IPA Delegation Agreement – Medi-Cal

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

In accordance, the Health Insurance Portability and Accountability Act, IPA/Medical group shall comply with the following provisions:

1. The IPA has a list of the allowed uses of protected health information. The IPA may only use PHI associated with performing functions outlined in this agreement. It may only be disclosed to the member, their authorized representative, IEHP, and other authorized healthcare entities.

2. The IPA has a process in place for ensuring that members and practitioners information will remain protected. Protections must include oral, written, and electronic forms of PHI.

3. The IPA has a description of the safeguarding the protected health information from inappropriate use or further disclosure.

4. The IPA has a written description stipulating that the delegate will ensure that sub-delegates have similar safeguards when applicable.

5. The IPA has a written description stipulating that the delegate will provide individuals with access to their protected health information. The IPA will have procedures to receive, analyze and resolve members' requests for access to their PHI.

6. The IPA will ensure that its organization will inform the organization if inappropriate uses of information occur. The IPA will have procedures to identify and report unauthorized access, use, disclosure, modification or destruction of PHI and the systems used to access or store PHI.

7. The IPA will ensure that the protected health information is returned, destroyed or protected if the delegation agreement ends.

REQUIRED REPORTING ELEMENTS

Department	Required Documentation/Materials	Frequency	Submission Deadline	Point of Submission
Quality Management and Improvement	Annual QM Program Description	Annually	Feb 28	SFTP Server
	Annual GQ P4P Quality Workplan	Annually	As designated by P4P Program	
Utilization Management	Monthly Referral Tracking Log Monthly Denial Files Monthly Second Opinion Log Monthly Approval File Review	Monthly	15th of each month	SFTP Server
	Quarterly UM Program Evaluation / HICE Report Quarterly UM Work Plan Update	Quarterly	May 15 August 15 November 15 February 15	
	Annual UM Program Description Annual UM Program Evaluation Annual UM Workplan / Initial / ICE Report	Annually	Feb 28	
Care Management	Monthly CM Log Monthly California Children's Services (CCS) Log Monthly CM Files for Review (Care Coordination, CCS and SPD)	Monthly	15th of each month	SFTP Server
Encounter Data	5010 / Encounters	Monthly	• Varies within the first days of the month. Refer to https://www.providerservices.iehp.org/en/resources/provider-resources/forms for details.	SFTP Server

* MUST PASS Element

REQUIRED REPORTING ELEMENTS

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

* MUST PASS Element

Claims	Annual Claims Payment and Provider Dispute Report	Annually	November 30	SFTP Server
Financial Analysis	Balance Sheet Income Statement, Cash Flow Statement, Supporting Worksheets for IBNR Organizational Informational Disclosures	Quarterly	May 15 Aug 15 Nov 15 Feb 15	SFTP Server
	Annual Audited Financial Statements, Including IBNR Certification Financial Statements, Including IBNR Certification	Annually	5 months after end of IPAs Fiscal year	
Compliance	Compliance Program Description and copies of Compliance Training	Annually	As required for DOA	SFTP Server
	Fraud Waste and Abuse (FWA) Program Description and copies of FWA Training	Annually	As required for DOA	
	Sanction/Exclusion Screening Process policies and procedures	Annually	As required for DOA	
	Standards/Code of Conduct	Annually	As required for DOA	
	Compliance Committee Meeting minutes from the last 12 months, to include agenda and sign in sheet (attendance)	Annually	As required for DOA	

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

ATTACHMENT I: DELINEATION OF QUALITY MANAGEMENT & IMPROVEMENT

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

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

| Quality Improvement Program Structure (NCQA QI 1, Elements A, B, C, D and E continued) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | 2. Involvement of a designated physician in the QI program.
3. Oversight of QI functions of the organization by the QI Committee.
   a. The program description defines the role, function and reporting relationships of the QI Committee and subcommittees, including committees associated with oversight of delegated activities.
B. The IPA documents and executes a QI program annual work plan that reflects | Semi-Annual and Annual | IPA is not delegated for this function, however IEHP will review the IPA's Policies and Procedures. Semi-Annually and Annually as part of the DOA | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

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

		ongoing activities throughout the year and addresses:
		 1. Yearly planned QI activities and objectives that address:
		     a. Quality of clinical care.
		     b. Safety of clinical care.
		     c. Quality of service.
		     d. Members' experience.
		 2. Time frame for each activity's completion.
		 3. Staff responsible for each activity.
		 4. Monitoring of previously identified issues.
		 5. Evaluation of the QI program.			

| Quality Improvement Program Structure (NCQA QI 1, Elements A, B, C and D continued) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual | C. The IPA conducts an annual written evaluation of the QI program that includes the following information:
1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
2. Trending of measures of performance in the quality and safety of clinical care and quality of service.
3. Evaluation of the overall effectiveness of the QI program and its progress toward influencing networkwide safe clinical practices with a summary addressing:
   a. Adequacy of QI program resources.
   b. QI Committee and subcommittee structure.
   c. Practitioner participation and leadership involvement in the QI program.
   d. Need to restructure or change the QI | Semi-Annual and Annual | IPA is not delegated for this function, however IEHP will review the IPA's program description, Global Quality P4P work plan and policies and procedures Annually.

Additional review of committee meetings as part of the DOA. | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |
| Quality Improvement Program Structure | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual | | Semi-Annual and Annual | IPA is not delegated for this function, however | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

(NCQA QI 1, Elements A, B, C, D and E continued)		program for the subsequent year.
		
		D. QI Committee Responsibilities:
		   1. Recommends policy decisions
		   2. Analyzes and evaluates the results of QI activities
		   3. Ensures practitioner participation in the QI program through planning, design, implementation or review.
		   4. Identifies needed actions.
		   5. Ensures follow up, as appropriate.
		
		E. The IPA promotes Organizational Diversity, Equity and Inclusion.:
		   1. Promotes diversity in recruiting and hiring.
		   2. Offers training to employees on cultural
				IEHP will review the IPA's program description, Global Quality P4P work plan and policies and procedures Semi-Annually and Annually.
				
				Additional review of committee meetings as part of the DOA.

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		competency, bias or inclusion.			

* MUST PASS Element

ATTACHMENT II: DELINEATION OF CONTINUITY AND COORDINATION OF CARE

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

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

ATTACHMENT II: DELINEATION OF CONTINUITY AND COORDINATION OF CARE

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

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

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

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Utilization Management Structure (NCQA UM 1 Elements A and B and other regulatory requirements continued)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	a. How the IPA develops and selects criteria b. How the IPA reviews, updates, and modifies criteria 4. Information sources used to determine benefit coverage and medical necessity. B. The IPA annually evaluates and updates the UM program, as necessary. • Must meet applicable IEHP Standards and are consistent with NCQA, State and Federal health care regulatory agencies standards.	Semi Annual and Annually.	Annual audit of IPA policies and procedures, workplan, program, and committee meetings	See Corrective Action Plan (CAP) Requirements in MC_25A4.

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

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

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

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

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

Timeliness of UM Decisions (NCQA UM 5 Element A*)
 	
California Health & Safety Code §1367.01(h)(1)(3)
	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA makes utilization decisions in a timely manner to minimize any disruption in the provision of health care.
		A. The IPA adheres to the following time frames for notification of non-behavioral healthcare UM decisions*:
		  1. Urgent Concurrent Decisions: The IPA gives electronic or written notification of the decision to Practitioners and Members within seventy two (72) hours of the request.
		  2. Urgent Pre-Service Decisions: The IPA gives electronic or written notification of the decision to Practitioners and Members within seventy-two (72) hours of the request.
		  3. Non-Urgent Pre-Service Decisions: The IPA gives electronic or written notification of the decision to members and practitioners within five (5) calendar days of the request.
		  4. Post-Service Decisions: The IPA gives electronic or written notification of the decision to Practitioners and members and written notification to the Member within thirty (30) calendar days of the request.
			Monthly	Annual audit of IPA policies and procedures, workplan, program, and committee meetings.
				
				Monthly log and focused denial and approval file selection review.
					See Corrective Action Plan (CAP) Requirements in MC_25 A4.

* MUST PASS Element

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

			Monthly	Annual audit of IPA policies and procedures, workplan, program, and committee meetings.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

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

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

| UM Denial System Controls (NCQA UM 12 Element A*) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | The IPA has policies and procedures describing its system controls specific to UM denial notification dates that*:

1. Define the date of receipt consistent with NCQA requirements.
2. Define the date of written notification consistent with NCQA requirements.
3. Describe the process for recording dates in systems.
4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. The IPA's policies and procedures identify:
  a. All staff titles or roles authorized to modify dates. Policies and procedures state if no staff are authorized to modify dates under any circumstances.
  b. The circumstances when modification is appropriate.
5. The IPA's policies and procedures describe how the system tracks date modifications, and includes:
  a. When the date was modified.
  b. The staff who modified the date.
  c. Why the date was modified.
6. Describe system security controls in place to protect data from unauthorized modification. The IPA's policies and procedures describe the process for:
  a. Limiting physical access to the operating environment that houses utilization management data, including the IPA's computer | Annually, at minimum | Annual audit of Delegate's policies and procedures | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

UM Denial System Controls (NCQA UM 12 Element A* continued)		servers, hardware and physical records and files.
		     i. "Physical Access" does not refer to the IPA's building or office location.
		 b. Preventing unauthorized access and changes to system data.
		 c. Password-protecting electronic systems, including requirements to:
		     i. Use strong passwords,
		     ii. Discourage staff from writing down passwords,
		     iii. Update User IDs and passwords to be unique to each user,
		     iv. Change passwords when requested by staff or if passwords are compromised.
		 d. Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.
		 7. Describe how the IPA monitors, at least annually, its compliance with the policies and procedures in factors 1-6 and analyzes date modifications that do not meet the IPA's established policy, and takes appropriate action, when applicable. At a minimum, the description includes:
		 a. The method used to monitor compliance with the IPA's policies and procedures described in factors 1–6.			

* MUST PASS Element

| UM Denial System Controls (NCQA UM 12 Element A* continued) | | | i. If the IPA conducts auditing as the method for monitoring:
1. All noncompliant modifications must be reviewed if the IPA's system can identify noncompliant modifications.
2. Sampling is allowed only if the IPA does not use a UM system that can identify all noncompliant modifications.
b. The staff titles or roles responsible for oversight of the monitoring process.
c. The IPA's process for taking actions if it identifies date modifications that do not meet its established policy, including;
   i. A quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three consecutive quarters.
   ii. The staff roles or departments responsible for the actions.
   iii. The process for documenting and reporting date | | | |

| UM Denial System Controls (NCQA UM 12 Element A* continued) | | | modifications that do not meet its established policy.
d. Sampling Methodology for auditing: Sampling is allowed for IPAs that use auditing as their monitoring method.
    i. The IPA must use the "5% or 50 files" audit method: Randomly select 5% or 50 files (whichever is less) from each applicable file type. To review against requirements;
        1. UM Denials
        2. UM Appeals
   ii. For each applicable file type noted above, the organization must determine the sample size of 5% or 50 files (whichever is less) based on all files in the file universe. The file universe includes all files, with or without modifications. The sample that will be audited must include only files with modifications (whether modifications are compliant or noncompliant with the IPAs policies and procedures).
  iii. Once the sample size is calculated from the entire file universe, the IPA determines how it selects the sample. NCQA does not specify how the organization selects the | | | |

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

UM Denial System Controls (NCQA UM 12 Element A* continued)		sample once the sample size is determined using the entire file universe.
		iv. If the IPA:
		    1. Can identify files with modifications, it may randomly select a sample from the universe that contains modified files.
		    2. Cannot identify files with modifications, it may randomly select a sample from the entire file universe; the IPA continues to pull files from the entire universe until 5% or 50 files in the sample have modifications.
		
		•			

| UM Denial System Controls Oversight (NCQA UM 12 Element B) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | At least annually, the IPA demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by:
1. Identifying all modifications to receipt and decision notification dates that did not meet the IPA's policies and procedures for date modifications.
   a. The IPA demonstrates that at least annually, it identifies all modifications to UM denial receipt and notification dates that did not meet the IPA's policies and procedures outlined in UM 12 Element A.
2. Analyzing all instances of date modifications that did not meet the IPA's policies and procedures for date modifications.
   a. The IPA demonstrates that at least annually, it conducts a quantitative and qualitative analysis of all modifications that did not meet its policies and procedures outlined in UM 12 Element A.
   b. A goal is not required for the quantitative analysis. The IPA reviews all instances of modifications that did not meet its policies and procedures.
      i. If the IPA uses sampling, it reviews all noncompliant modifications in the sample. | Annually, at minimum | Annual audit of Delegate's policies and procedures | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

UM Denial System Controls Oversight (NCQA UM 12 Element B)		c. The IPA's analysis report includes the number or percentage of noncompliant files. d. NCQA's definition of Qualitative analysis - An examination of the underlying reason for or cause of results, including deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. Qualitative analysis must draw conclusions about why the results are what they are and involves staff responsible for executing a program or process. Also called a causal, root cause or barrier analysis. e. NCQA's definition of Quantitative analysis - A comparison of numeric results against a standard or benchmark, trended over time. Quantitative analysis must draw conclusions about what results mean. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters. a. The IPA identifies and documents all actions it has taken, or plans to take, to address all date modifications that did not meet its policies and procedures, if			

UM Denial System Controls Oversight (NCQA UM 12 Element B)		applicable. One action may be used to address more than one finding, if appropriate.
		b. The IPA also implements a quarterly monitoring process to assess the effectiveness of its actions on all findings:
		    i. The IPA must continue to monitor until it demonstrates improvement of at least one finding over three consecutive quarters.
		    ii. If the IPA did not demonstrate improvement of at least one finding during the look-back period, it submits all quarterly monitoring reports demonstrating ongoing monitoring.
		    iii. If the IPA identified findings less than three quarters before IEHP is required to submit evidence for the NCQA Survey, the IPA will submit all monitoring information it has available.			

UM Appeal System Controls (NCQA UM 12 Element C)	Not Applicable	Appeals are not delegated.	Not Applicable	Not Applicable	Not Applicable
UM Appeal System Controls Oversight	Not Applicable	Appeals are not delegated.	Not Applicable	Not Applicable	Not Applicable

ATTACHMENT III: DELINEATION OF UTILIZATION MANAGEMENT

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

ATTACHMENT IV: DELINEATION OF CARE MANAGEMENT

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
CM 1: Care Management	IEHP will provide IPAs with guidelines for Policies and Procedures, and guidelines for Care Management Training via IEHP Provider Manual.	IPA's must submit a monthly care management log that includes the following: 1. Member name (First, Last) 2. Member ID number 3. Date of Birth 4. Referral 5. Referral Disposition *Members who are identified as potential Complex (CCM), must be referred to IEHP's Care Management team. Please see CM Referral Form. Send completed form to cmreferralteam@iehp.org.* 1.	Monthly	Annual audit of IPA policies and procedures. Monthly CM log and targeted case file review.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

CM 2: "High Risk" SPD HRA Review		IPAs are required to review the HRA for all Seniors and Persons with Disabilities (SPD). For High Risk, SPD Members, the IPA is responsible to complete the following: • Review HRA with Member to stratify and determine the appropriate level of care. • Document at least three (3) contact attempts that were made to Member within thirty (30) calendar days of HRA completion prior to determining if Member is unable to be reached. • Access all needed services that address Members health and health-related needs, including developmental, physical, mental health, SUD, dementia, LTSS, palliative care, oral health, vision, and pharmacy needs. • Refer Identified Members for potential Enhanced Case Management and Complex Case Management program enrollment. A.			

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

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Credentialing Policies (NCQA CR 1 Element A continued)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	8. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the credentialing committee's decision. 9. The Medical Director or other designated physician's direct responsibility and participation in the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. 11. The process for confirming listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.	Annually, at minimum	Annual audit of Delegate's policies and procedures	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

| Credentialing System Controls (NCQA CR 1 Element C*) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | The Delegates credentialing process describes*:

1. How primary source verification information is received, dated and stored.
2. How modified information is tracked and dated from its initial verification.
   a. When the information was modified.
   b. How the information was modified.
   c. Staff who made the modification.
   d. Why the information was modified.
3. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.
   a. All staff titles or roles authorized to access, modify and delete information.
   b. Policies and procedures state if no staff are authorized to modify dates under any circumstances.
4. The security controls in place to protect the information from unauthorized modification.
   a. Limiting physical access to the operating environment that houses credentialing information. | Annually, at minimum | Audit of Delegate's policies and procedures | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

* MUST PASS Element

Credentialing System Controls (NCQA CR 1 Element C* continued)		b. Preventing unauthorized access, changes to and release of credentialing information. c. Password-protecting electronic systems, including user requirements to: use strong passwords, discourage staff from writing down passwords, use IDs and passwords unique to each user, change passwords when requested by staff or if passwords are compromised, disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security. 5. How the IPA monitors its compliance with the policies and procedures in factors 1-4 at least annually and takes appropriate action when applicable. At a minimum, the description includes: a. The method used to monitor compliance with the organization's policies and procedures described in factors 1–4. b. The staff titles or roles responsible for oversight of the monitoring process. c. The organization's process for taking actions if it identifies modifications that do not meet its established policy, including: A quarterly monitoring process			

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Credentialing System Controls (NCQA CR 1 Element C* continued)		to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three (3) consecutive quarters. The staff roles or department responsible for the actions. The process for documenting and reporting modifications that do not meet established policy.			
Credentialing System Controls Oversight (NCQA CR 1 Element D)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	At least annually, the Delegate demonstrates that it monitors compliance with its Credentialing controls, as described in Element C, factor 5, by: 1. Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters.	Annually, at minimum	Review of Reports	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Credentialing Committee (NCQA CR 2 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate's Credentialing Committee: 1. Uses participating practitioners to provide advice and expertise for credentialing decisions. 2. Reviews credentials for practitioners who do not meet established thresholds. 3. Ensures that files that meet established criteria are reviewed and approved by a medical director, designated physician or Credentialing Committee.	Annually, at minimum	Audit of Delegate's policies and procedures and Credentialing Committee meeting minutes	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

* MUST PASS Element

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Credentialing Application (NCQA CR 3 Element C*)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	C. Delegate verifies that applications for credentialing include the following*: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary actions. 5. Current malpractice insurance coverage. 6. Current and signed attestation confirming the correctness and completeness of the application.	Annually, at minimum	IEHP reviews application and attestation within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Recredentialing Cycle Length (NCQA CR 4 Element A*)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	A. Delegate conducts timely recredentialing. The length of the recredentialing cycle is within the required 36-month time frame*.	Annually, at minimum	IEHP reviews verification of credentials within a random sample of up to 30 initial credentialing files and 30 recredentialing files from the decision made during the look-back period.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

* MUST PASS Element

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

* MUST PASS Element

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

* MUST PASS Element

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Written Delegation Agreement (NCQA CR 8 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate remains responsible for credentialing and recredentialing its practitioners, even if its delegates all or part of these activities. The written delegation agreement: 1. Is mutually agreed upon. 2. Describes the delegated activities and the responsibilities of IEHP and the Delegated entity. 3. Requires at least semiannual reporting of the Delegated entity to IEHP. 4. Describes the process by IEHP evaluates the Delegated entity's performance. 5. Specifies that IEHP retains the right to approve, suspend and terminate individual practitioners, providers, and sites, even if IEHP delegates decision making	Annually, at minimum	IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

* MUST PASS Element

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Written Delegation Agreement (NCQA CR 8 Element A)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	6. Describes the remedies available to IEHP if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement	Annually, at minimum	IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.
Written Delegation Agreement	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegated entity retains the right to approve, suspend and terminate individual practitioners, providers, and sites in situation where it has delegated decision making. This right is reflected in the delegation document.	Annually, at minimum	IEHP reviews delegation agreements from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4

* MUST PASS Element

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Pre-delegation Evaluation (NCQA CR 8 Element B)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	For new delegation agreements initiated in the look-back period, IEHP evaluated delegate capacity to meet NCQA requirements before delegation began.	Annually, at minimum	IEHP reviews the delegates pre-delegation evaluation from up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

| Review of Credentialing Activities (NCQA CR 8 Element C) | IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual. | For delegation agreements in effect for 12 months or longer, the organization:

1. Annually reviews the Delegate's credentialing policies and procedures.
2. Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.
3. Annually evaluates the Delegates performance against NCQA standards for delegated activities.
4. Semi-annually evaluates regular reports.
5. Annually the organization monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures.
6. Annually the organization acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. | Annually, at minimum | IEHP reviews a sample of up to four randomly selected delegates, or all delegates if the organization has fewer than four delegates. | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Opportunities for Improvement (NCQA CR 8 Element D)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	For delegation arrangements that have been in effect for more than12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.	Annually, at minimum	IEHP reviews reports for opportunities for improvement if applicable and appropriate actions to resolve issues from up to or four randomly selected delegates, or all delegates if the organization has fewer than four delegates.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.
Identification of HIV/AIDS Specialists – Written Process (CA H&SC §1374.16; DMHC TAG (QM-004). DHCS MMCD All-Plan Letter 01001)	IEHP will provide Delegate with guidelines for Policies and Procedures via IEHP Provider Manual.	Delegate has a written policy and procedure describing the process that the organization identifies or reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist, according to California State regulations on an annual basis		IEHP reviews delegate policies and procedures.	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

ATTACHMENT VI: DELINEATION OF CREDENTIALING and RECREDENTIALING

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

* MUST PASS Element

ATTACHMENT VII: DELINEATION OF ENCOUNTER DATA

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

ATTACHMENT VIII: DELINEATION OF CLAIMS ADJUDICATION

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

* MUST PASS Element

ATTACHMENT VIII: DELINEATION OF CLAIMS ADJUDICATION

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

* MUST PASS Element

ATTACHMENT IX: REQUIREMENTS OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND PRIVACY PROGRAM

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

* MUST PASS Element

| Compliance Program (CMS Managed Care Manual Ch. 21 and DHCS Two Plan Contract Exhibit E, Attachment 2) | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | The IPA has developed and implemented an Effective Compliance Program which includes the following structural components:
A. Written Policies, Procedures and Standards of Conduct that articulate a commitment to comply with all applicable Federal and State requirements;
B. Designation of a Compliance Officer who reports directly to the CEO and Board of Directors, Compliance Committee at the Board of Directors and/or Senior Leadership level charged with overseeing the compliance program;
C. Has an effective Compliance Training program for its employees to receive within 90 days of hire and annually thereafter or as updates/changes occur;
D. Distribute Standards/Code of Conduct within 90 days of hire and annually thereafter.
E. Effective Lines of Communication between the Compliance Officer, Compliance Committee and employees;
F. Well-Publicized Disciplinary Standards;
G. Provides guidance on how to report issues of non-compliance that includes non- intimidation and | Precontractual Assessment and Annually as part of the DOA | Initial Assessment

Annual DOA | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

ATTACHMENT IX: REQUIREMENTS OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND PRIVACY PROGRAM

Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
		non-retaliation for good faith participation. H. Establishment and implementation of an Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks; and I. Implementation of Procedures and System for prompt response to Compliance issues as they are raised, investigation of potential compliance problems as identified through the course of self-evaluation and audits, correction of such problems promptly and thoroughly.			

ATTACHMENT IX: REQUIREMENTS OF COMPLIANCE, FRAUD, WASTE, AND ABUSE, AND PRIVACY PROGRAM

Delegated Activity	IEHP Responsibilities	Delegate Responsibilities	Frequency of Reporting	Process for Evaluating Delegates Performance	Corrective Actions if Delegate Fails to Meet Responsibilities
Fraud, Waste and Abuse Program (CMS Managed Care Manual Ch. 21 and DHCS Two Plan Contract Exhibit E, Attachment 2)	IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual.	The IPA has developed and implemented an Effective Fraud, Waste and Abuse (FWA) program that is designed to deter, identify, investigate and resolve potentially fraudulent activities that may occur in daily operations, both internally and with contracted providers. IPA provides monitoring and oversight, both internally and externally, of daily operational activities to detect and/or deter fraudulent behavior. Such activities include, but are not limited to: A. Provider grievances B. Claims activity C. Financial Statements D. Utilization management monitoring E. Chart audits F. Clinical Audits G. Internal auditing and monitoring process H. Risk assessment The IPA has a FWA training program and requires training within ninety (90) days of hire/contracting and annually thereafter or as updates/changes occur. The IPA has a process in place, where needed, for reporting suspected fraudulent behavior to appropriate federal, state, local authorities, and IEHP.	Precontractual Assessment and Annually as part of the DOA	Initial Assessment Annual DOA	See Corrective Action Plan (CAP) Requirements in MC_25 A4.

| HIPAA/Privacy Title 45 CFR; HITECH Act ARRA COMIA | IEHP will provide IPA with guidelines for Policies and Procedures via IEHP Provider Manual. | The IPA maintains policies and procedures required by HIPAA and ARRA.

A. Uses and disclosures of PHI and PII
B. Confidentiality of Member Information
C. Auditing/Monitoring of Business Associates, Downstream/Subcontracted and Related Entities
D. General Security controls of Facilities and Information Systems
E. Record Retention
F. Paper Document Controls
G. Non-retaliation for exercising rights provided by the Privacy Rule.
H. Reporting incidents of HIPAA non-compliance to IEHP

A privacy officer has been designated by the IPA.

The IPA has a HIPPA Privacy training program and requires training prior to access to PHI is given and annually thereafter or as updates/changes occur.

The IPA has implemented a risk assessment process to assess privacy incidents and determine breach or breach exception.

Has policies and procedures to ensure that all persons who work with PHI/ePHI sign a confidentiality statement, upon prior to access to PHI is given and annually thereafter.

There are appropriate administrative, technical and physical safeguards to | See Attachment IPA Reporting Requirements Schedule in Section 25 | Initial Assessment

Annual DOA | See Corrective Action Plan (CAP) Requirements in MC_25 A4. |

		prevent intentional or unintentional use or disclosure of PHI.			