1. The range of actions available to the Delegate, that:

   a. Specify that the Delegate reviews participation of Practitioners whose conduct could adversely affect Members' health or welfare.

   b. Specify the range of actions available to the Delegate, that they may take to improve the Practitioner performance before termination[8], to include, but not limited to:

      1) Profiling

      2) Corrective actions(s)

      3) Monitoring

      4) Medical Record Audit

   c. Specify that the Delegate reports its actions to the appropriate authorities. Appropriate authorities include, but are not limited to:

      1) Appropriate Licensing Board[9]

         - Medical Board of California 805 and 805.01 reports or the appropriate licensing board must be filed 15 days after a recommendation or final determination. The following types of providers require 805 and 805.01

[8] NCQA, 2023 HP Standards and Guidelines, CR 6, Element A, Factor 1
[9] Bus. and Prof. Code § 805

reporting:

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

2) National Practitioner Data Bank (NPDB)

2. Making the appeal process known to Practitioners. The Delegates policies and procedures must give the Practitioners the right to appeal and must include the following steps within the appeal process:[10]
   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).[11]
3. Practitioner appeal process where the Delegate informs the affected Practitioner of its appeal process and includes the following information in process and notification.[12]
   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.

[10] NCQA, 2023 HP Standards and Guidelines, CR 6, Element A, Factor 2
[11] Bus. & Prof. Code § 809.3(c)
[12] NCQA, 2023 HP Standards and Guidelines, CR 6, Element A, Factor 2

b. Allowing the Practitioner to request a hearing and the specific time period for submitting the request.

c. Allowing at least 30 days after the notification for the Practitioner to request a hearing.

d. Allowing the Practitioner to be represented by an attorney or another person of the Practitioner's choice.

e. Appointing a hearing officer or a panel of individuals to review the appeal.

f. Providing written notification of the appeal decision that contains specific reasons for the decision.

4. Delegates must have policies and procedures that describe when and how reporting occurs, to whom incidents are reported and what specific incidents are reportable. The policy must address what is expected of the Delegates staff and outline accountability so that staff understand their responsibilities in order to perform their functions correctly. When the Delegate decides to suspend or terminate a Practitioner's contract, there must be procedures notifying the appropriate authorities (including state agencies, as appropriate) of the action, that includes, but is not limited to:

   a. 805 Reports.[13]

      1) Delegate is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason.

         - If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a Physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.
         - If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of podiatric medicine, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

      2) If an 805 is reported, it shall include the following information:

         - The name of the licentiate involved;
         - The license number of the licentiate involved:
         - A description of the facts and circumstances of the medical disciplinary cause or reason; and

[13] Bus. and Prof. Code § 805

- Any other relevant information deemed appropriate by the reporter.

3) Delegates must file an 805 report with the relevant agency within 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 30 days or more for any 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 15 days after the licentiate takes the action.[14]
   - Resigns or takes a leave of absence from membership, staff privileges or employment.
   - Withdraws or abandons his or her application for staff privileges or membership.
   - Withdraws or abandons his or her request for renewal of staff privileges or membership.

b. 805.01 Reports[15]

1) Delegate must file an 805.01 within 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

[14] Bus. & Prof. Code § 805
[15] Bus. & Prof. Code § 805.01

one (1) of the following reasons:

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

c. National Practitioner Data Bank (NPDB)

1) Reports must be submitted to the NPDB within 30 days of the action.[16]

d. Health Plan Reporting

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

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

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

[16] 45 CFR § 60

[17] Medicare Managed Care Manual, Chapter 6, "Suspension, Termination, or Nonrenewal for Physician Contract", Section 60.4

25. DELEGATION OVERSIGHT

B. Credentialing Standards
   6. Notification to Authorities and Practitioner Appeal Rights

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2020	
Revision Effective Date:	January 1, 2024	

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 DualChoice (HMO D-SNP) lines of business.

POLICY:

A. Delegate has written policies and procedures for the initial and ongoing assessment of Providers who contract with the Delegate to provide medical services to Members as designated in the IEHP Division of Financial Responsibility (DOFR) Matrix. Delegates must assess all health care delivery providers before contracting with a provider, and for at least every 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] Clinical Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Providers of End-stage Renal Disease Services, Hospice, Outpatient Diabetics Self-Management Training Providers, Portable X-ray Supplier, Outpatient Physical Therapy Providers, Speech Pathology Providers, Rural Health Clinics and Federally Qualified Health Centers.

C. Delegates are not responsible for the claim's payment for behavioral healthcare facilities, therefore are not required to include them in their scope. IEHP includes behavioral healthcare facilities, providing mental health or substance abuse services in an inpatient setting in their scope of providers. Residential Treatment Facilities and Ambulatory Behavioral Health Facilities are not covered by this policy as these are not a covered IEHP benefit.[6]

[1] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 7, Element A, Factors 1-3
[2] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 1
[3] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 2
[4] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 3
[5] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 4
[6] NCQA, 2023 HP Standards and Guidelines, CR 7, Element C, Factors 1-3

25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
7. Assessment of Organizational Providers

PURPOSE:

A. Delegate evaluates the quality of organizational Providers with which it contracts.

B. IEHP directly contracts with IPAs and Hospitals (Providers). In turn, Providers subcontract with Health Care Delivery Organizational Providers (subcontracted Providers) to provide services to Members as designated in the Division of Financial Responsibility (DOFR) Matrix outlined in IEHP's Capitated Agreements with the Hospitals and IPAs.

C. All Providers must adhere to all procedural and reporting requirements under state and federal laws and comply with the most recent NCQA, state and regulatory guidelines for subcontracted organizational Providers, as well as IEHP requirements.

D. Delegated Providers that subcontract with Ancillary and organizational Providers are responsible for ensuring that their subcontracted Providers meet IEHP's requirements as stated herein and in Policy 5A7, "Credentialing Standards - Assessment of Organizational Providers", IEHP audits Delegate's compliance with IEHP requirements on an annual basis, using the IEHP Delegation Oversight Audit Tool beginning with a pre-contractual assessment, in accordance with Policy 25A1, "Delegation Oversight - Delegated Activities." Delegated IPAs are subject to corrective action as defined in Policy 25A3, "Delegation Oversight - Corrective Action Plan Requirements."

E. IEHP reserves the right to perform facility site audits when quality of care issues arise and to deny contracted or subcontracted Providers participation in the IEHP network if IEHP requirements for participation are not met.

F. Contracted and/or subcontracted Provider's failure to meet IEHP's requirements may result in adverse action up to and including non-renewal or termination of the delegated entity contract or IEHP contract

DEFINITION:

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

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

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

    b. If information is gathered from a company website and the Delegate staff is pulling

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.

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 36 months thereafter:[9]

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 60 days following the expiration of the license and accreditation.

            - Accreditation and licensure must be maintained throughout the duration of the subcontractors' participation in the IEHP network. A current and unencumbered license; must also be appropriately licensed and no other negative license actions that may impact participation

                ° Physician-owned clinics are not required to be licensed by DHCS, but

[7] NCQA, 2023 HP Standards and Guidelines, Glossary
[8] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A
[9] California Welfare and Institutions Code (Welf. & Inst. Code), § 14043.6 and 14123
[10] NCQA, 2023 HP Plan Standards and Guidelines, CR 7, Element A, Factor 1

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);[11]

2) If a state license is not issued by the Department of Health Care Services, the facility should have a business license or certificate of occupancy.

b. Federal Regulatory Bodies. Delegates must ensure Providers have no sanctions that may impact participation. Delegates must ensure review of the:

1) Department of Health & Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities List (LEIE). Review of OIG or Medicare/Medicaid Sanctions must be completed and documented on the spreadsheet or the file. The monthly review of the OIG report as part of the "Ongoing Monitoring" qualifies as compliant for this section if the facilities are included on the OIG Report.[12]

- 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).[13,14]
    - CMS' Medicare Exclusion Database (MED) is the source that is used to populate the LEIE list. IEHP will use the LEIE to verify if practitioners are identified on the MED.[15]

2) CMS signed participating agreement letter, if applicable.[16]

3) An attestation from a Provider to the organization regarding the Providers regulatory status is not acceptable.

c. The Organizational Providers must maintain accreditation and license status in good standing and/or current at all times during their participation in the IEHP network.[17]

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

[11] Knox-Keene Health Care Service Plan Act of Title 28
[12] Medicare Managed Care Manual, Chapter 6 "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks," § 60.2
[13] DHCS APL22-013
[14] DHCS APL 21-003
[15] Ibid.
[16] Medicare Managed Care Manual, Chapter 6, "Institutional Provider and Supplier Certification", Section 70
[17] NCQA, 2023 HPP Standards and Guidelines, CR 7, Element A, Factor 1

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

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

a. Hospitals.
   1) The Joint Commission (TJC)
   2) Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the American Osteopathic Association (AOA), it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)
   3) Det Norske Veritas National Integrated Accreditation of Healthcare Organization (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)
   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)[18]

e. Behavioral Health Providers (Intensive Programs and Inpatient Treatment Programs)

1) The Joint Commission (TJC)

2) Commission on Accreditation or Rehabilitation Facilities (CARF)

3) Healthcare Facilities Accreditation Program (HFAP)

4) Council on Accreditation (COA)

f. Hospice

1) The Joint Commission (TJC)

2) Community Health Accreditation Program (CHAP)

3) Accreditation Commission for Healthcare INC (ACHC) (CMS approved accrediting body verified by IEHP)

g. Clinical Laboratories

1) The Joint Commission (TJC)

2) Clinical Laboratory Association Improvement (CLIA) Certificate or CLIA Waiver

3) Commission on Office Laboratory Accreditation (COLA)

4) College of American Pathology (CAP)

h. Comprehensive Outpatient Rehabilitation Facilities

1) The Joint Commission (TJC)

2) Commission on Accreditation or Rehabilitation Facilities (CARF)

i. Outpatient Physical Therapy Providers

1) American Association for Accreditation of Ambulatory Surgical Services (AAAASF)

2) If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

j. Outpatient Speech Pathology Providers

1) American Association for Accreditation of Ambulatory Surgical Services (AAAASF)

2) If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

[18] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 2

k. Providers of End-stage Renal Disease Services (Dialysis)
   1) The Joint Commission (TJC)
   2) If no Accreditation, must be certified by Medicare

l. Birth Centers
   1) Commission for the Accreditation of Birth Centers (CABC)

m. Congregate Living Health Facility
   1) The Joint Commission (TJC)

n. Outpatient diabetes self-management training Providers
   1) American Association of Diabetes educators (AADE)
   2) Indian Health Service (IHS)

o. Portable X-Ray Supplier
   1) Federal Drug Administration (FDA) Certification

p. Rural Health Clinics
   1) The Joint Commission (TJC)
   2) American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
   3) If no Accreditation, must be certified by Medicare

q. Federally Qualified Health Centers
   1) The Joint Commission (TJC)
   2) If no Accreditation, must be certified by Medicare

3. An onsite quality assessment must be conducted if the Provider is not accredited. Delegate policy must specify the onsite quality assessment criteria for each type of non-accredited provider includes, but is not limited to:
   a. Onsite quality assessment criteria for each type of Provider.
   b. A process ensuring that the Providers credential their Practitioners.
   c. Delegates policy may specify it only contracts with accredited Providers to meet this requirement.
   d. A CMS or state quality review in lieu or a site visit under the following circumstances (if the Delegate chooses to substitute the site visit with a with a CMS or state quality review), if it meets the following requirements:
      1) The CMS or state review is no more than three (3) years old.

- 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).[19,20]

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[21]
2. Home Health Agencies[22]
3. Skilled Nursing Facilities (SNFs)[23]
4. Free-Standing Surgical Centers[24]
5. Clinical Laboratories in its assessment
6. Hospices
7. Comprehensive Outpatient Rehabilitation Facilities (CORF)
8. Outpatient Physical Therapy Providers (only applies to institutional facilities who take Medicare Part A. Does not apply to independently licensed Physical Therapists (PTs)).
9. End-Stage Renal Disease Services Providers
10. Outpatient Diabetes Self-Management Training Providers
11. Portable X-Ray Suppliers
12. Rural Health Clinics (RHC)[25]

[19] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 32
[20] Medicare Managed Care Manual, Chapter 6, "Institutional Provider and Supplier Certification", Section 70
[21] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 1
[22] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 2
[23] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 3
[24] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 4
[25] Medicare Managed Care Manual, "Institutional Provider and Supplier Certification", Section 70

13. Federally Qualified Health Centers (FQHC)[26]
14. If Delegate policies and procedures address all Provider types, the Delegate will not need to specify which types they do not contract with.[27]

C. IEHP's delegation arrangements with Delegates "carves out" behavioral healthcare services, therefore, Delegates are not responsible for the initial and ongoing assessment for behavioral healthcare facilities providing mental health or substance abuse services in an inpatient setting. Residential Treatment Facilities and Ambulatory Behavioral Health Facilities are not covered in this policy, as these are not a covered IEHP benefit.[28,29]

D. Delegates must assess contracted medical health care Providers, Organizational Providers, against the requirements and within the time frame. Delegates may: [30]

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 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.[31]

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. The following sources are included in the assessment of non-accredited free-standing surgical centers:[32,33]

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

[26] Medicare Managed Care Manual, "Institutional Provider and Supplier Certification", Section 70
[27] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 1
[28] NCQA, 2023 HP Standards and Guidelines, CR 7, Element C, Factor 1
[29] Medicare Managed Care Manual, Chapter 11, "Delegation requirements," Section 110.2
[30] NCQA, 2023 HP Standards and Guidelines, CR 7, Element D
[31] NCQA, 2023 HP Standards and Guidelines, CR 7, Element E
[32] Health and Safety Code § 1248.1
[33] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 4

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

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

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

   a. IEHP

      1) Social Security Administration's Death Master File (SSADMF) applies to screening Practitioners against the (SSADMF); however Organizational Providers are not reviewed for individual practitioners, therefore the does not apply to the provider types referenced in this policy.

      2) Restricted Provider Database. Contracting will obtain the Restricted Provider Database report monthly, by the 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.[34]
         - 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.[35]

[34] DHCS APL 21-003
[35] Ibid.

b. Delegate

1) National Plan and Provider Enumeration System (NPPES). IEHP ensures the provider has an active and current Organization NPI.

2) List of Excluded Individuals/Entities (LEIE).

- Practitioners identified on the HHS-Office of Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.[36,37]
    - 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.[38]

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.[39]

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:[40]

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

[36] Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks", § 60.2
[37] DHCS APL 22-013
[38] Medicare Managed Care Manual, Chapter 21, "OIG/GSA Exclusion", Section 50.6.8
[39] DHCS APL 22-013
[40] California Welfare and Institutions Code (Welf. & Inst. Code), 14043.6 and 14123

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

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

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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 DualChoice (HMO D-SNP) 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), State, and Federal regulatory requirements before delegation began.[2]

C. For delegation arrangements in effect for 12 months or longer, Delegates must conduct oversight reviews of the Delegate's credentialing 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]

PURPOSE:

A. IEHP remains responsible for credentialing and recredentialing its Practitioners, even if it delegates all or part of these activities. Delegates are required to monitor the credentialing and recredentialing status and performance of their contracted Practitioners on a continuous basis in compliance with IEHP requirements and current NCQA, State, and federal regulatory guidelines.[5]

B. Delegates must verify that sub-delegates perform the functions discussed in Section 25, of the Provider Manual and in the Delegation Agreement between the Delegate and the sub-delegate.[6]

C. IEHP and any regulatory oversight agency have the right, within two (2) working days advance notice to the Delegate, to examine the Delegates credentialing and recredentialing files or sites as needed to perform oversight of all Practitioners or to respond to a complaint

[1] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 8, Element A, Factors 1-6
[2] NCQA, 2023 HP Standards and Guidelines, CR 8, Element B
[3] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factors 1-6
[4] NCQA, 2023 HP Standards and Guidelines, CR 8, Element D
[5] Ibid.
[6] Medicare Managed Care Manual, Chapter 11, "Delegation requirements," Section 110.2

or grievance.

D. If a Management Services Organization (MSO) and an IPA are owned or under the same ownership, this is not considered delegation.

E. If an IPA changes MSOs during the annual audit period, only the current agreement will be reviewed and scored.

F. If a Delegate terminates a delegation arrangement during the annual audit period, only the termination date will be reviewed.

G. Delegates who delegate to an NCQA accredited entity, the Delegate must audit for Medi-Cal and DMHC requirements. Acceptance of accreditation only will not meet compliance for the additional regulatory requirements.

H. If the Delegate utilizes their sub-delegate for their specialty panel for HIV/AIDS Practitioners, the Delegate must include the Identification of HIV/AIDS Specialists in their annual oversight review.

I. If the Delegate gives another organization the authority to perform certain functions on its behalf, this is considered delegation, e.g., Primary Source Verification of License, collection of the application, verification of Board Certification.

   1. Ongoing monitoring or data collection and alert services are NOT seen as delegation. IF the Delegate uses another organization for collecting data for ongoing monitoring or sanctions monitoring, and the Delegate then handles the review of information and intervention, it is not considered delegation.

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

J. Delegates must provide IEHP all sub-delegation agreements and effective dates.

DEFINITION:

A. Annual: A 12 month period, within a two (2) month grace period, defined by NCQA.

B. Audit Date: The date of the file review.

C. Auto-Credit: Credit given to elements that have been audited by previous accrediting authority and meets industry compliance. Those elements will not be subjected to oversight.

D. Credentials Verification Organization (CVO): An organization that conducts primary-source verification of Practitioner credentials for other organizations. AN organization may obtain the following certification under NCQA CVO status:

   1. Licensure

   2. DEA or CDS verification

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 Delegate via phone, email or in person.

G. Factor: A scored item in an element.

H. Implementation Date: NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

I. Look-back period: Is the date range used for pulling files for a review.

J. Management Services Organization (MSO): an entity that, under contract provides services such as a facility, equipment, staffing, contract negotiation, administration, and marketing.

K. NCQA CR Accreditation: A provider organization that has achieved an NCQA accreditation in credentialing would receive auto-credit for certain standards of credentialing.

L. NCQA CVO Certification: An organization that has been certified by NCQA to collect primary source verifications. AN organization that has obtained this certification will still need to have a full file/policy review but does not need to evaluate on actual verification documentation but on the current and timely verification.

M. NCQA Health Plan Accreditation: A health plan organization that has achieved NCQA accreditation and would receive auto-credit for credentialing. An organization that has obtained this accreditation will still need to have a file/policy review for CMS, or state requirements.

N. Pre-Assessment: Evaluation of a potential delegate's credentialing program prior to executing a delegated agreement.

O. Timeliness: A term used when auditing file elements to confirm they are within 180 calendar days of the credentials committee decision.

P. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source

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

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

PROCEDURES:

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

[7] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 1

the organization and the delegate specifies the CR activities:

a. Performed by the delegate in detailed language.

b. Not delegated but retained by the organization.

1) The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other CR functions not specified in this agreement as the Delegate's responsibility).

c. If the Delegate sub-delegates an activity, the delegation agreement must specify which organization is responsible for oversight of the sub delegate.[8]

d. The delegation agreement(s) must have language that the delegate will adhere to state and federal regulations.

1) This language is not required for Credentialing Verification Organization (CVO) Agreements.

3. Delegate must determine the method of reporting and the content of the reports, but the agreement specifies:

a. The reporting is at least semi-annually for DualChoice line of business. Reporting examples include:[9,10]

1) Lists of credentialed and recredentialed Practitioners.

2) Committee meeting minutes.

3) Facilities credentialed.

b. What information is reported by the Delegate about delegated activities.

c. How, and to whom, information is reported (i.e. joint meetings or to appropriate committees or individuals in the organization).

d. Delegate must receive regular reports from all sub-delegates, even NCQA accredited or NCQA Certified Delegates.

4. Delegates' Delegation Agreement states the process for monitoring and evaluating the delegate's performance.

a. If the organization contracts with delegates that store, create, modify or use credentialing data on the organization's behalf, the delegation agreement specifies:

1) The delegate has credentialing system security controls in place to protect data from unauthorized modification as outlined in CR (Credentialing) 1, Element C

[8] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 2
[9] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 3
[10] Medi-Cal Exhibit A, Attachment 4 of Plan Contract – QI Activities

(Credentialing System Controls), factor 4

2) The delegate monitors its credentialing system controls at least annually, as required in CR 8, Element C, Factor 5

3) The organization monitors the delegate's credentialing system security controls at least annually, as required by CR 8, Element C., Factor 5

b. Boilerplate language in delegation agreement for system controls. If the language specifies that the delegate must meet NCQA requirements (CR 1, Element C, factor 4; CR 8 Element C, Factor 5, template language may be used in the delegation agreement. Language specific to each delegate is not required.

c. Note: It is not considered delegation if the organization outsources credentialing data storage to a cloud-based entity that does not provide services that create, modify or use the credentialing data. [11]

5. Delegate retains the right to approve, suspend and terminate Providers, who participate in the Delegates' network.[12]

a. This does not apply if the subdelegate does not have decision making authority.

b. If the delegation agreement does not specify the right to approve language, the Delegate may provide alternate documentation through another communication between the Delegate and sub-delegate, for review for compliance.

6. If the subdelegate fails to meet the terms of the agreement and, at a minimum, circumstances that result in revocation of the agreement.[13]

B. For new delegation arrangements, the Delegate must evaluate the sub-delegates capacity to meet NCQA, State, and Federal regulatory requirements before delegation began. [14]

1. Delegates may use an accredited Health Plan audit as the pre-delegation evaluation.

a. If Delegate uses a health plan audit, there must be evidence that the health plan audit was reviewed, e.g., Committee minutes, email approval or other methods indicating acceptance of review.

b. If Delegate changes Management Services Organizations (MSOs), the Delegate must evaluate the new MSO prior to contracting.

2. For any amendments or newly delegated activities within the last 12 months, the Delegate must have documentation, dated before the delegation began showing that it evaluated

[11] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 4
[12] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 5
[13] Ibid.
[14] Ibid.

the subdelegate before implementing delegation.[15]

3. If the pre-delegation evaluation was performed more than 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:[16]
    a. Site Visit.
    b. Written review of the subdelegate's understanding of the standards and the delegated tasks.
    c. Staffing capabilities.
    d. Performance records (e.g. Audit).
    e. Exchange of documents and review.
    f. Pre-delegation/Committee meetings.
    g. Telephone consultation.
    h. Virtual review.

C. For delegation arrangements in effect for 12 months or longer the Delegate must:
1. Annually review its Delegate's credentialing policy and procedures.
    a. Review for evidence that the Delegate's staff or committee annually reviewed their subdelegate's credentialing policies and procedures, e.g. audit tool, audit correspondence, audit summary documentation, committee minutes, and email approval, noted in their database or other methods.
    b. A Delegate may use an accredited health plan audit as the annual evaluation.
        1) If Delegate uses a health plan audit, there must be evidence that the health plan audit was reviewed, e.g. Committee minutes, email approval or other methods indicating acceptance of review.
        2) For NCQA-Certified or Accredited Delegates, including certified CVOs:
            - Review evidence of annual review of policy and procedures for delegated functions, as applicable.[17]
2. Annually audits credentialing and recredentialing files against NCQA, State, and Federal regulatory standards for each year that delegation has been in effect.[18]

[15] NCQA, 2023 HP Standards and Guidelines, CR 8, Element B, Factor 2
[16] NCQA, 2023 HP Standards and Guidelines, CR 8, Element B, Factor 4
[17] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 1
[18] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 2

a. Review for evidence that the Delegate's staff or committee annually reviewed their subdelegate's credentialing policies and procedures, e.g. audit tool, audit correspondence, audit summary documentation, committee minutes, and email approval, noted in their database or other methods.

b. A Delegate may use an accredited health plan audit as the annual evaluation.

1) If Delegate uses an accredited health plan audit, there must be evidence that the health plan audit was reviewed, e.g. Committee minutes, email approval or other methods indicating acceptance of review.

2) If Delegate does not use an accredited health plan audit, the Delegate must audit per IEHP standards. (See "Credentialing DOA Audit Tool" found on the IEHP website[19])

c. For delegates NCQA Accredited in CR, accredited as a Health Plan, NCQA Certified CVOs and the contract effective date is greater than 12 months, will be deemed compliant for this element .

3. Annually evaluates delegate performance against NCQA, state and federal regulatory standards for delegated activities.[20]

a. The audit must include all pieces of the credentialing process (e.g., policies and procedures, ongoing monitoring, file audit, etc.).

b. For delegates NCQA Accredited in CR, accredited as a Health Plan, NCQA Certified CVOs and the contract effective date is greater than 12 months, will be deemed compliant for this element.

4. Semi-annually evaluates regular reports, as specified in element A. Acceptable methods of review include:[21]

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

[19] https://www.iehp.org/en/providers/provider-resources?target=forms
[20] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 3
[21] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 4

Improvement Meeting Minutes.

5. The Delegate process for monitoring system security controls covers delegates that store, create, modify of use credentialing or recredentialing data on its behalf. If the organization contracts with such delegates, it has a process for:

   a. Monitoring the delegate's credentialing system security controls in place to protect data from unauthorized modification, as outlined in CR 1, Element C (Credentialing System Controls), factor 4, at least annually.

   b. Ensuring that the delegate monitors, at least annually, that it follows the delegation agreement or its own polices and procedures.

   Both IEHP and the Delegate must monitor the delegate's system security controls as part of the delegation oversight requirements.

   a. Organization's monitoring of the delegate's system security controls. The organization provides documentation (e.g. a report or other type of evidence) that it competed the monitoring process at least annually during the look-back period.

   b. Delegates monitoring of its system security controls. The Delegate provides documentation of modifications that did not comply with its policies and procedures or with the delegation agreement at least annually during the look-back period.

   c. Documentation of monitoring must be provided regardless of system functionality (e.g. the system prevents changes to the original record under any circumstances, but allows creation of a new record to modify dates; allows date modifications only under specific circumstances; uses alerts or flags to identify non-compliance), with the exception of advanced system controls capabilities.

      1) Advanced system controls capabilities. If the credentialing system has advanced system control capabilities, the following are provided in lieu of monitoring reports or other monitoring evidence:

         - A description of the system functionality that ensures compliance with established policies and procedures with the delegation agreement.
         - Documentation or evidence of advanced system control capabilities that automatically record dates and prevent modifications that do not meet modifications criteria; the system must have both capabilities.

      2) Audit. Auditing may be chosen as the method for monitoring.

         - If the credentialing system can identify noncompliant modifications, all noncompliant modifications must be reviewed.
         - Sampling is allowed only if the credentialing system cannot identify all noncompliant modification.

d. IEHP is not required to conduct an audit if it determines that the Delegate adequately monitored and reported noncompliant modifications; the organization reviews the delegate's findings in the audit report instead of conducting its own audit of the delegate's system controls. The Delegate provides documentation (e.g. a report, meeting minutes, other evidence) that it reviewed and agreed with the delegate's findings.

1) If IEHP determines that the delegate did not adequately monitor noncompliant modifications, it must conduct its own audit of delegate's system controls.

2) IEHP must submit its documentation and the delegate's documentation. Documentation indicates the staff roles or departments involved in the audit.

- Delegate files may be audited using one of the following methods:
  - 5% or 50 files, whichever is less, to ensure that information is verified appropriately
    - At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit., the organization audits the universe of files rather than a sample
  - The NCQA "8/30" methodology

Either methodology is allowed, for consistency with other delegation oversight requirements for annual file audits.

3) If the Delegate only provide cloud-based credentialing data storage functions and does not provide services that create, modify or use credentialing data, this element does not apply.

6. The Delegate identifies and documents all actions it has taken, or plans to take, to address all modifications (findings from factor 5) that did not meet the delegation agreement or the delegate's policies and procedures, if applicable. One action may be used to address more than one finding for each delegate or across multiple delegates, if appropriate.

   The Delegate also implements a quarterly monitoring process for each delegate to assess the effectiveness of its actions on all findings.

   a. The Delegate must continue to monitor each delegate until the delegate demonstrates improvement of at least one (1) finding over three (3) consecutive quarters.

   b. If a Delegate did not demonstrate improvement of at least one finding during the look-back period, it submits all quarterly monitoring reports demonstrating ongoing monitoring.

   c. If the organization identified findings less than three (3) quarters before the survey

submission date, it submits all monitoring information is has available.

1) If the Delegate only provide cloud-based credentialing data storage functions and does not provide services that create, modify or use credentialing data, this element does not apply.

2) If the Delegate did not identify any modifications or if all identified modifications me the delegation agreement or the delegate's policies and procedures.

D. For delegation arrangements that have been in effect for more than 12 months, at least in the past year, the organization identified and followed up on opportunities for improvement, if applicable.[22]

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.

3. This does not apply to system controls. Areas of improvement for system controls are addressed in Section C above.

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[22] NCQA, 2023 HP Standards and Guidelines, CR 8, Element D, Factor 1

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 DualChoice (HMO D-SNP) lines of business.

POLICY:

A. Delegate has written policy and procedure describing the process that the Delegate identifies or reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS specialist, according to California State Regulations on an annual basis.

B. On an annual basis, the Delegate identifies and reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS, Specialist according to California State regulations.

C. The list of identified qualifying Physicians is provided to the department responsible for authorizing standing referrals.

DEFINITION:

A. AIDS – Acquired Immunodeficiency Syndrome.

B. Category 1 continuing medical education:

1. For Physicians, continuing medical education as qualifying for category 1 credit by the Medical Board of California;
2. For Nurse Practitioners, continuing medical education contact hours recognized by the California Board of Registered Nursing;
3. For Physician Assistants, continuing medical education units approved by the American Association of Physician Assistants.

C. HIV – Human Immunodeficiency Virus.

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

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub-delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub-delegation oversight.
    a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

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

PROCEDURES:

A. Delegate has a written policy and procedure describing the process that the Delegate identifies and verifies the appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist. An HIV/AIDS Specialist is a Physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the State of California, who meets any one of the four (4) 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 12 months has clinical managed medical care to a minimum of 25 patients who are infected with HIV; and
    b. In the immediately preceding 12 months has successfully completed a minimum of 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 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
    b. Has completed any of the following:
        1) In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious disease from a member board of the American Board of Medical Specialties; or
        2) In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment of both, of HIV-infected patients.

[1] Health and Safety Code (Health & Saf. Code) § 1300.74.16

3) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competence Examination administered by the American Academy of HIV Medicine.

B. Delegate identifies and reconfirms the appropriately qualified physician who meet the definition of an HIV/AIDS Specialist, on annual basis. Delegate must provide:

1. Evidence that the Delegate identifies HIV/AIDS Specialists on an annual basis, which may include, but not limited to the following:

   a. Review current and previous year's survey/spreadsheet/credentialing attestation/logs.

      1) This does not require screening of all the Delegate's practitioners, only those who potentially may qualify and wish to be listed as HIV/AIDS Specialists.

   b. The department responsible for standing referrals may conduct the annual survey, instead of the Credentialing Department; this would meet the intent of this requirement.

   c. Annual screening must be completed within 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 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]

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 30 days from the completion of the screening/survey assessment (e.g., The date of the last survey collected/signed is used to begin your calculation).

      1) A verbal statement that the list was provided to the appropriate department is not acceptable evidence of compliance.

      2) If the list is available to the appropriate department electronically, it is not required to send the list. No evidence is required.

[2] Health & Saf. Code § 1300.74.16
[3] DHCS MMCD All Plan Letter 02001, Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program

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		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2020	
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25. DELEGATION AND OVERSIGHT

B. Credentialing Standards
10. Credentialing Quality Oversight of Delegates

APPLIES TO:

A. This policy applies to all organizations delegated credentialing activities for IEHP DualChoice (HMO D-SNP) line of business.

POLICY:

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

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

C. All Delegates are responsible for recredentialing and/or employed Practitioners within the 36 months of the last credentialing decision, as required by National Committee for Quality Assurance (NCQA). Delegates are required to report their recredentialing activities to IEHP. Delegates must report recredentialing activities and terminations by the 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@iehop.org. All changes and terminations submitted through the Secure File Transfer Protocol (SFTP) server will not be processed.

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

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

PURPOSE:

A. IEHP must receive reports from its Delegates at least semi-annually, however IEHP requires Delegates to submit reports based on the IPA Reporting Requirements Schedule (See "IPA Reporting Requirements Schedule – IEHP DualChoice" found on the IEHP website.[1] At a minimum, Delegates must report its progress in conducting credentialing and recredentialing activities, and on performance-improvement activities, if applicable. Findings from the

[1] https://www.iehp.org/en/providers/provider-resources?target=forms

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.[2]

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.[3]

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.

[2] National Committee for Quality Assurance (NCQA), 2023 HP Standards and Guidelines, CR 8, Element A, Factor 3

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

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

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

2. The Delegate must submit the following for review and consideration:
    a. Contract (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, Nurse Practitioners and Nurse Midwife's to confirm the relationship between the Supervising Physician and Physician Extender(s). (See "Attachment I - Statement of Agreement by Supervising Provider" found on IEHP the website[4])
        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.

[4] https://www.iehp.org/en/providers/provider-resources?target=forms

1) If the IPA provides an alternative arrangement, IEHP does not have on file the IPA will be required to submit those arrangements to ensure compliance with IEHP requirements. (See Policy 5B, "Hospital Privileges")

e. Practitioner profile or spreadsheet that includes all the elements listed below, 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
15.	✓	✓	✓	Practitioner Cultural Background (optional);

	Primary Care Provider (PCP)	Specialist (SCP)	Mid Level (ML)	PROVIDER PROFILE ELEMENT(S)
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
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

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

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

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

1) Review of credentialed Practitioner specialty and relevant education, training, practice experience.
2) Review of requested age range
3) Review of Hospital arrangements, if applicable
4) Review of adverse history;
    - History of negative license action;
    - History of negative privileges action;
    - History of Medicare or Medicaid sanctions; and
    - Other adverse history (including felony convictions, etc.).

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

c. In cases where either the Delegate(s) submitted credentialing information is inconsistent with IEHP guidelines or data, or there is evidence of significant adverse history, the Practitioner is forwarded to the IEHP Peer Review Subcommittee for further review.

1) Delegates must provide a written plan of action for the respective practitioner that includes, but is not limited to:
    - The Credentialing Date the practitioner was presented to review and discussion.
    - The Credentialing Committee decision and/or outcome.
    - If the Delegate will conduct additional monitoring (i.e. grievances and complaints), if so, how frequent
    - If the Delegate issued a plan of action or requested any additional information for the practitioner.
2) The Practitioner is forwarded to the Peer Review Subcommittee for review, discussion and decision. The IEHP Medical Director presents the Practitioner's credentialing file and any other necessary supporting documentation from the IPA, Practitioners, or IEHP to determine if potential quality of care issues for Members exists.
    - If the IEHP Peer Review Subcommittee determines that no potential quality of care concern exists, no further action or review is undertaken.

- The IEHP Peer Review Subcommittee reviews all pertinent information necessary. The IEHP Peer Review Subcommittee determines if there is a potential quality of care concern or adverse event that exists. The Peer 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.[5]

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

1. Failure to meet this timeframe will result in "freezing" the Provider to auto-assignment

[5] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 5

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.[6]

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 dates specified on the IPA Reporting Requirements Schedule (See "IPA Reporting Requirements Schedule – DualChoice" found on IEHP the website.[7]

a. These dates are used to conduct file selections for the Delegates Delegation Oversight Audit for Credentialing; and

b. Track the Delegates Recredentialing timeliness (Recredentialing cycle length)

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

4. Delegates are required to report their credentialing and recredentialing activities, and terminations via excel format. (See "Credentialing and Recredentialing Report", found on the IEHP website.[8] Delegates must submit their report based on the IPA Reporting Requirements Schedule See "IPA Reporting Requirements Schedule – Dual-Choice" found on the IEHP website.[9,10]

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

[6] NCQA, 2023 HP Standards and Guidelines, CR 4, Element A, Factor 1
[7] https://www.iehp.org/en/providers/provider-resources?target=forms
[8] Ibid.
[9] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 3
[10] https://www.iehp.org/en/providers/provider-resources?target=forms

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
  - 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 18, "Provider Network").

1. PCP relocations must pass a California Department of Health Care Services (DHCS) required FSR Survey and close CAPs prior to receiving assignment of members, within 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").[11]
2. Changes in Specialty and age limits are considered practice parameter expansions and reductions and submit the required documentation in Policy 25B1, "Credentialing Standards - Credentialing Policies").
3. Advanced Practice Practitioners (PAs, NMs, and NPs) relocating or changing supervising Physicians, Delegates must provide a current copy of the following documents to ensure compliance with IEHP guidelines (See Policy 6F, "Non-Physician Practitioner Requirements").

   a. PAs must provide one (1) on the following:

      1) Delegation of Services Agreement and Supervising Physician Form See Attachment, "Delegation of Services Agreement and Supervising Physician Form" found on the IEHP website.[12,13] This agreement must:

         - Define specific services identified in practice protocols or specifically

[11] 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"
[12] Title 16 California Code of Regulations (CCR) § 1399.540(b)
[13] https://www.iehp.org/en/providers/provider-resources?target=forms

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, [14] the writing, developed through collaboration among one or more physicians and surgeons and one or more physicians' assistants, that defines the medical services the PA is authorized to perform pursuant to Section 3502[15] and that grants approval for Physicians and Surgeons on the staff of an organized health care system to supervise one or more PAs in the organized health care system. Any reference to a Delegation of Services Agreement relating to PAs in any other law shall have the same meaning as a practice agreement. The Practice Agreement must include provisions that address the following:

- A practice agreement shall include provisions that address the following:[16]
  - The types of medical services a PA is authorized to perform.
  - Policies and procedures to ensure adequate supervision of the PA, including, but not limited to, appropriate communication, availability, consultations, and referrals between a Physician and Surgeon and the PA in the provision of medical services.
  - The methods for the continuing evaluation of the competency and qualifications of the PA.
  - The furnishing or ordering of drugs or devices by a PA.[17]
  - Any additional provisions agreed to by the physician assistant and Physician and Surgeon.
- A practice agreement shall be signed by both of the following:
  - The PA.
  - One or more Physicians and Surgeons or a Physician and Surgeon who is authorized to approve the practice agreement on behalf of the staff of the Physicians and Surgeons on the staff of an organized health care system.

[14] Senate Bill 697
[15] Business and Professions Code (Bus & Prof. Code) § 3502
[16] Bus. & Prof. Code § 3502.3
[17] Bus. & Prof. Code § 3502.1

- 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 that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.
        - For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.
        - After performance of a physical examination by the PA under the supervision of a physician and surgeon consistent with this chapter, certify disability pursuant to Section 2708 of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.

b. NPs and CNMs may perform the following procedures if a standardized procedure is in place:

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

2) Standardized Procedures must be on-site site specific and[18]

- 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.

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

- 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 CNM and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
    - Evidence that the Standards of Care established by the sources were reviewed and authorized by the NP, Physician and administrator in the practice setting (i.e., signature page that includes all parties involved).
- Standardized Procedures written using the PAs Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.

4. Practitioner Terminations. Delegates must provide IEHP 60 calendar days advance notice of any significant change in their network, including the termination of a Practitioner.[19]
    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.[20]
1. On a semi-annual basis, IEHP provides Delegates with the Specialty ad 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

[19] (DHCS APL 21-003 Supersedes APL 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"
[20] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 3

(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.

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, and;

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

1) Within the same specialty;

2) Cover the same age range;

3) Within the same practice; and

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

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.

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

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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25. DELEGATION AND OVERSIGHT

C. Care Management -
1. Delegation and Monitoring

APPLIES TO:

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

POLICY:

A. IEHP delegates to its IPAs and their Provider network the responsibility of providing case management services and coordination of care for their assigned Members. This includes but is not limited to ensuring the coordination of medically necessary health care services delivered within and outside their network, provision of preventive services in accordance with established standards, continuity of care, health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs. For more information on delegated case management and care coordination responsibilities, please see section 12, "Coordination of Care".

B. IEHP maintains the responsibility of ensuring that Delegates continues to be, in compliance with all applicable State and federal laws, contractual and reporting requirements.

C. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated care management activities.[1] Oversight includes monitoring the IPAs' care management activities monthly, quarterly, annually, and as frequently as needed.

PROCEDURES:

Monitoring and Oversight

A. IEHP performs monitoring and oversight of the IPAs' care management activities through the review of care management report logs and files monthly, annually, and as needed.

B. On a routine basis and utilizing the IPA Care Management Review Tools, IEHP reviews the IPA's care coordination/care management activities for elements which may include, but are not limited to, the following (See, "IPA Care Management Review Tool - Medicare" found on the IEHP website[2]):[3]

1. A process for offering care management to all Members;
2. A person-centered, outcome-based approach;
3. Spanning medical and LTSS systems, including coordination with IHSS, with a focus on transitions;
4. Coordination with county agencies and IEHP, if applicable, for Behavioral Health

[1] Title 28 California Code of Regulations (CCR) § 1300.70
[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] DHCS Cal AIM Dual Eligible Special Needs Plans Policy Guide August 2022, Section VI. Quality and Reporting Requirements

services;

5. Development of ICPs with Members;
6. Stratification levels for the care management program and appropriate stratification of Members;
7. A process for ICT meetings; and
8. Frequency of care management contact for each care management stratification level.

C. IEHP selects and reviews, at a minimum, 15 targeted cases each month to ensure that care management requirements are met. Additional files may be selected depending on population size.

D. IEHP provides education and training on care coordination annually, per IPA request and as needs are identified through oversight activities.

E. Upon request, the IPA must submit a complete and comprehensive Corrective Action Plan (CAP) to IEHP that adequately addresses all deficiencies noted on the audit tool. See Policy 25A3, "Delegation Oversight – Corrective Action Plan Requirements" for more information.

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25. DELEGATION AND OVERSIGHT

C. Care Management
2. Reporting Requirements

APPLIES TO:

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

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable state and federal laws, as well as all contractual and reporting requirements.

B. IEHP oversees, monitors, and evaluates the performance of delegated and non-delegated care management activities.[1] Oversight activities include, but are not limited to, reviewing reports submitted by the IPAs, as described below.

PROCEDURES:

A. All reports must be submitted to IEHP timely and in the correct format via IEHP's Secure File Transfer Protocol (SFTP) (See, "Medicare Provider Reporting Requirements Schedule" found on the IEHP website[2]). Files not submitted in the correct format will be rejected, and the IPA will be required to resubmit in the appropriate format.

B. Each IPA must submit the information noted in the monthly Medicare Care Management logs (See, "Monthly Medicare Care Management Log," "Monthly Medicare Care Plan Outreach Log," and "Monthly Medicare Interdisciplinary Team Log," found on the IEHP website[3]). These logs are to include all Members, including those that the IPA are unable to contact, those enrolled into care management, Interdisciplinary Care Team (ICT) enrollment, and Long-Term Services and Supports (LTSS) services, as well as those that decline to participate.

C. IEHP will select cases from various data sources for monthly file review. IPAs will be provided with file selections by the 1st business day of the month for submission via the SFTP by the 15th day of the same month.

D. Repeated failure to submit required reports timely and in the right format may result in the request of a Corrective Action Plan (CAP), freezing of new Member enrollment or termination or non-renewal of the IEHP Agreement. Upon request, the IPA must submit a complete and comprehensive CAP to IEHP that adequately addresses all deficiencies noted on the audit tool. See Policy 25A3, "Delegation Oversight – Corrective Action Plan Requirements" for more information.

[1] Title 28 California Code of Regulations (CCR) § 1300.70
[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] Ibid.

25. DELEGATION AND OVERSIGHT

C. Care Management

2. Reporting Requirements

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25. DELEGATION AND OVERSIGHT

D. Quality Management

1. Quality Management Reporting Requirements

APPLIES TO:

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

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue maintain compliance with all applicable State and federal laws, contractual and reporting requirements.

B. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated quality improvement (QI) activities.[1] Oversight activities include but are not limited to the review of semi-annual and annual reports.

DEFINITION:

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

PROCEDURES:

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

1. Reporting requirements include a QM semi-annual assessment, which documents the progress of the QM, QI and Utilization Management (UM) activities found in the QM Work Plan.

    a. **Quality Management** – Reports must identify and address the following:

        1) Quality of Clinical Care;
        2) Quality of Service;
        3) Safety of Clinical Care;
        4) Members' Experience;
        5) Program Scope;
        6) Yearly Objectives;
        7) Yearly Planned Activities;
        8) Timeframe within which each activity is to be achieved;

[1] Title 28 California Code of Regulations (CCR) § 1300.70

9) Staff member(s) responsible for each activity;

10) Monitoring of previously identified issues; and

11) Evaluation of the QM/QI program.

2. QM Semi-Annual Reports must be submitted to IEHP via IEHP's Secure File Transfer Protocol (SFTP) by these due dates, regardless of whether these dates fall on a weekend or holiday:

   a. 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 25A3 "Delegation Oversight - Corrective Action Plan Requirements."

B. **Annual Reporting Requirements:** The following reports must be submitted annually to IEHP via IEHP's SFTP no later than the 15th of February each calendar year regardless of whether this date falls on a weekend or holiday:

1. **Quality Management**[2]

   a. **Quality Management Program Description:** Reassessment of the QM Program Description must be done on an annual basis by the QM Committee and reported to IEHP. The following must be included with the submission to IEHP:

      1) Any changes made to the QM Program Description during the past year or intended changes identified during the annual evaluation; and

      2) Signature page noting date of committee approval.

   b. **Quality Management Work Plan:** Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include planned audits, follow-up activities and interventions related to identified problem areas.

   c. **Quality Management Program Annual Evaluation:** The evaluation should include a description, trending, barrier analysis and evaluation of the overall effectiveness of the QM Program. See Policy 25D2, "Quality Management - Quality Management Program Structure Requirements," for more information.

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

25. DELEGATION AND OVERSIGHT

D. Quality Management

1. Quality Management Reporting Requirements

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

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25. DELEGATION AND OVERSIGHT

D. Quality Management
2. Quality Management Program Structure Requirements

APPLIES TO:

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

POLICY:

A. IEHP is accountable for all quality improvement functions and responsibilities that are delegated and maintains the responsibility of ensuring that Delegates maintain compliance with all applicable State and Federal laws, contractual and reporting requirements.[1]

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, "IPA Delegation Agreement – IEHP DualChoice" found on IEHP website).[2] IEHP monitors Delegates' QM Program Structure and implementation of quality management activities to ensure the delegate is continuously monitoring and improving the quality of care, access to care, service and patient safety delivered to IEHP Members.

C. Delegates must maintain a written QM Program Description, QM Work Plan, Annual QM Evaluation, and related QM Policies and Procedures that meet Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA) and IEHP standards for Quality Management.

DEFINITION:

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

PROCEDURES:

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

1. **Quality Management**

   a. **Quality Structure** – Delegates are required to have a structure in place that monitors quality activities, including a formal Committee structure and sufficient personnel in place to perform quality management activities.

   b. **Quality Studies** – Delegates are required to perform a minimum of two (2) quality studies for their Membership per calendar year. One (1) study must be in the area of access; the other study should be an area pertinent to the Delegate, IEHP Membership

[1] Medicare Managed Care Manual, "Chapter 11 – Medicare Advantage Application Procedures and Contract Requirements" Section 110.2

[2] https://www.iehp.org/en/providers/provider-resources?target=forms

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 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 25C1, "Care Management – Delegation and Monitoring," for more information.
5. **Practitioner Education**[3] – Delegates and IEHP share Provider education and training responsibilities including orientation to IEHP DualChoice line of business, delineation of IEHP policies and procedures pertinent to the Practitioner, site and medical record audit preparation, specialized support, and training such as pediatric or adult preventive services and health education.
    a. Delegates are also required to be aware and require their Practitioners' use of certain forms, supplied by IEHP on the Provider website, including the Perinatal Risk Assessment Forms, Individual Health Education Behavioral Assessment (IHEBA) forms, etc. IEHP forms are available online at www.iehp.org.
6. **Health Education** – IEHP notifies the Delegate's CM department for the purpose of individualized care management and referral to appropriate health education programs. IEHP works collaboratively with Providers and Practitioners to identify and educate these Members. IEHP provides certain network-wide health education programs to all Members. IEHP supplies Delegates and PCPs with health education brochures, materials, forms and a Provider Resource Directory. Refer to Section 15, "Health Education" for more information.
7. **Medical Records Maintenance** –IEHP and Delegates are required to monitor Physician offices for compliance with medical record requirements. Practitioners are required to maintain policies and procedures consistent with IEHP requirements, see policy 7A, "Provider and Delegated IPA Medical Records Requirements."
8. **Preventive Care and Non-Preventive Care Guidelines** – Practice guidelines are developed by IEHP using current published literature, current practice standards, and expert opinions. They are based upon specific medical issues commonly found within IEHP's Membership. Delegates are expected to monitor Practitioner's care related to clinical practice guidelines as applicable.
9. **Access Standards**[4] – 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 12 months prior to implementing delegation activities using an audit tool that reflects current NCQA, DHCS, and IEHP standards.[5]

C. **Annual Quality Management Program Description**

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

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

D. **Quality Management Work Plan**

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

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

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

- General Medical Care
- General Medical and Behavioral Health

3) Access;

4) Experience Improvement;

5) Patient Safety; and

6) Other QI Activities.

b. Each Component must include:

1) Objectives;

2) Activities planned;

3) Responsible person for each activity; and

4) Timeframe within which each activity is to be completed.

c. Semi-annually, the Delegate must include a description of the following areas for each separate component:

1) Reporting Period;

2) Key findings;

3) Interventions taken;

4) Analysis of findings along with progress; and

5) Any follow-up actions.

3. QM Semi-Annual Reports must be submitted to IEHP. Please see policy 25D1, "Quality Management - Quality Management Reporting Requirements" for information on schedule and method of submission.

F. **QM Program Annual Evaluation**

1. The QM Annual Evaluation may be included in the QM Work Plan or be a separate document. The Annual Evaluation must evaluate the Delegate's performance on planned QM Activities described in its QM Program Description and Work Plan, including all delegated activities. The Annual Evaluation must include the following:

a. A description of completed and ongoing QM and QI activities that address quality and safety of clinical care and quality of service;

b. Trending of measures to assess performance in the quality and safety of clinical care and quality of service;

c. Analysis of the results of QM and QI initiatives, including barrier analysis; and

d. Analysis and evaluation of the overall effectiveness of the QM program and of its progress toward influencing network-wide safe clinical practices.

2. The QM Annual Evaluation must be submitted to IEHP. See policy 25D1, "Quality Management - Quality Management Reporting Requirements" for more information on schedule and method of submission.

G. **QM Reporting Requirements** - Delegates are required to report the following information on a periodic basis see Policy 25D1, "Quality Management - Quality Management Reporting Requirements," for more information on these reporting requirements:

1. QM Program Description;
2. QM Work Plan;
3. QM Semi-Annual Reports of quality improvement activities; and
4. QM Program Annual Evaluation; and
5. Quality Studies performed by the Delegate when appropriate or as requested by IEHP.

H. **Quality Management Committee**[6]

1. The QM Committee is an interdisciplinary committee with participation from the Delegate's appointed Practitioners who represent network Physicians. The Delegate's QM Committee is responsible for monitoring, measuring, and evaluating the quality, effectiveness, safety, coordination and appropriateness of the care provided by Practitioners to Members for the purpose of continued quality improvement.
2. The Delegate's description of the QM Committee must include the following:
   a. Role;
   b. Function;
   c. Structure that includes organizational structure and reporting responsibility;
   d. Membership;
   e. Terms of service;
   f. Voting rights;
   g. Quorum definition;
   h. Meeting frequency;
   i. Minute format and storage; and
   j. Committees associated with oversight of delegated activities.
3. The Delegate's description of the QM Committee must its involvement and oversight of

the following activities:

a. Recommending policy decisions;

b. Analyzing and evaluating QM Activity findings;

c. Ensuring Practitioners' participation in the QM Program through planning, design and implementation or review;

d. Implementing needed actions;

e. Ensuring needed follow-up; and

f. Maintain signed and dated meeting minutes.

4. The Delegate's QM Committee must meet at least quarterly and follow a prescribed agenda.

5. The Delegate's QM Committee discussions, conclusions, recommendations, and actions must be documented in the signed Committee minutes.

I. **Confidentiality -** Providers must fully comply with all State, Federal and IEHP regulatory requirements pertaining to confidentiality, privacy and information disclosure of medical records. See Policy 7B "Information Disclosure and Confidentiality of Medical Records."

1. **Medical Records Release –** Medical records contain confidential information that must not be released to any party other than the Member's Primary Care Provider (PCP) without the expressed written consent of the Member or legal representative. The PCP must maintain procedures for obtaining such written consent prior to release of records. See Policy 7B, "Information Disclosure and Confidentiality of Medical Records," for more information.

2. **Members' Right to Confidentiality** – Members have the right to confidentiality of medical information.[7] 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 9D, "Access to Services with Special Arrangements."

4. **Conflict of Interest**[8] **–** Should an issue arise involving care provided by a Physician member of the QM Committee or any Subcommittee, that Physician is replaced by a substitute until the issue is resolved. The Member involved in the issue has all rights normally given to anyone with a case presented to the Committee or Subcommittee. Committee members are required to sign a confidentiality and conflict of interest statement.

5. **Informed Consent for Treatment** – Practitioners must obtain appropriate written consent for treatment prior to actual procedure performance. See Policy 7C, "Informed Consent," for more information.

J. **Provider Participation**

1. **Provider Information** – Delegates are required to inform network Practitioners of guidelines, policy and procedure changes, and other important information. Delegates' methods of Practitioner education or notification are evaluated annually during Delegation Oversight Audits. Providers are informed of policy and procedure changes and other important information through the IEHP Provider Newsletter, letters, memorandums, distribution of updates to the Provider Manual, and training sessions. Delegates are notified through letters, memorandums, Provider Manual updates, training sessions for specific issues, Joint Operations Meetings, and by attending IEHP University, when available.

2. **Provider Cooperation:** IEHP requires that Delegates and Hospitals cooperate with IEHP QM Program studies, audits, monitoring, and quality related activities. Requirements for cooperation are included in Hospital and Delegate Provider contract language that describes contractual agreements for access to information.

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

1. Delegate and Provider Agreements include the following provisions:

   a. Delegate is subject to, and agrees to participate in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievance and/or appeal resolution.

   b. Delegate shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records, financial records pertaining to the cost of operations and income received by Delegate for

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

c. Delegate shall cooperate with IEHP's QM Program and, upon reasonable request, shall provide IEHP with summaries of or access to records maintained by Delegate and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.

d. Delegate shall not impede open Practitioner-patient communication. Members are allowed to participate with doctors in decision-making about their own health care including the ability to talk with their doctor about their medical condition regardless of cost or benefit.

2. Hospital contracts include provisions for the following:

a. Hospital agrees to participate with IEHP in the IEHP QM Program, with regular IEHP monitoring and evaluation of compliance with QM Program standards and IEHP policies and procedures, including participation in Member grievances and resolution. Hospital shall also provide access to IEHP utilization review and case management personnel for the purpose of conducting concurrent review and case management on Members who are receiving Hospital services.

b. Hospital shall implement an ongoing QM Program and shall develop procedures for ensuring that the quality of care provided by Hospital conforms with generally accepted Hospital practices prevailing in the managed care industry. Hospital shall develop written procedures for remedial action whenever, as determined by the QM Program, inappropriate or substandard services have been furnished, or services that should have been furnished have not been furnished.

c. Hospital shall provide access at reasonable times, upon demand by IEHP, to inspect facilities, equipment, books and records including Member patient records and financial records pertaining to the cost of operations and income received by Hospital with a five (5) working day prior written notice of any such inspection. Hospital shall ensure that Providers allow IEHP to access and use Provider performance data.

d. Hospital shall cooperate with IEHP's QM Program and, upon reasonable request, provide IEHP with summaries of or access to records maintained by Hospital and required in connection with such programs, subject to applicable state and federal law concerning the confidentiality of medical records.

L. **Auditing and Monitoring Activities[9] -** IEHP performs a series of activities to monitor Delegate functions including the following:

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

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

2. **Joint Operations Meetings (JOMs)** - JOMs with Delegates are intended to provide a forum to discuss issues and ideas concerning care for Members. They allow IEHP a method of monitoring plan administration responsibilities that the Delegates are required to perform. JOMs may address specific UM, QM, QI, CM, grievance, study results, or any other pertinent quality issues.
3. **Member or Practitioner Grievance Review -** IEHP reviews individual grievances and their resolutions for Delegate policies or procedures, actions, or behaviors that could potentially negatively impact health care delivery or Member health status.
4. **Specified Audits -** IEHP performs specific audits of Delegates and PCPs to assess compliance with IEHP standards. These audits include facility reviews, claims audits, CM audits, and health education audits.
5. **Focused Audits** - IEHP performs focused audits of Delegates or Practitioners as indicated whenever a quality or clinical issue is identified.
6. **Review of Referral Universes -** All Delegates are required to submit monthly referral universes to IEHP as well as denial letters sent to Members. All denials are reviewed for appropriateness and trends or patterns of concern. See Policy 25E2, "Utilization Management Reporting Requirements" for complete information on UM reporting requirements.
7. **Review of CM Logs and Case Files -** All Delegates are required to submit monthly CM Logs to IEHP listing all CM cases from the previous month. In addition, Delegates are required to submit copies of CM files. All files are reviewed for appropriateness and trends or patterns of concern. See Policy 25C2, "Care Management - Reporting Requirements" for complete information on CM reporting requirements.
8. **Delegated Reporting Requirements Review -** IEHP performs review of scheduled submitted reports as defined in the IPA Reporting Requirements Schedule (See, "IPA Reporting Requirements Schedule – Medicare" found on IEHP website),[10] and delegated activities as defined in the Delegation Agreement (See, "IPA Delegation Agreement – IEHP DualChoice" found on IEHP website).[11]
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

[10] https://www.iehp.org/en/providers/provider-resources?target=forms
[11] https://www.iehp.org/en/providers/provider-resources?target=forms

and the denial process, including denial letters. See 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 25A3, "Delegation Oversight – Corrective Action Plan Requirements."

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25. DELEGATION AND OVERSIGHT

E. Utilization Management
1. Reporting Requirements

APPLIES TO:

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

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates comply with all applicable State and federal laws, contractual and reporting requirements.

B. IEHP oversees, monitors, and evaluates performance of delegated and non-delegated utilization management activities.[1,2] Oversight activities include but are not limited to the review of these monthly, quarterly, and annual reports.

DEFINITION:

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

PROCEDURES:

A. **Monthly Reporting Requirements:**

1. Monthly reports are due to IEHP by the 15th of the month following the month in which services were approved, denied, partially approved (modified), or dismissed and include the following:

   a. **Referral Universe** – Using the universe templates in Excel file format, the Delegate must report all approved, denied, partially approved (modified), and dismissed referrals during the report period (See "IEHP Universe Standard Auth MSSAR Template," "IEHP Universe Standard Auth MSSAR Data Dictionary," "IEHP Universe Expedited Auth MESAR Template," and "IEHP Universe Expedited Auth MESAR Data Dictionary" found on the IEHP website[3]).

   b. **Denials and Partial Approvals (Modifications)** – The Delegate must submit all referral and clinical information, as well as copies of all denial letters from the reporting period. Partial approvals (modifications) occur when a decision is made, and proposed care is denied or altered.

[1] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/ Coverage Determinations and Appeals Guidance", Section 10.4.3
[2] Title 28 California Code of Regulations (CCR) § 1300.70
[3] **https://www.iehp.org/en/providers/provider-resources?target=forms**

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

- **Not Medically Necessary** – Does not meet approved nationally recognized criteria or IEHP UM Subcommittee Approved Authorization Guidelines. Please see Policy 25E1, "Utilization Management Delegation and Monitoring" for a list of these criteria.
- **Out-of-Network** – Requested provider is a non-contracted Provider. Out-of-Network requests must be reviewed by a physician and must be considered as a medical necessity decision.
- **Experimental** – Requested service has not been approved by the Food and Drug Administration (FDA) and/or is not an accepted practice in the medical community and/or has not been proven to have a therapeutic benefit.
- **Non-Benefit** – Not a covered benefit.

c. **Approval File Review** – Using the universe reports submitted by the Delegate, IEHP will select ten (10) Approval Files to audit. Delegate submissions of Approval Letters need to include the supporting documentation used to make the decisions. Delegates must submit all required documentation related to the file selections by the 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 "Second Opinion Tracking Log" found on the IEHP website[4]).

B. **Quarterly Reporting Requirements:**

1. Quarterly report deadlines are outlined in "Medicare Provider Reporting Requirements Schedule" (found on the IEHP website[5]), Delegates should refer to this document for specific report due dates. The reports should include, at a minimum, the Delegate's IEHP Member-specific UM goals and activities, trending of utilization activities for under and over utilization, Member and Practitioner satisfaction activities, interrater reliability activities, and a narrative of barriers and improvement activities. The quarterly reports must also include:

   a. **UM Program Annual Evaluation/HICE Report** - The Delegate's evaluation of the overall effectiveness of the UM Program, including whether goals were met, data, performance rates, barrier analysis, and improvement activities; and

[4] https://www.iehp.org/en/providers/provider-resources?target=forms
[5] https://www.iehp.org/en/providers/provider-resources?target=forms

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 by February 15th of each calendar year:

1. **UM Program Description:** Reassessment of the UM Program Description must be completed annually by the UM Committee and/or Quality Management (QM) Committee and reported to IEHP including the following:

   a. Any changes made to the UM Program Description during the past year or intended changes identified during the annual evaluation; and

   b. UM Program Description Signature Page.

2. **UM Work Plan/Initial HICE Report:** Submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include measurable goals, planned audits, follow-up activities and interventions related to identified problem areas.

D. Delegate reports must be received by IEHP electronically using a Secure File Transfer Protocol (SFTP) server.

E. Reports are due on or before the due dates regardless of whether the due date lands on a weekend or a holiday.

F. Repeated failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), and may lead to freezing of new Member enrollment, termination, or non-renewal of the IEHP Agreement.

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	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2012	
Revision Effective Date:	January 1, 2024	

25. DELEGATION AND OVERSIGHT

E. Utilization Management
2. Referral and Denial Audits

APPLIES TO:

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

POLICY:

A. IEHP maintains the responsibility of ensuring that Delegates continue to be in compliance with all applicable State and federal laws, contractual and reporting requirements.

B. IEHP oversees, monitors and evaluates performance of delegated and non-delegated utilization management activities.[1,2] Oversight activities include but are not limited to monthly, annual and focused audits.

DEFINITION:

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

PROCEDURES:

Monthly Retrospective Audit of Denials and Partial Approvals (Modifications)

A. IEHP performs a monthly retrospective audit of up to 30 denied and partially approved (modified) referrals submitted by the Delegate (See, "Denial Log Review Tool – IEHP DualChoice" found on IEHP website.[3]

B. IEHP may request for more denied and partially approved referral files in addition to those submitted monthly by the Delegate.

C. IEHP uses the standard and expedited authorization universes for the monthly retrospective denial audits to evaluate referral timeliness and document the examined referral results.

D. In order to pass the Monthly Retrospective Audit for Denials and Partial Approvals (Modifications) audit, the Delegate must achieve an overall score of 90%:

1. See the Denial Log Review Tool for a list of Audit Elements (See, "Denial Log Review Tool – IEHP DualChoice" found in IEHP website.[4].

[1] Medicare Managed Care Manual, "Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance", Section 10.4.3
[2] Title 28 California Code of Regulations (CCR) § 1300.70
[3] https://www.iehp.org/en/providers/provider-resources?target=forms
[4] https://www.iehp.org/en/providers/provider-resources?target=forms

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 new Member and Provider notification of the overturned decision.

E. If the Delegate fails to achieve a Compliance score of 90% for two (2) consecutive months on any of the audit areas above, a Corrective Action Plan (CAP) will be required. IEHP may issue a CAP in any given month for significant declines in performance. At its discretion, IEHP may also enforce one (1) or more of the following:

1. Concurrent denial/partial approval review for a percentage of total denials/partial approvals (modifications) may be initiated at which time the Delegate may receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
3. A focused meeting with the Delegate's administration and IEHP's leadership;
4. Sanctions may be enforced as outlined in the Delegate's contract with IEHP under Retrospective Denial Audits; and/or

F. Other actions as recommended by IEHP's Delegation Oversight Committee.

G. Repeated non-compliance may result in the termination of the Delegate's contract.

H. Delegates who disagree with the audit score can appeal in writing to the IEHP Senior Medical Director within 30 calendar days after the release of the final audit results.

Denial Letter Sanction Program

A. IEHP applies the Denial Letter Sanction to ensure that denial letters meet CMS standards (See, "Program Description - Denial Letter Sanction – IEHP DualChoice found on IEHP website.[5]

B. The Denial Letter Sanction Program includes the following components:

1. Denial Letters must meet, with 100% accuracy, the below components (See, "Denial Log Review Tool – IEHP DualChoice" found on IEHP website;[6]
2. Use of correct letter template including attachments; Member denial language that is understandable (sixth (6^{th}) grade reading level);
3. Denial letter is processed timely, with the inclusion of accurate dates of receipt; and

[5] https://www.iehp.org/en/providers/provider-resources?target=forms
[6] https://www.iehp.org/en/providers/provider-resources?target=forms

4. Denial reason is in accordance with appropriate criteria cited and coincides with denial type.

Monthly Retrospective Audit of Approvals

A. IEHP performs a monthly retrospective audit of 10 approved referral files selected by IEHP from the SARAG SOD and SARAG EOD universes submitted by the Delegate for the reporting month.

B. IEHP may request for more approved referral files in addition to the 10 referral files submitted monthly by the Delegate.

C. IEHP uses standard and expedited authorization universes for the monthly retrospective approval audits to evaluate referral timeliness and document the examined referral results.

D. In order to pass the Monthly Retrospective Audit of Approvals, the Delegates must achieve a score of 90% or greater on the Overall Approval File Review (See, "Approved Referral Audit Tool" found on IEHP website.[7]

E. If the Delegate fails to achieve a Compliance score of 90% for two (2) consecutive months, a Corrective Action Plan (CAP) will be issued. IEHP may issue a CAP in any given month for significant declines in performance. At its discretion, IEHP may also enforce one (1) or more of the following:

   1. Concurrent approval review for a percentage of total approvals may be initiated at which time the Delegate may receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
   2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly audit for two (2) consecutive months;
   3. A focused meeting with the Delegate's administration and IEHP's leadership; and/or
   4. Other action as recommended by the Delegation Oversight Committee.

F. Repeated non-compliance may result in the termination of the Delegate's contract.

G. Delegates who disagree with the audit score can appeal in writing to the IEHP Senior Medical Director within 30 calendar days after the release of the final audit results.

Delegation Oversight Audit (DOA)

A. IEHP performs an annual Delegation Oversight Audit (DOA) of all Delegates to review their UM process. Please see Policy 25A2, "Delegation Oversight – Audit" and the Delegation

[7] https://www.iehp.org/en/providers/provider-resources?target=forms

Oversight Audit Preparation Instructions (See, "Delegation Oversight Audit Preparation Instructions – IEHP DualChoice" found on IEHP website)[8] for more information.

B. UM Process Review Components:

1. IEHP selects, at minimum, 15 approved/denied/partially approved/dismissed referrals to review. File review will be performed via webinar. The Delegate is responsible for walking IEHP through each referral via the Delegate's medical management system.
2. IEHP ensures that mechanisms are in place to ensure data integrity.
3. One (1) hour before the audit, the Delegate will be provided with the list of referrals to be reviewed with the exception of the dismissed referrals.
4. IEHP will request details of the process used by the Delegate to ensure ongoing compliance with CMS regulations and Plan policies.

C. In order to pass the UM Referral and Denial audit sections of the DOA, the Delegate must achieve a score of at least 90% on the file review.

D. Delegates that score below 90% on the approved referral and/or denial and partial approval (modification) sections above are required to submit a CAP addressing all deficiencies noted at the audit within a specified timeframe. Delegates who disagree with the audit results can appeal through the IEHP Provider appeals process by submitting an appeal in writing to the IEHP Senior Medical Director within 30 calendar days after the release of the final audit results.

E. Delegates that score 90% may still be required to submit a CAP to address any deficiencies.

F. Audit results are included in the overall annual assessment of Delegates.

Focused Audits

A. Focused audits are conducted under the following circumstances:

1. Follow-up audit for deficiencies identified from prior audits including but not limited to the DOA and monthly retrospective audit;
2. Review of approvals, denials, partial approvals (modifications), and/or dismissals demonstrate that decisions are being made inconsistently, do not appear to be medically appropriate, or are not based on nationally recognized clinical criteria.
3. Number of Corrective Action Responses (CARs) issued to Delegate as a result of IEHP routine monitoring;
4. Compliance issues self-reported by the Delegate;

[8] https://www.iehp.org/en/providers/provider-resources?target=forms

5. Potential risk areas identified by IEHP (i.e., Member and Provider grievances, appeals);
6. Number of months IEHP has placed Delegate on concurrent review for specific delegated UM functions;
7. Significant increase in volume of IEHP assigned Members in the applicable LOB;
8. A specific inquiry initiated by the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), or Centers of Medicare and Medicaid Services (CMS); and
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 30 cases which consist of approvals, denials and partial approvals (modifications) for the case file review. The cases are provided to the Delegate one (1) hour before the start of the audit webinar. Sample cases are reviewed against defined compliance standards to determine any areas of non-compliance and/or systemic problems within the Delegate's utilization management process.

E. IEHP will also select five (5) dismissed referrals from the submitted universe to review for appropriateness. The dismissed referrals will not be provided to the Delegate prior to the audit webinar.

F. If IEHP identifies a potential issue during the case file review, additional detail will be required to determine:

1. If the issue is systemic;

2. The root cause of the issue; and
3. How many Members were impacted.

G. 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.

H. 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 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".

I. 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.

J. IEHP will review and approve ICARs and CARs after IEHP determines that CAPs adequately address all the identified deficiencies.

K. IEHP will perform a CAP validation webinar audit to ensure that all CAPs have been implemented per Delegate's CAP.

L. Once validation is complete, and all findings have been resolved, then IEHP will close out the focused audit CAP and notify the Delegate accordingly. Any unresolved findings will require for the CAP to remain open. At its discretion, IEHP may also enforce one (1) or more of the following:

1. Concurrent denial review for a percentage of total denials may be initiated at which time the Delegate will receive a score of zero (0) for each month the concurrent review is conducted. IEHP will determine the percentage required for concurrent review;
2. The Delegate may be frozen to new Member enrollment until the Delegate passes the monthly Focused audit for two (2) consecutive months;
3. A focused meeting with the Delegate's Administration and IEHP's leadership; and/or
4. Sanctions may be enforced as outlined in the Delegate's contract with IEHP under Retrospective Approval and Denial Audits.

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25. DELEGATION AND OVERSIGHT

F. Encounter Data Reporting

1. Medicare Reporting Requirements – IEHP DualChoice (HMO D-SNP) Plan

APPLIES TO:

A. This policy applies to IPAs contracting with IEHP DualChoice (HMO D-SNP) Plan.

POLICY:

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

PURPOSE:

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

PROCEDURES:

A. IPAs are required to provide the DHCS D-SNP data elements that are reported to the Centers for Medicare and Medicaid Services (CMS) on a pre-determined schedule. IPAs must submit IEHP DualChoice (HMO D-SNP) data for all DHCS D-SNP measures as follows:

   1. Medicare Provider Reporting Requirements (See, "Medicare Provider Reporting Requirements Schedule" found on IEHP website.[1]

B. IPAs must submit their required report(s) using the appropriate naming convention on a monthly, quarterly, semi-annual and/or annual basis via IEHP's Secure File Transfer Protocol (SFTP) (See, "Medicare Provider Reporting Requirements Schedule" found on IEHP website.[2]

C. IPAs must provide complete and accurate data submissions for each element requested for each reportable measure. Details for the Universe template layouts are available as follows:

   1. Attachment, "Table1 OD and Table PYMT_C Data Dictionary" found on IEHP website;[3]

D. For each reportable measure, IPAs must use the provided reporting template that supports the required reporting elements:

   1. Reporting Template - The report includes aggregate metrics supporting each element specified for each measure (Sees, "Care Transition Cases Log," "Table 1 Standard and Expedited Pre-Service Organization Determinations (OD)", "Table 3 Payment

[1] https://www.iehp.org/en/providers/provider-resources?target=forms
[2] https://www.iehp.org/en/providers/provider-resources?target=forms
[3] https://www.iehp.org/en/providers/provider-resources?target=forms

Organization Determinations and Reconsiderations (PYMT_C)", – "Monthly Medicare Care Management Log," "Monthly Medicare Care Plan Outreach Log" and "Enrollee Protections Report Template" found on IEHP website.[4]

E. If CMS releases revised DHCS D-SNP specifications for the measures requested during the reportable calendar year, IPAs must re-submit reports using reporting templates with the most current reporting specifications. IEHP may re-issue a revised template if necessary. Resubmissions must be complete within IEHP-defined timelines.

F. Any questions IPAs have regarding CMS DHCS D-SNP reporting requirements should be communicated through IEHP's Delegation Oversight Department.

G. IEHP works with each Delegate to ensure that any identified problem areas are corrected in a timely manner. Additionally, when a report and/or data file is not submitted to IEHP by the due date, IEHP requests a Corrective Action Plan (CAP) from the Delegate to remedy the problem, see Policy 25A3, "Delegation Oversight - Corrective Action Plan Requirements." Failure to submit DHCS D-SNP reports that meet IEHP's submission requirements for Timeliness and Accuracy may result in IEHP deducting one percent, unless successfully appealed, of the Delegate's monthly capitation for reports that fails to meet Timeliness and Accuracy reporting requirement. Appeals must be submitted following the appeal process as defined in Policy MA_25A1, "Delegation Oversight - Delegated Activities."

ATTACHMENTS FOUND ON IEHP WEBSITE:[5]

A. Care Transition Cases Log (TOC Log)

B. Care Coordinator to Member Ratio Template (5.1)

C. Monthly Medicare Care Management Log

D. Enrollee Protections Report Template, CA2.1

E. Care Coordinator Training for Supporting Self-Direction

F. Medicare Provider Reporting Requirements Schedule

G. MM Capitated Financial Alignment Model Reporting

H. Monthly Medicare Care Plan Outreach Log

I. Table 1 Standard and Expedited Pre-Service Organization Determinations (OD)

J. Table 3 Payment Organization Determinations and Reconsiderations (PYMT_C)

[4] https://www.iehp.org/en/providers/provider-resources?target=forms
[5] https://www.iehp.org/en/providers/provider-resources?target=forms

25. DELEGATION AND OVERSIGHT

F. Encounter Data Reporting

1. Medicare Reporting Requirements – IEHP DualChoice (HMO D-SNP) Plan

K. Table1 OD and Table PYMT_C Data Dictionary

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25. DELEGATION AND OVERSIGHT

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

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Delegates and Providers.

POLICY:

A. Delegates are required to have a process to receive and act on all information sent to them from IEHP for purposes of supporting Member care coordination activities.

B. Each IPA and subcontractor agree to share with IEHP available supplemental data related to Healthcare Effectiveness Data and Information Set (HEDIS®), Star Ratings Program, Risk Adjustment and other Quality Management (QM) and Quality Improvement (QI) Activities.

DEFINITION:

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

PROCEDURES:

A. IEHP provides IPAs and Provider Subcontractors, Member information that supports Care Coordination activities for its Members, specifically;

1. Completed Health Risk Assessment (HRA) data;
2. Care Management Care Plans (if applicable);
3. Care Management Program Details;
4. Open Authorizations;
5. Medicare Hierarchical Condition Categories (HCC) information;
6. Monthly Membership Report (MMR) and MOR (Model Output Report) data files;
7. Annual Model Output Report Final (MORF);
8. Supplemental Data (e.g. Healthcare Effectiveness Data and Information Set (HEDIS®), Encounter Data System (EDS), lab results, pharmacy claims data);
9. Eligibility;
10. Encounters;
11. Capitation; and

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

B. On a daily basis, IEHP will provide a file of all newly completed initial HRAs to the IPAs for their assigned IEHP DualChoice Members via the secure IEHP Provider web portal.

C. On a weekly basis, IEHP will provide a file of all newly completed annual reassessment HRAs to the IPAs for their assigned IEHP DualChoice Members via the secure IEHP Provider web Portal.

D. On a daily basis, IEHP will provide the IPA the following Care Management information on all newly transitioned Members from IEHP-Direct:

1. Most current HRA completed survey (if applicable); and
2. Most current and up-to-date Care Plan (if applicable).

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

E. On a monthly basis, IEHP will provide a listing of all open authorizations for Members newly transitioned from IEHP Direct into an IPA. This information is transmitted via IEHP's Secure File Transfer Protocol (SFTP).

F. On a monthly basis, IEHP provides a roster of all Members due for preventive care services or who have gaps in care based on the IEHP Quality Improvement program via the secure IEHP Provider web portal. This information should be reviewed and incorporated into the IPAs Quality Improvement program activities/work plan.

G. During the first week of each month, IEHP will provide a listing of all CMS-stored HCC Member Information Profile report information related to Members who newly transitioned from IEHP Direct to an IPA (including the MMR, MOR, Annual MORF and EDS Return Files) via SFTP. This information should be reviewed and incorporated into the IPA's HCC program activities/annual work plan.

H. During the first week of each month, IEHP will provide HCC Member Information Profile reports for all Members assigned to the IPA via SFTP. This information should be reviewed and incorporated into the IPAs HCC program activities/work plan.

I. On a monthly/weekly basis, IEHP will provide a listing of assigned membership. This information will be transmitted via SFTP.

J. On a monthly/weekly/daily basis, IEHP will provide a summary of encounters submitted to the health plan via SFTP.

K. On a monthly basis, IEHP will provide capitation information for the prior month. This information will be transmitted via SFTP.

25. DELEGATION AND OVERSIGHT

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

L. On a monthly basis, IEHP will provide historical claims for assigned IEHP DualChoice Members, Medi-Cal FFS claims, Medicare Part A, Part B and Part D data and IHSS payment data. This information will be transmitted via SFTP.

M. On a semi-annual basis (or more frequently), the IPA will share with IEHP any supplemental data to support HEDIS®, Quality Withhold, Risk Adjustment or any other Quality Improvement Activities.

1. The type, format, mode of transmission and frequency of this supplemental data sharing will be mutually agreed-upon by both the IPA and IEHP. IEHP will accept the IEHP Alternative Submission Method (ASM) file template in lieu of a EDS submission. Additionally, the IPA will also be required to submit an encounter for each DOS submitted on the ASM file.

2. For HCC supplemental data sharing, the format of HCC supplemental data files must be approved by IEHP prior to submission for EDS processing. The IPA must submit any additional validated HCC data following CMS Risk Adjustment data submission timelines (e.g., CMS Sweeps). To process data files prior to the CMS Sweeps deadline, all data files should be submitted to IEHP according to the following Sweeps timeline:

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

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