18. PROVIDER NETWORK

A. Primary Care Provider

1. IPA and Hospital Affiliations

APPLIES TO:

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

POLICY:

A. Primary Care Providers (PCPs) may have a maximum of two (2) unique IEHP Provider IPA/Hospital Affiliations, except in rural areas where PCP coverage is limited due to geographic location at the discretion of IEHP. PCPs may have a maximum of three (3) unique IEHP Medi-Cal Provider IPA/Hospital Affiliations at the discretion of IEHP.

B. Within IEHP's service area, IEHP contracts with available Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Facilities (IHFs) to ensure Member access to the services provided by these Providers.[1]

PROCEDURES:

A. A PCP must spend a minimum of 16 hours per week at each participating location with the exception of Residency Teaching Clinics and Rural Clinics who may be exempt from the minimum 16 hours on site requirement for PCPs as outlined in Policy 6D, "Residency Teaching Clinics" and Policy 6E, "Rural Health Clinics."

B. Attending physicians receiving Membership assignment as a PCP at a residency teaching clinic or at a rural clinic must be on-site a minimum of eight (8) hours per week.

C. A PCP is allowed a maximum of two (2) unique Provider IPA/Hospital Affiliations under the following circumstances:

1. The PCP has two (2) offices within IEHP's service area and spends a minimum of 16 hours per week at each site.
2. The PCP has one (1) office but has an admitter or covering Hospitalist agreement at two (2) IEHP contracted Hospitals that are both located within the PCP's geography, as deemed by IEHP.
3. The above is allowed if the PCP is contracted with an IPA that meets the criteria specified in Policies 18F, "Specialty Network Requirements" and 18H, "Hospital Affiliations."

D. Given the above criteria, a PCP may join a maximum of two (2) different IPAs, and/or may admit Members to a maximum of two (2) IEHP contracted Hospitals to comply with the two (2) Provider IPA/Hospital Affiliations rule, with the exception of PCPs with rural clinics

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001 supersedes APL 21-006, "Network Certification Requirements"

which are allowed three (3) Provider IPA/Hospital Affiliations as long as they fit the criteria outlined in Policy 6E, "Rural Clinics."

E. A PCP may not transfer their assigned Membership with one (1) Provider Delegated IPA/Hospital Affiliation to another Provider IPA/Hospital Affiliation unless a written notification has been submitted to IEHP specifying that they will no longer continue with one of their Provider affiliations and that Provider Affiliation will be terminated. IEHP does not allow Providers to transfer Members back and forth between their existing Provider IPA/Hospital Affiliations due to the undue burden it places on Members being transferred from one IPA or Hospital relationship to another. If a PCP has decided not to continue a relationship with an IPA or Hospital, that Provider Affiliation must be terminated for Members to be transferred to the PCP's other or new Provider Affiliation.

F. IEHP will allow PCPs to have two (2) IPA affiliations at one (1) site linked to one (1) Hospital as long as that IPA meets the criteria specified in Policies 18F, "Specialty Network Requirements" and 18H, "Hospital Affiliations."

G. IEHP verifies IPA and Hospital affiliation privileges and geographic distribution as stated in Policy 5B, "Hospital Privileges."

H. PCPs employed by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Facilities (IHFs) are subject to the same stipulations cited above although assignment of Members is made to the clinic and not to the individual PCPs at the clinic. If an employed PCP leaves one of these types of clinics, the Members remain assigned to the clinic under the care of the PCP(s) currently credentialed at the clinic.[2]

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[2] DHCS APL 23-001

18. PROVIDER NETWORK

A. Primary Care Provider
2. Enrollment Capacity

APPLIES TO:

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

POLICY:

A. IEHP follows Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) regulatory requirements for Provider network adequacy to assure the required one full-time equivalent (FTE) Primary Care Provider (PCP) per two thousand (2,000) Member ratio.

B. IEHP ensures that our overall contracted network satisfies regulatory requirements are as follows.[1,2,3] Ratios are calculated on the Plan's full time equivalent (FTE) Primary Care Provider (PCP) network as a whole and is not applied to an individual PCP.

1.	Primary Care Providers (PCP)	1 FTE: 2,000
2.	Advanced Practice Practitioner	1 FTE: 1,000
3.	Total Physicians	1 FTE: 1,200

C. State regulations also require that FTE physician supervisor to Advanced Practice Practitioners or non-physician medical practitioners must be supervised in accordance with Policy 6F, "Advanced Practice Practitioner Requirements." ratios do not exceed the following:

1.	Nurse Practitioners (NP)	1 : 4
2.	Certified Nurse Midwives (CNM)	1 : 3
3.	Physician Assistants (PA)	1 : 4

4. Maximum of four (4) Non-Physician Medical Practitioners in any combination that does not include more than three (3) midwives.

DEFINITIONS:

A. Primary Care Provider (PCP) – A Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001 supersedes APL 21-006, "Network Certification Requirements"
[2] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 5.2.4, Network Ratios
[3] California Health and Safety (Health & Saf.) Code § 1375.9(a)

practitioner, or obstetrician-gynecologist (OB-GYN). For SPD Members, a PCP may also be a Specialist or clinic.[4]

B. Advanced Practice Practitioners – These are non-physician medical Practitioners, such as Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs) and Physician Assistants (PAs).

PROCEDURES:

PCP Enrollment Capacity

A. PCPs are listed in the IEHP Provider Directory and receive Members through auto assignment and Member choice, unless otherwise requested. See Policy 3E, "Primary Care Provider Assignment" for more information.

B. Each PCP is listed in the IEHP data system as having a general standard for an enrollment capacity of 2,000 Members. If a PCP has two (2) IEHP Provider Affiliation Numbers, each Provider Affiliation Number is assigned an enrollment capacity that when combined meets the general recommended enrollment capacity.

C. For each advanced practice practitioner supervised by a PCP at the same location, the above recommended enrollment capacity can be increased by 1,000 Members per advanced practice practitioner. Please see Policies 5A.1, "Credentialing Standards – Credentialing Policies" and 6F, "Advanced Practice Practitioner Requirements" for more information.

D. All participating Pediatric, Family Practice and General Practice PCPs must be willing to accept a minimum of 500 Members in all contracted lines of business combined, unless otherwise approved. Participating Internal Medicine PCPs must be willing to accept a minimum of 250 Members in all contracted lines of business combined, unless otherwise approved.

   1. PCPs reaching the minimum limit may elect to not participate in the auto assignment process and Member choice process by contacting IEHP and requesting that their enrollment panels be set to a "Closed" status.

   2. If a PCP has not met the minimum enrollment requirement of Members for their specialty, a PCP can request to NOT be included in the auto assignment process for defaulted Members but not Member choice, have the minimum requirement unless otherwise approved.

Monitoring and Oversight

A. On an ongoing basis, IEHP reviews and monitors its overall PCP capacity to ensure adequate access regardless of enrollment capacity.

[4] DHCS-IEHP Primary Operations Contract, Exhibit A, Attachment I, Provision 1.0, Definitions

18. PROVIDER NETWORK

A. Primary Care Provider
2. Enrollment Capacity

B. PCPs that reach the general standard enrollment capacity will be monitored by the Provider Services department for access related issues on a monthly basis to assess if the PCP's enrollment panels should be closed or limited to new enrollment to ensure compliance with access standards.

C. Access related grievances are reported and tracked by the Grievance and Appeals department and provided to the Provider Relations, Provider Network, Credentialing, Provider Operations and Delegation Oversight department to review for possible closing or limiting PCP's panel for new membership. At least annually, IEHP assesses its network capacity as it pertains to the standards stated herein. IEHP takes corrective action as necessary with Providers to ensure its network continuously satisfies IEHP and legislative requirements.

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18. PROVIDER NETWORK

B. Provider Directory

APPLIES TO:

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

POLICY:

A. Each Provider Directory and web-based Provider Directory (known as "Find a Doctor" search) contain information on IPAs and Hospitals[1], Primary Care Providers (PCPs), OB/GYNs, Specialists, Behavioral Health (BH) Providers, Behavioral Health Treatment (BHT) Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, Advanced Practice Practitioners (e.g. Nurse Practitioners (NPs), Physician Assistants (PAs), and Nurse Midwives), and other Providers) who have been credentialed and are contracted with IEHP directly or through a subcontracted agreement with network IPAs.[2]

B. Each PCP is listed individually in the Provider Directory to help facilitate the selection process by the Member.

C. Based on IEHP PCP/ IPA affiliations, a PCP can be listed twice in the Provider Directories, except for those Physicians who also service IEHP rural areas.

D. A PCP with two (2) IPA/Hospital affiliations, credentialed and board certified in two (2) IEHP approved specialties, can be listed a maximum of four (4) times in the Provider Directory.

E. If a contracted Provider informs IEHP of a Provider Directory change or inaccuracy, IEHP will make that change to its internal systems or inform the delegated Provider of the change. Network updates are reflected on the web-based Provider Directory by the following business day.

F. IEHP investigates each time it receives a report of a potential Provider Directory inaccuracy. IEHP will contact the affected Provider no later than five (5) business days following receipt of the inaccuracy report. IEHP will document the receipt of the reported inaccuracy, investigation, and the outcome of the investigation. If the inaccuracy is confirmed and the correct information is verified, the Provider Directory and web-based Provider Directory will be updated within 30 calendar days of the inaccuracy being reported. The validation process includes, but is not limited to, the following:[3,4]

   1. Provider is no longer accepting new patients for any line of business;
   2. Removal of Provider or Provider group who has retired, ceased to practice, or no longer under contract with IEHP for any reason;

[1] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, NET 5, Element G
[2] California Health and Safety Code (Health & Saf. Code) §1367.27
[3] NCQA, 2024 HP Standards and Guidelines, NET 5, Element D, Factor 1
[4] CA Health & Saf. Code §1367.27

3. Change in Provider's practice location or update of demographic information; or
4. Any information that affects the content or accuracy of the Provider Directory.

H. As part of IEHP's monitoring process, on an annual basis, IEHP requires delegated contracted entities such as American Specialty Health (ASH) to provide a report of identified/reported inaccuracies and the timeframe of the correction as stated in Policy 25A2, "Delegation Oversight Audit."

PROCEDURES:

A. Members, potential members or other requestors can receive the IEHP Provider Directory through the following:[5]

1. Medi-Cal Members receive a Provider Directory in the State Medi-Cal pre-enrollment packet from Health Care Options.
2. IEHP mails a copy of the Provider Directory directly to new Members upon enrollment with IEHP.[6]
3. Members, potential members, or other requestors may call IEHP Member Services Department directly at (800) 440-4347 to receive a copy within five (5) business days.[7]
4. Members can also access the Find a Doctor Search online at www.iehp.org. All network updates are reflected on web-based Provider Directory the following business day.

B. The printed IEHP Provider Directory contains information regarding IEHP's network Practitioners, including the following elements which are subject to change based on regulatory requirements, including but not limited to:[8]

1. Headers to indicate City or Region Names (in alphabetical order);
2. Specialty (e.g. Family Medicine) including board certification if any;
3. Provider Name (last, first – listed alphabetically);
4. Gender;
5. Eye Exams or Frame and Lens only (Vision Provider only);
6. Provider's office email address, where the mail is intended for Member communication, regularly monitored and maintained in a manner consistent with State and Federal health privacy laws. The Provider will also attest to the security of the email address;
7. Street Address, City and Zip Code;
8. California license number and type of license;

[5] CA Health & Saf. Code §1367.27 (d)(1)
[6] NCQA, 2023 HP Standards and Guidelines, NET 5, Element J, Factor 1
[7] NCQA, 2023 HP Standards and Guidelines, NET 5, Element J, Factor 2
[8] CA Health & Saf. Code §1367.27 (h)

9. Age Restriction;
10. Appointment Needed;
11. Federally Qualified Health Center (FQHC);
12. Board Certified;
13. Telephone Number (including area code);
14. Fax Number (including area code);
15. Website;
16. Affiliated Hospital;
17. Hospital Admitting Privileges;
18. Affiliated IPA/Clinic;
19. IEHP Assigned Doctor Number;
20. National Provider Identifier (NPI) Number;
21. Languages (other than English) spoken by clinical staff including Physician;
22. Business Hours and Days of operations;
23. Bus Route Information;
22. Panel Status (indication of whether a Provider is accepting new Patients, existing Patients only, not accepting new Patients currently or if they are only available to see Patients by referral or only through a hospital or facility);[9]
23. Accessibility Level; and
24. Extended Office Hours (Providers who are open before 8am, open after 5pm, or open weekends are 'bolded'.)

C. The online IEHP Provider Directory also known as "Find a Doctor," contains information regarding IEHP's network Practitioners, including the following elements which are subject to change based on Program requirements, including but not limited to**:**

1. Provider Name
2. Gender
3. Office Phone Number
4. Office Fax Number
5. Office e-mail Address
6. Office Hours

[9] CA Health & Saf. Code §1367.27 (j)(1)(A)

7. Website
8. After Hours
9. Walk In
10. Languages
11. Address
12. Bus Information
13. Language Interpreter Available
14. Clinical Staff Language
15. Non-Clinical Staff Language
16. Specialty
17. Provider Number
18. National Provider Identification
19. Medical Board License
20. Directory ID
21. Plan (Line of Business)
22. Panel Status
23. Hospital
24. Age Restriction
25. Independent Practice Association (IPA)

D. The Provider Directory also includes:

1. Instructions for Members on how to use the Directory for selecting a Provider; and
2. Information regarding Members are entitled to language interpreter services at no cost and how to obtain interpretation services.[10]

E. IEHP informs Members regarding the standards for timely access to care through at minimum, the Member Handbook, www.iehp.org, and its Provider Network through Policy 9A- Access Standards.[11]

F. IEHP requires all contracted Providers who are not accepting new patients to direct Members or potential members to IEHP for additional assistance in finding a Provider and to the

[10] CA Health & Saf. Code §1367.27(g)(1)
[11] CA Health & Saf. Code §1367.031(d)

California Department of Health Care Services (DHCS) to report any potential Directory inaccuracy.[12]

G. IEHP verifies 100% of the elements listed below:[13]

1. A semi-annual verification of Provider information is performed through various modalities, including but not limited to fax, email, and phone call.
2. Failure to respond to the Provider Network verification may result in a delay of payment or reimbursement of a claim.
3. Non-responsive Providers, except for general acute care Hospital, are notified 10 business days prior to their removal from the Directory.

H. IEHP may omit a Provider, Provider Group, or category of Providers similarly situated, from its directory if one of the following conditions are met:

1. Upon submission of a signed statement from an individual Provider to IEHP that the Provider is currently enrolled in the Safe at Home Program;
2. Upon submission of a signed statement from an individual Provider to IEHP that the Provider fears for his or her safety or the safety of his or her family due to his or her affiliation with a health care service facility or due to his or her provision of health care services;
3. Upon submission of a signed statement from a person authorized by a Provider group to IEHP stating that a facility or any of its Providers, employees, volunteers, or Members is or was the target of threats or acts of violence within one (1) year of the date of the statement; or
4. Upon the Department's prior approval pursuant to a finding of good cause or extraordinary circumstances.

I. In instances where IEHP does not meet time and distance standards for specific Provider types in IEHP's service region, IEHP will allow Members to see a Provider who is not currently in IEHP's contracted network. IEHP has identified some zip codes and Provider types that do not meet the required time and distance standards. DHCS requires approval for alternative access standards for these zip codes and Provider types. IEHP's web-based Find a Doctor Search contains information on the list of approved zip codes and Provider types by county.[14]

J. Due to population mix in Riverside and San Bernardino counties, IEHP surveys threshold language-speaking Practitioners and their staff who have indicated they have the language capabilities, at the time of entry into the network and annually through language competency study, before this designation is listed in the Provider Directory as outlined in Policies 9H1,

[12] CA Health & Saf. Code §1367.27 (i)(2)
[13] CA Health & Saf. Code §1367.27 (n)(1)
[14] Department of Health Care Services (DHCS), All Plan Letter (APL) 23-001 Supersedes APL 21-006, "Network Certification Requirements"

"Cultural and Linguistic Services - Foreign Language Capabilities" and 9H2, "Cultural and Linguistic Services – Language Competency Study."[15]

K. IEHP posts a report every six (6) months on the secure Provider portal of the most current listing of contracted and credentialed PCPs, Specialists, OB/GYNs, Physician Extenders and Ancillary Providers, including their Hospital affiliation. All IPAs must examine these lists carefully in order to ensure the validity and integrity of the information provided.

L. Providers who are found to be ineligible through the Provider Appointment Availability Survey (PAAS) administration. IEHP will update the information and make the necessary changes to the internal systems. After the internal systems have been updated, the network updates will be reflected on the "Find a Doctor" by the following day.[16,17]

M. Changes made to the Provider Directory information as a result of any investigation will take place at the next required update, or the next scheduled update thereafter as applicable to the online Directory.[18]

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[15] CA Health & Saf. Code §1367.27 (i)(9)
[16] CA Health & Saf. Code §1367.27 (e)
[17] Provider Appointment Availability Survey Manual, Paragraph 60
[18] NCQA, 2023 HP Standards and Guidelines, NET 5, Element D, Factor 2

18. PROVIDER NETWORK

C. PCP, Specialist, Vision and Behavioral Health Provider Network Changes

APPLIES TO:

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

POLICY:

A. Primary Care Providers (PCPs) must provide 60 days advance written notice to IEHP and their IPA regarding any changes in their operations including but not limited to address, IPA and/or Hospital affiliations.

B. Specialist, Vision and Behavioral Health Providers must provide 60 days advance written notice to IEHP of any changes in their clinic operation including but not limited to address.

C. IPAs are required to submit coverage plans 60 days in advance of the effective date whenever they are notified that a subcontracted PCP is relocating or terminating their IPA affiliation as outlined in Section 18D1, "IPA Reported Provider Changes - PCP Termination."

D. IEHP allows changes in Hospital and IPA affiliations; however, PCPs should review their current contractual clauses regarding contract termination with their IPA before terminating the agreement.

E. IEHP sends to Members 30 days advance written notice about any changes to their PCP, Specialist and Behavioral Health Providers' clinic operations including but not limited to address and terminations of agreements. If sufficient advance notice of 60 days is not provided to IEHP regarding a change to the aforementioned Providers' clinic operations, IEHP sends Members notice as soon as possible upon receiving notification of the change from the Provider.[1]

PROCEDURES:

PCP Change in Affiliations

A. PCPs must send written notification informing IEHP and their IPAs of a change in IPA and/or Hospital affiliation 60 days prior to the effective date of the change.

B. IPAs have 60 days from the effective date of a PCP's IPA affiliation change to submit the initial credentialing packet to IEHP. Failure to do so will result in freezing of PCP to new membership assignment for 60 days from the effective date of the IPA affiliation change or possible termination.

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Supersedes Policy Letter (PL) 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"

C. For IPA changes, IEHP verifies that the new IPA has an approved specialty network in accordance with Policy 18F, "Specialty Network Requirements." If the Hospital changes, IEHP verifies the new IPA has an approved Hospital link and the PCP has privileges or admitting arrangements in place at the new Hospital. A signature page of the agreement between the PCP and IPA is required to be submitted to IEHP by the new IPA. Once all information is verified and the new affiliation is accepted and processed, then the PCP is assigned a new Provider IPA/Hospital Affiliation.

D. Members are transferred from the old Provider IPA/Hospital Affiliation to the new Provider IPA/Hospital Affiliation on the first day of the month when the change is deemed effective by IEHP. Members are notified by IEHP 30 days in advance of the effective date of the change.[2]

1. An IPA change becomes effective on the first of the month following 60 days from the date notification is received by IEHP, unless otherwise approved by Provider Relations Management with a different date.

2. A Hospital change becomes effective on the first of the month following 60 days from the date notification is received by IEHP, unless otherwise approved by Provider Relations Management with a different date.

E. Once all information is verified, IEHP sends a letter to the PCP with a copy to the old IPA and new IPA, if applicable, informing the PCP of his/her new Provider IPA/Hospital Affiliation, effective date of the change, and status of his/her membership.

F. The above procedures for Member assignment may be modified due to circumstances that, in the judgement of the IEHP Chief Operating Officer (COO) or Chief Medical Officer (CMO), are in the best interest of the Member.

PCP Changes in Office Location

A. IPAs and PCPs must provide written notification to IEHP that a PCP is relocating to another office within IEHP's geographic service area 60 days prior to the relocation.

B. When a PCP site relocates, an initial FSR is completed within 60 days of notification or discovery of the completed move. IEHP allows the PCP to continue to see their assigned Members however, the PCP site is not assigned new Members until they receive passing FSR and MRR scores as outlined in Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."[3]

C. If a 60 days advance notice is not received, the PCP is frozen to Member auto-assignment, not Member choice enrollment, for a period of 60 days from the date IEHP received notification from the IPA.

[2] DHCS APL 21-003
[3] DHCS APL 20-006 Supersedes PL 14-004, "Site Reviews: Facility Site Review and Medical Record Review"

D. When geographically appropriate, Members remain with the PCP unless the PCP moves to a different geographic area, defined as 10 miles, from the PCP's former location. IEHP makes every effort to notify Members 30 days in advance of the effective date of the relocation.

E. If a PCP moves to a different geographic area, IEHP reassigns Members to a new PCP that has the capacity and can accommodate the affected Member. IEHP cannot guarantee that a Member remains part of the IPA's network.

F. If the PCP practiced in a hospital-based clinic, county clinic, teaching clinic, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Tribal Federally Qualified Health Center (Tribal FQHC), or other site IEHP determined functions as a clinic in which PCPs are employed, the Member will remain assigned to the clinic where the PCP practiced and the Member can continue care at the clinic.

G. The above procedure for Member assignment may be modified due to circumstances that in the judgment of the IEHP Chief Operating Officer or the Chief Medical Officer are not in the best interest of the Member.

H. IPA and PCPs also must submit written notification to IEHP Provider Services when there is a change in other office operations. For example, but not limited to, a change in phone or fax number, office hours, specialty, and/or capacity status.

Specialist, Vision and Behavioral Health (BH) Provider Change in Office Location

A. Specialist, Vision and BH Providers must submit written notification to IEHP that they are relocating to another office within IEHP's geographic service area 60 days prior to the relocation.

B. Specialist, Vision and BH Providers also must submit written notification to IEHP Provider Services when there is a change in other office operations. For example, a change in phone or fax number, office hours, specialty, and/or capacity status.

Specialist, Vision and Behavioral Health (BH) Provider Termination

A. Specialist, Vision Providers and BH Providers no longer interested in participation in the IEHP network must submit a minimum of 60 days written notice of intent to terminate. IEHP makes every effort based on the timing of notification by the Provider to provide impacted Members with a minimum of 30 days' notice in advance of the effective date of the termination.[4]

B. When a BH Provider is unable to continue to provide treatment for an IEHP Member, either due to going on medical leave, maternity leave, vacation, military duty, etc., the BH Provider or the Providers' office is responsible for coordinating the transition of impacted IEHP Members to other appropriate IEHP BH Providers to avoid patient abandonment. IEHP BH

[4] DHCS APL 21-003

Providers are expected to follow all licensing board requirements and maintain ethical standards of practice while care is being transitioned.

C. When a BH Provider is being terminated, the BH Provider or the BH Provider's office needs to cooperate with IEHP Behavioral Health and Care Management department in developing a transition plan for impacted IEHP Members that ensures Members are not abandoned and that BH Providers are compliant with their licensing board requirements and maintain ethical standards of practice. In order to coordinate the transition of IEHP Members, BH Providers may be required to provide a list of active IEHP Members who will need to be transitioned to another BH Provider, treatment records, and/or medication lists with the IEHP BH Department.

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D. IPA Reported Provider Changes
1. PCP Termination

APPLIES TO:

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

POLICY:

A. All IPAs must provide IEHP with a 60 days advance written notice of any significant changes in the IPA's network, including the termination of a Primary Care Provider (PCP).

B. IEHP retains the right to obligate the IPA to provide medical services for existing Members for the entire 60 days period.

C. IEHP notifies affected Members at least 30 days prior to the effective date of termination of a PCP.[1]

D. IEHP monitors IPA compliance with policy on an annual basis.

PROCEDURES:

A. IEHP requires advance 60 days written notification from the IPA that a PCP is terminating as an IEHP network PCP whether voluntary or involuntary, if possible. The notice must include a coverage plan where applicable and supporting documentation/letter from PCP as to reason for termination.

   1. Upon receipt of the 60 days advance notification, IEHP works with the IPA to develop a coverage plan in order to determine Member transfers.

   2. IEHP reviews submitted coverage plans and either approves, denies, or requests additional information within two (2) working days of the receipt of information from the IPA.

   3. If the same PCP status (i.e., age limitations, geographic location, etc.) as that of the original PCP cannot be achieved or an acceptable coverage plan is not received 30 days prior to the effective date of termination of a PCP, IEHP reassigns these Members to a new PCP within IEHP's geographic service area who has the capacity and can accommodate the affected Members. IEHP does not guarantee that Members remain part of the IPA's network.

   4. Once all information is verified and an appropriate PCP is established for Member transfer, IEHP sends a letter to the Member notifying him/her of the impending termination and of the new PCP assignment. The letter informs Members of their right to select their own PCP. Notification to the Members occurs five (5) working days after IEHP approves the submitted coverage plan and submits internal notification of systems at least 30 days prior to the effective date of the impending termination.

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Supersedes Policy Letter (PL) 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"

5. Notification of the change is also sent to the IPA and PCP confirming the termination date and transfer of Members (See Attachments, "Compliant Termination Letter" and "Non-Compliant Termination Letter" found on the IEHP website[2]).

B. In situations where less than 60 days advance notice is received. IEHP will notify the Member within five (5) working days from the date IEHP learns the PCP has termed and makes a good faith effort to allow the Member up to 30 days to make an alternate PCP change.

1. The IPA may provide coverage by a PCP not credentialed for participation in the IEHP network as stated in Policy 18I, "Leave of Absence."
2. If the PCP's status (i.e., age limitations, geographic location, etc.) cannot be achieved, IEHP reassigns these Members to a new PCP within IEHP's geographical service area that has the capacity and can accommodate the affected Members. IEHP does not guarantee that Members remain part of the IPA's network.
3. Upon verification of all information and an appropriate PCP is selected for Member transfer, IEHP sends a letter to the Member notifying him/her of the impending termination and of the new PCP assignment. The letter informs the Member of his/her right to select another PCP \. Notification to the Member occurs at least 30 days prior to the effective date of the impending termination.
4. Once IEHP establishes an effective date for the PCP termination and Member transfer, IEHP sends the IPA and PCP a written notification regarding the effective date of the termination and transfer of Members who have not selected a PCP (See Attachment, "Non-Compliant Termination Letter" found on the IEHP website[3]).

C. IEHP monitors IPA's compliance with the written notification required as part of the IPA Performance Evaluation Tool as stated in Policy 25A3, "Delegation Oversight – IPA Performance Evaluation."

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

18. PROVIDER NETWORK

D. IPA Reported Provider Changes
2. Specialty and Ancillary Provider Termination

APPLIES TO:

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

POLICY:

A. All IPAs must provide IEHP with a 60 day advance written notice of any significant changes in the IPA's network, including the termination of a specialty or ancillary Provider.

B. IEHP requires IPAs to notify Members in writing 30 days prior to the effective date of a specialist's termination, or determination by the IPA to terminate a Specialist.[1]

C. IPAs will ensure Members under care, including women in their 2nd or 3rd trimester, maintain uninterrupted care with the same Specialist, as outlined in Policy 12A2, "Care Management Requirements - Continuity of Care".

D. IEHP retains the right to obligate the IPA to continue care uninterrupted with the same Specialist for existing Members:

1. Who are undergoing treatment for an acute condition or serious chronic condition through the current period of active treatment or for up to 90 days, whichever is shorter. Existing care may continue beyond the 90 days if necessary, for a safe transfer to another Provider.

2. Who are currently undergoing treatment for a high-risk pregnancy or a pregnancy that has reached the second or third trimester pregnancy until postpartum services related to the delivery are completed. Care may be extended beyond postpartum care if necessary, for a safe transfer to another Provider.

E. IPAs are not required to continue care with Providers terminated for quality issues, fraudulent behavior, or criminal activity.

F. IEHP monitors IPA compliance with all notification requirements on an annual basis.

PROCEDURES:

A. IPAs must provide IEHP with a 60 day advance written notice of the termination of a Specialty or ancillary Provider from the IEHP network to IEHP's Provider Updates at ProviderUpdates@iehp.org. IPAs are responsible for identifying Members currently under the care of a terming Specialist or Ancillary and providing ongoing care as noted below.

1. The written notification from the IPA to IEHP must include a list of all the Members who have seen the Specialist two (2) or more times in the preceding 12 month period, are

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Supersedes Policy Letter (PL) 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"

currently under on-going care, or have an open referral, as well as a copy of the notification letter sent to Members as stated below.

B. IPAs must send written notification to Members 30 days prior to the effective date of the Specialist's termination or a determination by the IPA to terminate the specialty Provider's affiliation with the IPA or IEHP. As applicable, the notice to Members must include the right of the Member to continue care under the specialist as outlined in Policy 12A2, "Care Management Requirements - Continuity of Care." The written notification from the IPA must be sent to all Members that:

1. Have seen the Specialist two (2) or more times within the preceding 12 month period; or
2. Are currently under on-going care; or
3. Have an open referral.

C. After receiving written notification from the IPA, the Specialty or Ancillary Provider is terminated in IEHP's system with the effective date of the termination.

D. IEHP reserves the right to make final decisions regarding continuity of care for all Members.

E. Members have the right to review IEHP final decisions, as well as obtain copies of this policy. Members desiring review of a decision, or wanting a copy of this policy, should contact IEHP Member Services at (800) 440-4347.

F. IEHP monitors IPA compliance with Specialist and Ancillary Termed notification requirements on a quarterly and annual basis, as part of its oversight of the IPA's specialty network, as outlined in Policy 18F, "Specialty Network Requirements," and Policy 25B10, "Credentialing Standards – Credentialing Quality Oversight of Delegates."

G. IEHP monitors IPA compliance with notification requirement on an annual basis, as part of the IPA performances evaluation tool, as stated in Policy 25A3, "Delegation Oversight –IPA Performance Evaluation."

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E. Management Services Organization Changes

APPLIES TO:

A. This policy applies for all IPAs that serve IEHP Medi-Cal Providers.

POLICY:

A. IEHP evaluates all Management Services Organizations (MSOs) that are contracted with IPAs to ensure that they can meet regulatory and IEHP operational requirements and standards.

B. Any IPA wishing to contract with a new MSO must provide adequate notice to IEHP so that a pre-contractual audit can be performed to ensure that the MSO can meet regulatory and IEHP operational requirements and standards.

C. Prior to being included in IEHP's Provider network**,** the IPA or MSO must meet IEHP's contractual, financial, administrative, and quality standards.

D. IEHP performs an audit of the IPA or MSO to review information provided in the pre-contractual response.

E. The new MSO will be subject to a pre-contractual audit prior to approval.

F. The IPA must submit a transition plan of services 30 days prior to change from the existing MSO to the new MSO.

G. If the MSO does not meet IEHP standards, the IPA is not allowed to transition to the new MSO. For new IPAs, failure to have an MSO or in-house staff and procedure that meet minimum standards will result in all contracting efforts being halted.

H. In the event that a MSO contracted with an IPA experiences significant operational or financial failures that result in the termination of the IPA, IEHP reserves the right to eliminate the MSO or its principals for future management services for any of our currently contracted or new IPAs.

I. If the MSO is providing management services for more than one (1) currently contracted IPA in the IEHP network and is undergoing significant operational or financial failures a review will be performed to ensure that the MSO is meeting IEHP operational requirements and standards for each contracted IPA.

J. If the MSO is providing management services for more than one (1) currently contracted IPA in the IEHP network and is in good standing, a new pre-contractual audit may be waived, only the transition plan will be required.

PROCEDURES:

A. In the event an IPA decides to change its MSO or to bring MSO functions under the umbrella of the IPA, the IPA must:

1. Provide IEHP with a 90 day advance written notice if the MSO is not currently

affiliated with IEHP; or

2. Provide IEHP with a 60 day advance written notice if the MSO is already affiliated with IEHP;
3. Provide IEHP with a copy of the signed MSO agreement; and
4. Submit the applicable, revised sections of the pre-contractual for services that the new MSO is responsible for performing on behalf of the IPA.

B. IEHP requires any new MSO to have:

1. Been in business for at least two (2) years;
2. Managed a minimum of two (2) fully capitated HMO contracts for two (2) years;
3. A local satellite office or be available to travel to the two (2) counties, when necessary;
4. Capitation payments sent directly to the IPA; and
5. Performed management services that meet or exceed the performance of the previous MSO, if applicable, as measured by the outcome of the Medical and Administrative Management Audits as appropriate.
6. Demonstrate the administrative and operational capacity to take on the additional IPA membership.

C. Prior to the effective date of change in management, IEHP performs an audit of the new MSO.

D. If the IPA/MSO is unable to pass the IEHP audit, the IPA/MSO is required to contract with an existing IEHP MSO or maintain their current relationship to continue participation in the IEHP network.

E. Failure by the IPA to comply with the above notification requirements may result in the IPA being frozen to new enrollment and network expansion, may incur financial penalties or may be terminated from the IEHP network.

F. IEHP does not approve of new MSOs that exceed regulatory ownership and control limits or have significant ownership or officer overlap with the IPA owners or officers.

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G. Provider Resources

APPLIES TO:

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

POLICY:

A. IEHP provides various informational resources to Providers to assist them in carrying out their contractual obligations. Among those resources are the following:

1. Joint Operations Meeting (JOMs)
2. Behavioral Health and Care Management Teams
3. IEHP Provider Relations Team
4. Nurse Educators (NE) and/or Quality Program Nurses (QPN)
5. IEHP University
6. Provider Newsletter (The Heartbeat)
7. Provider Staff Newsletter (Scrub Talk)
8. Special Provider Notices
9. IEHP Website - www.iehp.org
10. Other resources as made available

B. IEHP expects IPAs to communicate IEHP's policies and procedures to contracted Primary Care Providers (PCPs) and Specialists. In some cases, IEHP sends correspondence directly to IPAs, relying on them to disseminate the information to its Providers in a timely manner.

C. Some situations require that IEHP directly notify PCPs or Specialists. In such situations, IEHP uses its best efforts to provide IPAs with a copy of the correspondence five (5) days prior to mailing to Providers, when applicable.

D. IEHP provides clinical performance data and Member experience data or results, as applicable when requested by Providers and/or Delegates.

E. Additionally, IEHP communicates directly to Providers on information or program updates through newsletters, physician surveys, blast fax, fliers, Provider website and other programs where IEHP works directly with Providers. Such communications are delivered directly to participating Providers, IPAs, and Hospitals concurrently. Prior notification is not provided by IEHP in these cases.

F. In instances where Providers are unable to receive faxes, IEHP communications or updates are mailed or e-mailed directly to the Providers depending on their preference. IEHP's Provider Communications team maintains an exception table list of these Providers with their mailing address or email address.

18. PROVIDER NETWORK

G. Provider Resources

G. It is crucial to the success of IEHP and its Delegates to develop relationships and communication between its Practitioners, ancillary Providers, and contracted partners.

PROCEDURES:

A. Joint Operations Meetings (JOMs):

1. JOMs create a forum to discuss issues and ideas concerning care for Members, and to allow IEHP a method of monitoring plan administration responsibilities delegated to the Providers.
2. IEHP attempts to meet with each IPA quarterly.
3. Periodically, JOMs focusing on IPA/Hospital coordination and communication are held (when necessary or as requested with each IPA/Hospital relationship).
4. In addition, IEHP also holds JOMs individually with contracted Hospitals.
5. All JOMs are held within IEHP's geographical service area regardless of Management Services Organization (MSO) location.

B. Care Management Teams

1. IEHP has Behavioral Health and Care Management Teams that serve as a resource for IEHP Team Members, Providers, and contracted IPAs on information including but not limited to:
    a. Continuity of Care (COC) Regulatory Guidelines
    b. California Children's Services (CCS) (referrals, benefits, etc.)
    c. Long Term Services and Supports (LTSS) (referrals, benefits, etc.)
        1) Community Based Adult Services (CBAS)
        2) Multipurpose Senior Services Program (MSSP)
        3) In Home Supportive Services (IHSS)
    d. Medi-Cal Seniors and Persons with Disability (SPD) Regulatory Guidelines
2. The Behavioral Health and Care Management Teams are comprised of clinical and non-clinical Team Members.
3. An Interdisciplinary Care Team (ICT) is offered to Members to coordinate delivery of services and benefits when a need is demonstrated and in accordance with Member's functional status, assessed need and Care Plan. Members may request an ICT meeting at any time through communication with IEHP or Delegate staff. The Care Manager coordinates invitation notices to Providers and caregivers as needed.
4. Member, Provider and Practitioner issues, excluding Member eligibility, should be directed to the Behavioral Health and Care Management Teams. These issues may include:

a. Access issues
b. Case management
c. Discharge planning
d. Coordination of care
e. Medical care standards
f. Waiver programs

C. IEHP Provider Relations Team

1. The IEHP Provider Relations Team serves as an information resource for IEHP Member Services Representatives, Providers (both participating and non-participating), contracted IPAs, Hospitals and Ancillary Providers.
2. The IEHP Provider Relations Team is comprised of Provider Services Representatives, Provider Call Center Representatives and Provider Services Specialists and Provider Communication Team.
3. Provider and Practitioner issues, including Member eligibility, should be directed to the IEHP Provider Relations Team. These issues may include:
    a. Access issues
    b. Global Quality P4P Program
    c. Pay for Performance (P4P)
    d. Reconciliation of capitation to eligibility
    e. Benefits
    f. Credentialing Issues
    g. Provider Network Issues
    h. Encounter Data
    i. Claims
    j. Referrals
    k. Vision Issues
    l. Vision Referral Request
    m. Referral Authorization status
    n. Request for in-service training
    o. Behavioral Health
    p. Website Issues

4. Provider Services Representatives (PSRs):
   a. IEHP PSRs are trained in accordance with regulations set forth by the State Programs Regulations.
   b. IEHP PSRs provide detailed information about IEHP benefits, IEHP programs, and managed care concepts to IEHP Providers and serve as the focal point for Provider office staff to obtain information about IEHP programs, California Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and other regulatory issues, as applicable.
   c. For the purposes of visits the PSRs are assigned geographic areas to visit IEHP Providers. PSRs are assigned by IPA or geographically for directly contracted Providers.
   d. On an initial, periodic, and Provider-requested basis, PSRs provide training to Providers and their staff covering an array of topics, including but not limited to:
      1) Encounter Data Submission Requirements
      2) Prior Authorization Requests
      3) Website Tools
         - Pay for Performance (P4P) – DualChoice Annual Visit
         - Electronic Referrals
         - Health Education Referrals
         - Care Plans
         - Member Health Records
         - Online formulary search
         - IEHP Guidelines for Care Management
         - Member Preventive Care Rosters
      4) Claims
         - Provider Dispute Resolution (PDR) Process
         - Correct Billing Entities and Division of Financial Responsibility
         - Prohibition of balance billing Members
      5) Program updates and communications
         - Review of blast faxes sent in previous quarter

6) Providers and their staff are encouraged to direct their questions to their IEHP PSRs, especially to help the staff understand complex State regulations concerning Medi-Cal Program beneficiaries.

D. Nurse Educators (NE) and/or Quality Program Nurses (QPN)

1. Nurse Educators develop Provider Trainings for areas determined to be of concern such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, Quality Improvement initiatives and Medical Record documentation.
2. Provide on-site trainings to the Provider Network in areas determined to be of concern. Coordinate trainings with other departments such as Provider Services, Contracting and Medical Management.
3. Perform Facility Site Audit and Medical Record Audits trainings for Primary Care Providers (PCPs).

E. IEHP University:

1. On an annual basis or when applicable, IEHP conducts a one (1) day training seminar ("IEHP University") for IPAs and Hospital key staff.
2. IEHP offers various IEHP plan administration "courses" for the IPAs and hospital key staff to choose from.
3. Each IPA and Hospital is required to send a minimum of three (3) key staff members to each IEHP University.

F. Provider Newsletter (The Heartbeat)

1. The Heartbeat is a newsletter that is distributed by mail to all IEHP on a quarterly basis.
2. The purpose of the Heartbeat is to communicate information to Providers and office staff regarding: any policy, benefit, service, program, State and Federal or regulatory changes and/or updates.
3. The Provider Newsletter also informs Providers of featured health education programs available to Members, so that Providers can refer Members to applicable IEHP health education programs or encourage attendance at those programs.
4. Inform Providers of results of quality studies or other quality of care related information.
5. Provide and reiterate important information to Providers and office staff.

H. Special Provider Notices

1. Regulatory changes made by DHCS, California Department of Managed Health Care (DMHC), or CMS are communicated to our Providers.
2. The Provider Communication team determines the need for such special notices.

18. PROVIDER NETWORK

G. Provider Resources

I. IEHP Website – www.iehp.org

1. IEHP's website is a valuable business tool created to provide our Providers with 24 hours, seven (7) days a week access to IEHP resources.
2. IEHP's website has an enhanced security system that provides additional levels of security to Providers. These features ensure Health Insurance Portability and Accountability Act (HIPAA) privacy, security compliance and can limit employee access to claims, clinical, P4P and other reimbursement information.
3. Providers are encouraged to use the IEHP website in an effort to go 100% paperless.
4. IEHP strives to provide our Provider Network with all the tools necessary to deliver the highest quality of care. These include:
   a. Non-Secure Site
      1) Find a Doctor
      2) Provider Login
      3) Pay for Performance (P4P)
         - Pay For Performance (P4P) Program – DualChoice Annual Visit
         - Provider Quality Incentives Brochure
         - Medicare P4P IEHP Direct Program
         - Direct Stars Incentive Program
         - D-SNP Model of Care Incentive Program
         - Global Quality P4P Program
         - Quality Improvement Activity Strategy Forms
         - Potentially Avoidable Emergency Department (ED) Visits: Potentially Preventable Diagnosis Codes
         - OB/GYN P4P Program
         - Hospital P4P Program
         - Substance Use Disorders and Mental Health Diagnosis Lists
      4) Proposition 56 & GEMT
         - Electronic Payments
         - Adverse Childhood Experiences Screening (ACES) Services
         - Developmental Screening Services
         - Family Planning Services

- Ground Emergency Medical Transport (GEMT)
- HYDE
- Proposition 56 and GEMT Payment Schedule
- Proposition 56 Payment Dispute Process

5) Private Hospital Directed Payment Program (PHDP)
   - Enhanced Payment Program (EPP)
   - District and Municipal Public Hospital Quality Incentive Pool and Designated Public Hospital Quality Incentive Pool
6) Plan Updates
   - Correspondence
   - Coronavirus (COVID-19) Advisory
   - IEHP Holiday Schedule
   - Medicare Beneficiary Identifier (MBI)
   - Newsletters
     - The Heartbeat
   - Public Health Advisory
     - Riverside County Public Health System
     - San Bernardino County Public Health System
     - Centers for Disease Control and Prevention (CDC)
     - California Department of Public Health (CDPH)
   - Regulatory Updates
     - Medicare Outpatient Observation Notice (MOON)
   - Updates
     - Medicare – Medicaid (MMP) Quality Withhold Measures
     - A Message From IEHP Medical Director, Dr. Takashi Wada
     - Mpox Vaccination Locations
     - Frequently Asked Influenza (Flu) Questions: 2022-2023 Season (CDC Recommendations)
     - Preventive Services
7) Provider Policy and Procedure Manuals

- General Information
  - Acknowledgement of Receipt (AOR)
- 2024 Manuals
  - Provider Policy and Procedure Manual – Medi-Cal
  - Provider Policy and Procedure Manual – IEHP DualChoice (HMO D-SNP)
  - Provider Policy and Procedure Manual – Covered California (CCA)
  - Benefit Manual Information
  - Electronic Data Interchange
  - Regulatory Trainings
  - 2024 Acknowledgement of Receipt

8) Provider Resources

- Claims
  - Medi-Cal Learning Portal
  - Medi-Cal Rates and Codes
  - Medicare Physician Fee Schedule
  - IEHP Fee Schedule
  - Provider Dispute Resolution Process
  - Other Health Coverage (OHC)
    - Coordination of Benefits with Other Health Coverage (OHC)
    - Frequently Asked Questions (FAQs) - OHC
- Compliance
  - Compliance Program
  - Code of Business Conduct and Ethics
  - Compliance, Fraud, Waste and Abuse (FWA), and Privacy Program Training
  - Eligibility to Participate in Federal and State Health Program
  - Exclusion Screening
  - Fraud, Waste, and Abuse (FWA)
  - Privacy Incident/Breach

  - Reporting Information
  - Frequently Asked Questions (FAQs)
  - IEHP DualChoice (HMO D-SNP) Model of Care Training
  - Contact the OIG
- IEHP DualChoice (HMO D-SNP) – Model of Care
  - IEHP DualChoice (HMO D-SNP) Model of Care Training
- Educational Opportunities
  - Interdisciplinary Care Team (ICT) Fact Sheet
  - DualChoice Medicare CM IPA Training
  - Alzheimer's and Dementia Care
  - Specialty Mental Health Care Coordination
  - National Lesbian, Gay, Bisexual, Transgender (LGBT) Health Education Webinars
  - Online Cultural Competency Training
- Forms
  - Behavioral Health
  - Claims
  - Compliance
  - Delegation Oversight Audit (DOA)
  - Grievance
  - Growth Chart
  - Health and Wellness
  - Historical Data Form
  - Inland Regional Center
  - Medi-Cal Letter Templates
  - Medicare-Medicaid Plan Letter Templates
  - D-SNP Letter Templates
  - Medicare
  - Non-Contracted Providers
  - Perinatal

  - Pharmacy
  - Provider Preventable Conditions (PPC)
  - UM/CM
  - Vision
  - Other
- FSR Training
  - Facility Site Review Training Index
  - Department of Health Care Services (DHCS)
  - IEHP Addendum Tools
  - PARS
  - Facility Site Review Menu
- Health & Wellness
  - Brochures and Handouts
  - Diabetes Prevention Program (DPP) – Live the Life You Love
  - Educational Resources
  - Loving Support Program
  - Member Education Resources
- Non-Contracted Providers
  - Provider Dispute Resolution Process for Contracted and Non-Contracted Providers
  - Emergency and Post-Stabilization Care for IEHP Members
  - IEHP DualChoice (HMO D-SNP) Model of Care Training for Non-Contracted Providers
- POLST Registry
- Pharmacy Services
- Clinical Practice Guidelines
  - Preventive Care Guidelines
  - Clinical Practice Guidelines Library
- Additional Tools & Resources
  - After Hours Care

- After Hours Phone Numbers for Coverage Determination and Expedited Appeals (IEHP DualChoice (HMO D-SNP) Members)
- IEHP Access Standards
- IEHP Direct Adult Hospitalists
- LabCorp Locations
- Urgent Care Clinics

- Utilization Management Criteria
  - Behavioral Health
  - Community Supports Services
  - Diagnostic Testing
  - Gynecology and Obstetrics
  - Neurology
  - Pain Management
  - Pharmacy
  - Surgical Procedures
  - Other

9) Pharmacy Services

- DHCS Medi-Cal Rx
  - Communications from DHCS
  - Communications from IEHP
- Academic Detailing
- IEHP DualChoice (HMO D-SNP)
- Clinical Information
  - Clinical Practice Guidelines
  - High Risk Medications
  - Medication Therapy Management
  - Pharmacy Pain Management
  - Prescription Drug Prior Authorization Drug Treatment Criteria
  - Safety Resources
- Drug MAC

- Formulary
- Pharmacy Forms and Manuals
  - Coverage Redetermination
  - Drug Request
  - Medicare
  - Mail Order
  - Other Pharmacy Provider Forms
  - WIC Program Forms (California Department of Public Health)
- Pharmacy Network Lists
  - IEHP Pharmacy Network
  - Specialty Pharmacy Network List
  - Vaccine Pharmacy Network List
- Pharmacy Quality Ratings
- Provider Communications

10) Special Programs

- Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT)
- Baby-N-Me
- California Children Services (CCS)
- Community Supports
- Enhanced Care Management
- IEHP Gender Health
- Independent Living and Diversity Resources
  - ADA and Beyond
  - Enforcement
  - Facts and Information
  - Legal Obligations
  - Technical Assistance
  - Community Based Adult Services (CBAS)
  - SPD Awareness Training

- Major Organ Transplant (MOT)
  - What Transplant Services are Available for Members?
  - Centers of Excellence (COE)
- MyPath Palliative Care
- Services for Teen Patients
- Tobacco Cessation Services
  - Provider Education Resources
  - Tobacco Cessation Services
- Total Fracture Care Program

11) CalAIM
12) Physician Wellness
13) Join Our Network
    - Ancillary
    - Behavioral Health
      - Behavioral Health Forms
      - Frequently Asked Questions (FAQs)
    - Community Supports
    - Hospitals
    - IPA
    - PCP and Specialists
    - Provider Network Expansion Fund
    - Screening and Enrollment
    - Vision

b. Secure Site Login

1) Home (Landing Page)
   - Alcohol and Drug SABIRT (formerly known as SBIRT) Services
   - Coronavirus (COVID-19) Advisory
   - Department of Public Health
   - Department of Social Services Requirements

- Division of Financial Responsibility (DOFR) (for IPAs only)
- Events and Training
- Forms
- Global Quality P4P Program
- IEHP Direct Hospitalist for Adults (for IPAs only)
- Inland Regional Center (IRC)
- Provider Alerts
- Provider Network Expansion FundSpecial Programs
- Updates

2) Eligibility (including Other Health Coverage information)
   - Other Health Coverage FAQs
3) Care Management
   - Care Plans and HRAs
4) Rosters (for PCPs and IPAs)
   - Admitter List (for IPAs only)
   - Annual Eligibility Redetermination (AER) Roster
   - Ancillary Roster (for IPAs only)
   - Assigned Roster
   - CM Plan Referrals (for IPAs only)
   - CCS
   - COVID-19 Positive
   - COVID-19 Vaccine
   - Direct Ancillary (for Direct Contracted Providers only)
   - Direct Specialty (for Direct Contracted Providers only)
   - DocOnline
   - Early Start Roster
   - HCC (for IPAs only)
   - Health Management
     - Asthma Roster

  - Care Plans and HRAs
  - Diabetes Roster
- Initial Health Assessment
- Inpatient Discharges
- Long Term Services and Support (LTSS) Roster
- NEMT PCS Roster
- Nurse Advice Line
- Preventive Care
  - ADHD Medication (Follow-up Care)
  - Blood Lead Screen
  - DualChoice Annual Visit

5) Reports
   - GQ P4P (IPAs and PCPs)
   - IEHP Direct Stars Incentive Program (PCPs only)
   - Medicare Stars Quality Withhold (IPAs only)
6) Encounter
   - Entry
   - Status
7) Vision (for Vision Providers only)
   - Claims Entry
   - Vision Exception Request
   - VER (Status)
   - Vision Referral Request
   - Diabetes Care
   - ICD Codes
8) Pharmacy
   - Coverage Determination Request
   - DualChoice Formulary
   - Prior Authorization Criteria

- Pharmaceutical Services

9) Claims Status
10) Behavioral Health
    - Referral Request Form
    - COC Treatment Plan
    - Claims Submission
11) Referrals
    - Status
    - Request
12) Finance
    - Claims Remittance Advice (RAs)
    - GQ P4P PMPM
    - Prop 56 RAs
    - Quality Bonus Services RAs
13) Census Reports (IPAs only)
14) Pay for Performance (P4P)
    - P4P Entry
        - DualChoice Annual Visit
        - Historical Data
    - P4P Status
        - DualChoice Annual Visit
        - Historical Data
15) Health Education
    - Request
16) Clinical Resources and Tools

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G. Provider Resources

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H. Hospital Affiliations

APPLIES TO:

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

POLICY:

A. To ensure that a contracted Hospital is fully participating in the IEHP network, the IPA must have a minimum of five (5) Primary Care Providers (PCPs) who must, as a group, be capable of providing care to Members of all ages and genders, and admit to the designated Hospital or have an admitting arrangement. PCPs must be contracted and credentialed by the IPA who links to the contracted Hospital, as delineated in Policy 18F, "Specialty Network Requirements."

B. IEHP may choose to approve an IPA to have less than the minimum five (5) individual PCPs required at a specific Hospital due to geographic needs of Members and/or to avoid the potential monopolistic situation of an IPA and/or to ensure the opportunity for substantial participation of traditional Medi-Cal Providers in the health care delivery system.

C. IPAs are required to contract with a dedicated adult Hospitalist group at the Hospitals they are linked to and where such adult Hospitalist group exists.

D. Each PCP office must be within 15 miles or 30 minutes from the affiliated Hospital. The office should also be in the same county as the affiliated Hospital and you must not pass a different Hospital to get to the affiliated Hospital. In rural areas or in specific situations, IEHP may approve PCP links to Hospitals outside of these standards.

E. An IPA is not eligible to receive enrollment at a specific Hospital until they have met all criteria as listed above.

PROCEDURES:

A. IPAs must submit a complete PCP credentialing information to IEHP for those PCPs meeting the requirements of Section A above, as specified in Section 25, "Credentialing and Recredentialing."

B. Upon receipt of the credentialing information, IEHP reviews each packet in accordance with Section 25, "Credentialing and Recredentialing" and verifies that the IPA has:

   1. A minimum of five (5) PCPs who, as a group, can provide care to Members of all ages and genders, who admit to the designated Hospital or have admitting arrangements.

   2. A complete specialty network under contract to see Members at the designated Hospital, as stated in Policy 18F, "Specialty Network Requirements."

C. If the IPA does not have the required five (5) PCPs who meet the above criteria, IEHP contacts the IPA with the following options:

1. Designate another IEHP approved Hospital affiliation for the PCP in the interim until the IPA has the required five (5) PCPs contracted at the designated Hospital.
2. IEHP pend the PCP who is pending credentialing until the IPA has the required five (5) PCPs contracted at the designated Hospital.
3. Remove the PCP's application for participation with IEHP.

D. If Option C1 is chosen, for a new PCP IEHP schedules a facility site review and upon receipt of a passing score, the PCP is eligible to receive Member assignment.

E. If Option C2 is chosen, for a new PCP IEHP holds the pended file for six (6) months. If after six (6) months the IPA has been unable to contract with five (5) PCPs to admit to the designated Hospital, IEHP designates the PCP file as inactive and does not establish a Hospital link.

F. If an existing PCP terminates affiliation with an IPA or Hospital, resulting in the IPA having less than a group of five (5) PCPs who are capable of providing care to Members of all ages and genders, the IPA must contract and credential another PCP prior to the PCP's termination date in order to maintain compliance with this policy before IEHP initiates termination of the IPA's Hospital affiliation and transfer of Membership.

G. In addition, if IEHP does not receive the required 60 day advance notice of the practitioner termination, IEHP may freeze the IPA during this transition period as stated in Policy 18D1, "IPA Reported Provider Changes – PCP Termination."

H. In the event of the above, IEHP works with those PCPs affected by the termination to help retain the Member/Physician relationship.

I. IEHP monitors the IPA/Hospital link monthly. If the IPA cannot contract and credential another PCP to complete a group of five (5) PCPs who are capable of providing care to Members of all ages and genders, the IPA/Hospital link may be frozen up to a period of 90 days. If the IPA/Hospital link is not compliant within a 90 day timeframe, the IPA/Hospital link may be terminated.

J. The above procedure for IPA/Hospital link termination may be modified due to circumstances that in the judgment of the IEHP Chief Medical Officer (CMO) or the Chief Operating Officer(COO) is not in the best interest of the Member.

K. In cases where an IPA contracted with IEHP for Medi-Cal Members is not delegated Inpatient Utilization Management, the following shall apply:

1. IPAs are required to contract with a delegated adult Hospitalist group at the Hospitals they are linked to and where such adult Hospitalist group exists.

2. It is required that the IPA contract with the Hospitalist group contracted with IEHP Direct. The IPA may request to contract with another dedicated adult Hospitalist group present at the Hospital subject to IEHP approval.
3. In the situation where a dedicated adult Hospitalist group does not exist at a Hospital the IPA can contract with admitters to admit their assigned Members.

L. In the absence of a contract between an IPA and a Hospital, the IPA may be required to use the rates that exist in the contract between the Hospital and IEHP. IEHP will periodically update the IPA of any such Hospital arrangements.

M. In certain instances when emergency medical condition arises that requires medical care, to ensure uninterrupted care to Members from a Specialist not currently contracted, IEHP reserves the right to impose payment requirements on the IPA at the IEHP specified rate.

N. On occasional basis, where a health care service was provided by a non-contracted Hospitalist or Specialist at a non-contracted hospital, this unique relationship requires IPAs to pay the Hospitalist or Specialist at the IEHP specified rate.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	March 9, 1998	
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18. PROVIDER NETWORK

I. Leave of Absence

APPLIES TO:

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

POLICY:

A. IPAs must ensure adequate coverage for Primary Care Providers (PCPs) on leave of absence for less than two (2) weeks.

B. IPAs must submit written coverage plans to IEHP for any PCP that is scheduled to be on a leave of absence greater than two (2) weeks.

C. IPAs must ensure that PCP completes the IEHP PCP leave of absence coverage form and return it to their Provider Services Representative (PSR) (See Attachment, "IEHP PCP Leave of Absence Coverage Form" found on the IEHP website[1]).

D. IEHP PSR collects the leave of absence coverage form from PCPs contracted with IEHP Direct.

E. In general, leaves of absence by PCPs greater than 90 days require transfer of assigned Members to another PCP.

DEFINITION:

A. A leave of absence is defined as a complete absence from the PCP practice for medical, personal, or other reasons, including vacation.

PROCEDURES:

A. IPAs must ensure an adequate plan of coverage for all PCPs absent from their practice for less than two (2) weeks. Adequate coverage is not utilizing network urgent cares or the emergency room for Member care. Adequate coverage must include:

   1. Use of a credentialed IEHP PCP in the appropriate specialty for the practice, either at the PCP site or at another approved IEHP PCP site.

   2. The covering PCP must be available at the original PCP site, or another IEHP approved site, at least 16 hours per week.

   3. If coverage is not provided at the same office, a process for informing Members of the covering PCP's name, phone number and office address utilizing the assigned PCP's phone number (e.g., voice message) and site (e.g., signs, notices) must be in place.

B. PCPs planning a leave of absence greater than two (2) weeks must inform their IPA at least 60 days in advance.

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

C. IPAs must submit a written coverage plan to IEHP no less than two (2) weeks prior to the PCP's leave date for all PCPs whose leave of absence is greater than two (2) weeks. The coverage plan must include at a minimum:

1. Name and location of the credentialed IEHP PCP providing coverage.
2. If the covering PCP is not at the same location as the PCP on leave, the plan for informing Members of the covering PCP's name, phone number and office address.
3. The timeframe coverage is needed.
4. Any significant change in schedule or hours of coverage from the original PCP site.

D. For PCPs on a leave of absence greater than 90 days, the IPA must submit either:

1. A plan for reassigning Members to another credentialed IEHP PCP within appropriate geographic proximity and specialty type of PCP; or
2. A specific request to keep the assigned Members with the original PCP with supporting documentation as to why this is in the best interest of the Members and including a plan for interim coverage.

E. IPAs must provide IEHP a written Member transfer plan within five (5) days when a PCP leaves his/her practice without timely notice.

1. If the IPA plans to have current Members transferred to the covering PCP who is not credentialed for participation in the IEHP network, complete credentialing information must be submitted to IEHP within four (4) weeks of the original event.

F. IEHP reviews all submitted plans and either approves, denies, or requests additional information within five (5) working days of the receipt of the information from the IPA. If the coverage plan is denied, IEHP may determine reassignment of the Members.

G. PCPs must complete an IEHP PCP leave of absence coverage form at the time of recredentialing so that IEHP has a record of who will provide services during the PCP's future leave of absence. The PCP must advise the PSR of any changes to this plan if they occur in the interim.

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Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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18. PROVIDER NETWORK

J. IEHP Termination of PCPs, Specialists, Vision, and Behavioral Health Providers

APPLIES TO:

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

POLICY:

A. IEHP involuntarily terminates PCPs, Specialists, Vision, and Behavioral Health Providers from the IEHP network due to reasons delineated in credentialing and site audit policies.

B. IEHP notifies Members in writing 30 days prior to the effective date of the determination by IEHP to remove a PCP from participation in the IEHP network.

C. IEHP or IPA is required to notify Members of a Specialist's termination from the IEHP network upon receipt of notice from IEHP of the determination to remove a Specialist from participation in the IEHP network. The notification to Members must occur no later than 30 days prior to the effective date of the termination.

D. IEHP retains the right to obligate the IPA to continue to provide medical services for existing Members in accordance with Policy 12A2, "Care Management Requirements - Continuity of Care."

DEFINITION:

A. Block Transfer: A transfer or redirection of 2,000 or more Members from a terminated IPA or hospital to one or more contracted Providers that takes place as a result of the termination or non-renewal of a Provider contract.[1,2]

PROCEDURES:

PCP Termination

A. If IEHP is initiating the termination of the PCP due to site review failure, expiration of any credentialing requirements, insufficient access, peer review or quality of care issues or other reasons deemed appropriate by IEHP, and all appeal levels have been exhausted, IEHP notifies the PCP and the IPA (if applicable) that the PCP is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, "Peer Review Termination Letter" found on the IEHP website[3]). A copy of the notification to the PCP is sent to the IPA.

[1] Title 28, California Code of Regulations (CCR) § 1300.67.1.3
[2] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Supersedes 16-001, "Medi-Cal Network Provider and Subcontractor Terminations"
[3] https://www.iehp.org/en/providers?target=forms

B. IEHP sends affected Members a letter notifying them of the PCP termination no later than 30 days prior to the effective date (See Attachments, "Member PCP Termination Notification Letter – English" and "Member PCP Termination Notification Letter – Spanish" found on the IEHP website[4]). The letter provides the Member with the opportunity to contact IEHP to select a different PCP at least 30 days prior to the effective date of termination of the Member's current PCP from the IEHP network.

   1. In situations where immediate termination of the PCP is required, IEHP makes a good faith effort to allow Members sufficient notice to select a new PCP, however, in order to ensure that there is no interruption in care for the Member, IEHP may immediately transfer the Member and allow the Member to select a PCP retroactively.

C. IEHP makes an effort to transfer the existing enrollment of the terminated PCP to other PCPs within the terminated PCP's IPA network. The final decision regarding Member transfers rests with IEHP.

D. If Members cannot be transferred within the IPA network due to age limitations, geographic location or other determination by IEHP, IEHP reassigns Members to a new PCP within IEHP's geographic service area who has the capacity and can accommodate the affected Members. IEHP does not guarantee that Members remain part of the IPA's network.

E. Once IEHP establishes an effective date for the PCP termination and Member transfer, IEHP:

   1. Sends the IPA written notification regarding the effective date of termination and transfer of Members who have not selected another PCP (See Attachments, "Compliant Termination Letter" and "Non-Compliant Termination Letter" found on the IEHP website[5]).

   2. Sends the affected Members a letter notifying them of the change in PCP 30 days in advance of the new effective date. The letter again informs Members of their right to select their own PCP (See Attachments, "Member PCP Termination Notification Letter – English" and "Member PCP Termination Notification Letter- Spanish found on the IEHP website[6]). Members may contact IEHP Member Services at (800) 440-4347 to select another PCP.

Specialist Termination

A. If IEHP is initiating the termination of a Specialist due to peer review or quality of care issues and expiration of any credentialing requirements, IEHP notifies the Specialist and their IPA (if applicable) that the Specialist is being terminated from the IEHP network and the effective date of termination (See Attachment, "Peer Review Termination Letter" found on the IEHP

[4] https://www.iehp.org/en/providers?target=forms
[5] Ibid.
[6] Ibid.

website[7]).

B. Upon receipt of the termination notice from IEHP, the IPA must notify Members of the termination in accordance with Policy 18D2, "IPA Reported Provider Changes - Specialty Provider Termination." The notice to Members must be sent no later than 30 days prior to the effective date and must include the option for Members to continue care with their existing Provider for up to 90 days in accordance with Policy 12A5, "Care Management Requirements - Continuity of Care." A sample Member notification is included as Attachments, "Specialist Termed Member Notification – English" and "Specialist Termed Member Notification – Spanish" found on the IEHP website[8].

Vision Provider Termination

A. If IEHP is initiating the termination of the Vision Provider due to expiration of any credentialing requirements, peer review or quality of care issues or other reasons deemed appropriate by IEHP, and all appeal levels have been exhausted, IEHP notifies the Vision Provider that the Vision Provider is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, "Peer Review Termination Letter" found on the IEHP website[9]).

Behavioral Health Provider Termination

A. If IEHP is initiating the termination of the Behavioral Health Provider (BH) due to expiration of any credentialing requirements, peer review or quality of care issues or other reasons deemed appropriate by IEHP, and all appeal levels have been exhausted, IEHP notifies the BH Provider that he/she is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, "Peer Review Termination Letter" found on the IEHP website[10]).

B. When a BH Provider is being terminated, the BH Provider or the BH Provider's office needs to cooperate with IEHP BH Department in developing a transition plan for impacted IEHP Members that ensures Members are not abandoned and that BH Providers are compliant with their licensing board requirements and maintain ethical standards of practice. In order to coordinate the transition of IEHP Members, BH Providers may be required to provide a list of active IEHP Members who will need to be transitioned to another BH Provider, treatment records, and/or medication lists with the IEHP BH Department.

Block Transfers[11,12,13]

[7] https://www.iehp.org/en/providers?target=forms
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Title 42 Code of Federal Regulations (CFR) § 438.207(c)(3)
[12] Knox-Keene Health Care Services Plan Act of 1975, §1373.95
[13] DHCS APL 21-003

18. PROVIDER NETWORK

J. IEHP Termination of PCPs, Specialists, Vision, and Behavioral Health Providers

A. In the event that the termination of a Provider contract impacts 2,000 or more Members, IEHP will complete a block transfer as follows:

1. Provide all assigned Members with no less than a written notice 30 calendar days in advance of the contract termination, including language regarding their rights to continue obtaining care from existing Providers. In the case of a Hospital termination, all assigned Members who reside within a 15 mile or 30 minutes travel time radius[14] of the Hospital or linked to that Hospital, will be sent a written notice regarding the termination of the Hospital contractual relationship.
2. If, after sending the required notice to Members, IEHP reaches an agreement with the Provider to enter a new contract or to not terminate their contract prior to the termination date, IEHP will return Members' assignment to their original Provider.
3. Re-assign all block transferred Members within geographic access standards, as applicable.
4. Send notification to Compliance Department via email.
5. Compliance will notify Centers for Medicare and Medicaid Services (CMS) and California Department of Health Care Services (DHCS) of the block transfers.[15,16]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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[14] DHCS APL 23-001 Supersedes APL 21-006, "Network Certification Requirements"
[15] Title 28, California Code of Regulations (CCR) §1300.67.1.3, subdivision (b).
[16] 42 CFR §438.207 (e).

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

APPLIES TO:

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

POLICY:

A. IEHP is responsible for the initial and ongoing assessment of Hospitals directly contracted with IEHP.

B. IEHP maintains the appropriate records to document the verification process for contracted Hospitals per the most recent NCQA and CMS guidelines and IEHP requirements.[1]

C. IEHP does not contract with prospective Hospitals and entities for the IEHP Medicare line of business if the Provider is on the CMS Preclusion List or has opted-out of the Medicare Program. However, IEHP will consider contracting for the Medi-Cal line of business.[2]

PURPOSE:

A. IEHP verifies Hospitals are in good standing with regulatory bodies and are in compliance with the most current National Committee for Quality Assurance (NCQA) standards, IEHP requirements, Centers for Medicare and Medicaid Services (CMS), and State and Federal regulatory requirements prior to contracting with such organizations and during every contract renewal period.

B. IEHP reconfirms the status of all contracted Hospitals concurrently upon expiration and every contract renewal period, and for at least every 36 months.[3]

PROCEDURES:

A. IEHP does not contract with Hospitals if they appear on the list of indicated Providers provided by DHCS. If the Hospital is under investigation and a credible allegation of fraud has been found against the facility, as a result of this investigation IEHP will temporarily suspend/suppress the Hospital contract from the network pending resolution of the fraud allegation.[4]

B. IEHP does not contract with prospective Hospitals if they have been sanctioned, suspended, or excluded from participation in the Medicare or Medi-Cal/Medicaid Program by the U.S. Department of Health and Human Services, Office of Inspector General (OIG) list of excluded

[1] NCQA, 2023 HP Standards and Guidelines, CR 7, Element D
[2] Title 42 Code of Federal Regulations (CFR) § 422.222
[3] 42 CFR § 422.222
[4] Ibid.

individuals and Entities (LEIE), Restricted Provider Database (RPD), DHCS Medical Suspended & Ineligible Provider list, and Systems for Award Management (SAM).[5,6,7]

C. IEHP does not contract with Hospitals if they appear on the Provider decertification list provided by the Department of Health Care Services (DHCS). Hospitals listed on the decertification list are no longer certified to receive payment from the Medi-Cal Program for services rendered to Medi-Cal beneficiaries as the effective date noted for each Provider. IEHP reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Provider Agreement.[8]

D. Any Hospital Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the IEHP's Provider network. However, IEHP may consider contracting when the suspension and/or exclusion has been lifted.[9]

E. Hospitals must submit evidence of services provided, accreditation status and/or CMS site survey, license status, and regulatory standing at the time the Hospital applies to participate in IEHP's network. Copies of the Hospital's accreditation certificate, state license and most recent CMS or state survey report results satisfy this requirement.[10]

F. To contract with and remain in the IEHP network, the Hospital must provide:

1. Inpatient Services
    a. Intensive Care Unit;
    b. Medical Service, Surgical Service or combined Medical/Surgical Service;
    c. Pediatric Service; and
    d. Obstetrics/Perinatal Unit (or established arrangements for care approved by the IEHP Chief Medical Officer).
2. Outpatient Services
    a. Basic Emergency Department physician on-duty, or
    b. Standby Emergency Department (applicable only for Hospitals located in remote areas), with IEHP Chief Medical Officer (CMO) approval.

G. If Hospital offers Behavioral Health services, the following applies:

1. Inpatient Services

[5] Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004 Supersedes APL 17-019 and 16-012, "Provider Credentialing/Recredentialing and Screening/Enrollment"
[6] DHCS APL 21-003 Supersedes APL 16-001 and 06-007, "Medi-Cal Network Provider and Subcontractor Terminations"
[7] Medicare Managed Care Manual, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks," Section 60.2
[8] DHCS APL 21-003
[9] DHCS APL 19-004
[10] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 1 and 2

a. Inpatient hospitalization in semi-private accommodation, unless a private room is medically necessary;

b. Secure inpatient psychiatric unit;

c. Psychiatric and substance abuse services;

d. Ancillary services and supplies, including laboratory and x-ray services;

e. Administration of outpatient prescription drugs (take home medications) in instances where continuation of hospital-based treatment must not be interrupted: three (3) days' supply minimum; and

f. Administration of blood, blood plasma, or its derivatives, including cost of blood, blood plasma, or its derivatives.

2. Outpatient Services

a. Structured outpatient Behavioral Health Program;

b. Partial hospitalization services; and

c. Others.

H. IEHP accepts an accreditation report or letter form the regulatory and accrediting bodies regarding the status of the Hospital, as evidence that the Hospital has been reviewed and approved by an accredited body. Accreditation and licensure must be maintained throughout the duration of the Hospital's participation in the IEHP network.:[11]

1. IEHP recognizes the following Hospitals accrediting agencies:

a. The Joint Commission (TJC);

b. Healthcare Facilities Accreditation Program (HFAP);

c. Commission on Accreditation of Rehabilitation Facilities (CARF);

d. Det Norske Veritas Healthcare (DNV); and

e. Center for Improvement in Healthcare Quality (CIHQ).

2. An onsite quality assessment must be conducted if the Hospital is not accredited by an agency not listed above, the Hospital and IEHP must agree upon an alternate solution that meets IEHP's requirements, including the requirement to complete a CMS or State quality review , as applicable, in addition to meeting other standards as defined by IEHP.[12] IEHP's onsite quality assessment criteria for Hospitals includes, but is not limited to:

a. A CMS or state quality review in lieu of a site visit under the following circumstances (if IEHP chooses to substitute the site visit with a CMS or state quality review), if it meets the following requirements:

[11] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 2
[12] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 3

1) The CMS or state review is no more than three (3) years old.

2) IEHP obtains a survey report or letter from CMS or the state, from either the Hospital or the agency, stating that the facility was reviewed and passed inspection.

- The report meets IEHP quality assessment criteria or standards.

b. A Medicare certification number is not acceptable for use in lieu of a site visit if a facility is not accredited.

c. IEHP 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).[13]

I. As part of the application review process, and again during each contract renewal period but no less than every three (3) years, IEHP verifies that each Hospital has:[14]

1. A current and unencumbered license;
2. Current certification from The Joint Commission, HFAP, CARF, DNV, CIHQ as applicable, or an alternative accreditation or CMS or state quality review as determined by IEHP; and
3. No Medicare/Medicaid sanctions against them.

J. IEHP expects the Hospital to maintain its accreditation and license status in good standing and/or current at all times during the Hospital's participation in the IEHP network. The Hospital is responsible for providing IEHP with copies of its renewed license and accreditation within 30 days following the expiration of the license and accreditation.

1. Licensing and Accreditation must be re-verified at a minimum every three (3) years from the date of the original verification to confirm the Hospital continues to be in good standing with the State and Federal regulatory bodies.[15]

K. Hospital must have no sanctions that may impact participation, from any of the following Federal and State Databases:[16,17]

1. List of Excluded Individuals/Entities (LEIE)
2. System for Award Management (SAM) List
3. DHCS Medi-Cal Suspended and Ineligible List
4. CMS Preclusion List

[13] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 3
[14] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 1
[15] Ibid.
[16] DHCS APL 21-003
[17] DHCS APL 19-004

L. On a monthly basis, the Contracts Administration Specialist, or designee will submit a file on the 5th day each month prepared by Health Care Informatics (HCI) containing of contracted Hospitals to be screened by the sanction screening service, OIG Compliance Now.

1. Review of the Compliance OIG or Medicare/Medicaid Sanctions must be completed and documented on the spreadsheet or the file for any adverse actions. The monthly review of the OIG report as part of the "Ongoing Monitoring" for contracted facilities.

2. IEHP prohibits employment or contracting with Hospitals (or entities that employ or contract with such practitioners) that are excluded/sanctioned from participation (practitioners or entities found on OIG Reports).

M. On a monthly basis, the Contracts Administration Specialist, or designee will review the Restricted Provider Database (RPD) to determine the exclusion status of all Entities and verify all IPA's in the IEHP Network maintain good standing in the Medicare or Medi-Cal/Medicaid Program.[18]

N. IEHP reserves the right to perform facility site review when quality of care issues arise and to deny Hospital's participation in the IEHP network if IEHP requirements are not met.

O. If during the contract period, IEHP becomes aware of a change in the accreditation and/or CMS or state survey, license or certification status, or sanctions, fraudulent activity or other legal or remedial actions have been taken against any Hospital, the Contract Administration Specialist must take the following steps:

1. Notify the Director of Provider Contracting, Provider Contracting Manager, Contracts Administration Manager and the Compliance Department at DGStateProgram@IEHP.org within five (5) days of discovering our Provider/Hospital has been added to a disciplinary list.

2. The Director of Provider Contracting informs the Hospital in writing that it is in violation of its contract with IEHP and begins the cure process. Depending on the seriousness of the offense, IEHP:

   a. Reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Agreement.[19]

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

[18] Ibid.
[19] DHCS APL 21-003

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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18. PROVIDER NETWORK

L. Providers Charging Members

APPLIES TO:

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

POLICY:

A. California Welfare and Institutions Code 14019.4 prohibits contracted Health Care Providers from charging and/or collecting payment from managed Medi-Cal Members, or other persons on behalf of the Member, for missed appointments and for filling out forms related to the delivery of medical care. Any Provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or any person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.[1]

B. According to California Health and Safety Code, Section 123110.b, any Member or Member's representative shall be entitled to copies of all or any portion of the Member medical records that he or she has a right to inspect, upon presenting a written request to the Health Care Provider specifying the records to be copied, together with a fee to defray the cost of copying, that shall not exceed $0.25 per page or $0.50 per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. The Health Care Provider shall ensure that the copies are transmitted within 15 days after receiving the written request.[2]

C. In circumstances where charging a Member for completion of a form is allowed, fees should be nominal and not to exceed $0.25 per page with a maximum charge allowed of $20.

D. Under no circumstances can a Health Care Provider deny or refuse service to an IEHP Member for non-payment of a missed appointment, lack of payment for co-payments and owed balance or deductibles, as applicable.

E. Any contracted Health Care Provider who has furnished documentation of a person's enrollment in the Medi-Cal program, shall not seek reimbursement nor attempt to obtain payment for any covered services provided to the IEHP Member other than the participating health plan.

F. IEHP Members are not liable for any portion of a bill provided by a Health Care Provider, except non-covered benefits, items, or services.

[1] California Welfare and Institutions Code (Welf. & Inst. Code), § 14019.4
[2] California Health and Safety Code (Health & Saf. Code), § 123110.b.

18. PROVIDER NETWORK

L. Providers Charging Members

DEFINITION:

A. A "Health Care Provider" means any Practitioner or professional person, Acute Care Hospital organization, health facility, Ancillary Provider or other person or institution licensed by the State to deliver or furnish health care services directly to the Member.

PROCEDURES:

A. A Provider cannot charge or bill a Medi-Cal Member or IEHP for a covered service, except to:

   1. Collect payments due under legal entitlement.

B. A missed appointment is not a co-payment or a service therefore, Providers cannot charge Medi-Cal Members for missed appointments.

C. The following procedures will be followed when a Provider attempts to charge a Member for any missed appointment:

   1. IEHP will call the Provider and educate regarding the inappropriate practice of charging for a missed appointment.
   2. If a Provider insists on charging the Members, IEHP will send a letter educating the Provider, which includes a reference to Title 22 § 51002 of the California Administrative Code that prohibits Providers of Service from billing Medi-Cal Members. At IEHP's sole discretion, IEHP can provide the Member with a toll-free number to report the Provider for Medi-Cal fraud.[3]
   3. If a Provider continues the practice of charging for missed appointments, IEHP will request that a DHCS Fraud Investigator contact the Provider.
   4. Under no circumstances can a Provider deny service to a Member for non-payment of a missed appointment charge or other charges to Member when they were not an eligible IEHP Member.

D. Provider of Service cannot charge or collect payments at any time for filling out any of the following forms or required medical documentation:

   1. WIC referral forms;
   2. Lead Testing questionnaire;
   3. Prescriptions;
   4. Yellow Cards and/or any request for the documentation of a Member's immunization history;

[3] California Code of Regulations (CCR), Title 22, §51002.

5. Other forms related to the delivery of medical care;
6. Any forms required for a Member to qualify as eligible for Medi-Cal including, but not limited to, Cal Works Forms (CW 61 or an equivalent);
7. Any forms to facilitate transportation, including applications for paratransit service and Department of Motor Vehicles Disabled Placard Applications;
8. In-Home Support Services (IHSS) Medical Certification Form SOC 873;
9. Any forms related to Long-Term Services and Supports (LTSS) benefits including Community Based Adult Services (CBAS); and
10. Emotional Support Animal letter for housing authority/landlord completed by Behavioral Health Providers.[4]

E. Providers can charge IEHP Members a nominal fee for filling out any of the following forms:

1. History and Physical form that is school specific;
2. Sports Physical;
3. Disability forms; and
4. Utility Company Medical Baseline Program Applications.

F. A Health Care Provider that is not paid at billed charges may not pursue any balance billing or collection actions against any IEHP Member. Such collections actions may include:

1. Sending or mailing bills to IEHP Member;
2. Calling any IEHP Member with demands to pay outstanding balance; and
3. Referrals to collection agency.

G. If the Provider of Service continues to charge a Member in violation of this policy after being notified to stop, or sends the Member's account to a collections agency, IEHP reserves the right to inform the DMHC, DHCS or other regulatory agencies of the violation. In addition, the billing of Members is in violation of IEHP policy, and IEHP takes all necessary actions, up to and including termination of the Provider's participation with IEHP to ensure that such actions stop.

[4] Americans with Disabilities Act, the Fair Housing Act, and the Rehabilitation Act of 1973.

18. PROVIDER NETWORK

L. Providers Charging Members

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
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18. PROVIDER NETWORK

M. Outsourcing Standards and Requirements

APPLIES TO:

A. This policy applies to all Medi-Cal IPAs in IEHP's network who outsource.

POLICY:

A. Outsourcing is a business practice where a service is performed from an outside organization. The outsourced vendor provides services to contracted IPAs in IEHP's network.

   1. Onshore Outsourcing is allowed for services from a third-party located within California.

   2. Onshore Outsourcing outside of California is allowed for obtaining services from a third-party outside the IPA or IEHP but located within the Continental United States.

B. IPAs or IEHP are prohibited from Offshore Outsourcing any services outside of the Continental United States.

C. With respect to the onshore outsourcing of IEHP PHI and/or PII, IPAs must perform due diligence on any vendors considered for outsourcing PHI and/or PII before any agreements or contracts are executed to ensure such agreements comply with IEHP's established standards and requirements.

   1. Any IPAs wishing to outsource any service involving PHI and/or PII must obtain written approval from IEHP prior to utilizing such vendors as outlined in "Procedures", below. Without prior written approval from IEHP, the IPA is not permitted to outsource any of the work outlined in the IPA Agreement. If services were ongoing prior to the IPA's contract with IEHP, the IPA shall seek immediate approval by IEHP to apply retrospectively.

   2. IPAs must ensure that any vendor to whom it has onshore outsourced services involving IEHP PHI or PII complies with all applicable state and federal privacy laws, such as HIPAA.

   3. IEHP does not permit the transmission or accessibility of IEHP Member PHI and/or PII outside of the Continental United States.

D. With respect to the onshore outsourcing of clinical services (i.e. utilization management services), the IPAs must ensure compliance with all State of California requirements regarding in-state clinical licensure.

E. IEHP is firmly committed to complying with all applicable legal and contractual obligations under all state and federal programs, laws, regulations, and directives applicable to Medi-Cal, IEHP DualChoice, Covered California, and other lines-of-business in which IEHP may choose to participate. As a result, IPAs outsourcing services involving IEHP PHI and/or PII, or clinical services, are expected to comply, and require their vendors to comply, with all such applicable obligations.

DEFINITION:

A. Offshore subcontractor is defined as First tier, downstream, related entity located outside of the Continental United States.

B. First Tier Entity is defined as any party that enters into a written arrangement with IEHP to provide administrative services or health care services to IEHP Members.

C. Downstream Entity is defined as any party that enters into a written arrangement with persons or entities involved in with administrative or health care services, below the level of the arrangement between IEHP and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

D. Subcontractors defined as an individual or entity that has a contract with IEHP or subcontracts with an individual or entity that directly contracts with IEHP, that relates directly or indirectly to the performance of IEHP's obligations under contract with the Department of Health Care Services (DHCS). A network provider is not a subcontractor by virtue of the network provider agreement.

PROCEDURES:

A. As to outsourcing of business services/activities involving IEHP PHI and/or PII: IPAs seeking to obtain approval of a vendor who will use and/or disclose IEHP PHI and/or PII shall submit a written request IEHP.

1. The IPA shall first conduct a background check and verify vendor's services through a minimum of two (2) references. The background check shall consist of:

   a. Corporate history, reputation, capabilities and financial stability.

   b. Verification the vendor is eligible to participate in state and federal health care programs and does not appear on the Suspended and Ineligible Provider List,[1] US Department of Health and Human Services Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), or the General Services Administration (GSA) System for Award Management (SAM) exclusion list.

   c. Any subcontracted or outsourced activities provided or currently being provided to comparable entities to ensure the entity meets/is meeting all state, federal, and IEHP/IPA contractual requirements.

   d. Assessment of what information/tools is necessary for the vendor to deliver the said product and/or service, and whether the vendor maintains such information/tools.

2. Should vendor pass the step outlined in subsection "Policy", above, the IPA shall perform a detailed assessment of the vendor's ability to maintain data security (i.e. administrative, technical, and physical safeguards required by HIPAA). This assessment may include but is not limited to:

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Supersedes APL 16-001, "Medi-Cal Network Provider and Subcontractor Terminations

a. Review of the entity's current data security and privacy training program.

b. Review of technical specifications of anti-virus, firewall and other software being utilized to prevent intrusion.

c. Review of company's policy on securing communications.

3. If the vendor's ability to maintain data security has been successfully assessed, the IPA and the vendor shall enter into an agreement (subject to IEHP's approval) that, at minimum, addresses the following:

   a. The product and/or service to be delivered by the vendor to the IPA.

   b. A statement clearly indicating vendor's agreement to comply with all applicable provisions under HIPAA and California law relating to the privacy and/or security of the IEHP PHI.

   c. Subcontractual contract requirements as outlined in the IEHP/IPA contract.

4. Once the IPA has conducted the due diligence outlined above, the IPA shall submit a written report detailing all areas and items assessed and the findings.

5. Decisions to accept the vendor to whom the IPA wishes to onshore outsource business services/activities involving IEHP PHI and/or PII are subject to review by the IEHP Compliance Department, Delegation Oversight Department, Provider Network Department, and approval by IEHP's Director of Delegation Oversight and IEHP's Chief Operating Officer (COO).

6. IEHP will complete the review within 30 days and determine if we can move forward with seeking any applicable regulatory approval from appropriate regulatory agencies.

B. As to outsourcing of clinical services or functions: IPAs shall be required to ensure compliance of all vendors as outlined under "Policy, Section C" and shall demonstrate such compliance as requested by IEHP.

C. Final Decision:

1. IEHP reserves the right to request, modify or terminate the IPA agreement at any time if the IPA is non-compliant with IEHP's requirements under this policy.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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18. PROVIDER NETWORK

N. IPA Medical Director Responsibilities

APPLIES TO:

A. This policy applies to all Delegated IPAs providing care to IEHP Medi-Cal Members.

POLICY:

A. A full-time Medical Director is required to be onsite for all IPAs with greater than one hundred thousand (100,000) IEHP Medi-Cal Members. If the position is shared by two (2) Physicians, then the total full-time equivalents should be greater than one (1) per each one hundred thousand (100,000) Members. One (1) Physician should be on-site daily.

B. For IPAs with less than one hundred thousand (100,000) IEHP Medi-Cal Members, the Medical Director(s) should be immediately available during all workday hours and on-site physically with the medical management team no less than three (3) days per week.

C. IEHP and its IPAs must maintain a fulltime Medical Director whose responsibilities shall include, but not be limited to the following:[1,2]

1. Ensuring medical decisions are:
    a. Rendered by qualified medical personnel; and
    b. Are not influenced by fiscal or administrative management considerations;
2. Ensuring that the medical care provided meets the standards for acceptable medical care;
3. Ensuring that medical protocols and rules of conduct for medical personnel are followed;
4. Developing and implementing medical policy;
5. Resolving grievances related to medical quality of care;
6. Actively involved in the execution of grievance and appeal procedures;
7. Directly involved in the implementation of Quality Improvement (QI) activities and Health Equity activities;
8. Directly involved in the design and implementation of the Population Health Management Strategy and initiatives;
9. Ensuring engagement with local health department(s); and
10. Actively participating in the functioning of the health plan or their IPA.

[1] Department of Health Care Services (DHCS) – IEHP Primary Operations Contract, Exhibit A, Attachment III, Provision 1.1.6, Medical Director
[2] Title 22, California Code of Regulations (CCR) § 53857

18. PROVIDER NETWORK

N. IPA Medical Director Responsibilities

PROCEDURES:

A. The Medical Director serves as the physician liaison between the IPA and IEHP, Skilled Nursing Facilities (SNFs), Hospitals and other network Providers.

B. The Medical Director is highly encouraged to network with IEHP and Medical Directors from other Delegated IPAs to stay current with recent managed care/industry trends and best practices and act as the communicator back to their organization.

C. The Medical Director shall serve as chair for clinical committees such as Credentialing, Utilization Management (UM), Quality Management (QM), or Peer Review committees, as applicable.

D. The Medical Director identifies IPA network gaps in primary and specialty care coverage and ensures access to care for IEHP Members. The Medical Director maintains an open professional relationship with the IPA Physician network.

E. The Medical Director should be involved in tracking and trending of potential fraud, waste and abuse involving IEHP Members and Providers.

F. Preference should be given to hiring Medical Directors with Primary Care experience.

G. **Utilization Management** - The Medical Director ensures that the utilization management process meets the standards and requirements outlined in Policy 14A, "Utilization Management." These include but are not limited to:

   1. Timely and appropriate review and decision-making on all authorization requests;
   2. Physician-level review of denials and partial approvals (modifications) on the basis for medical necessity;
   3. Appropriate and consistent application of IEHP-approved authorization criteria using the hierarchy appropriate to the line of business;
   4. Medical Director-level consultation with the requesting Provider for medical services, as necessary; and
   5. Providing clinical expertise for Members requiring complex medical care, higher level of care and out-of-network services.

H. **Quality Management** - The Medical Director ensures their direct involvement in the implementation of QI activities through the following, at minimum:

   1. Having oversight of the IPA Quality Improvement process, policy and strategy;
   2. Reviewing all Provider and IPA grievances for adverse trends or Potential Quality Incidents (PQIs);
   3. Understanding community standards for medical care and providing input on all PQI cases; and

4. Fundamental understanding of National Committee on Quality Assurance (NCQA) metrics, Medi-Cal regulations and involvement in the IPA metric improvement strategy.

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	☒ DMHC	☐ NCQA
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18. PROVIDER NETWORK

O. Provider Disruptive Behavior

APPLIES TO:

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

POLICY:

A. Inland Empire Health Plan (IEHP) is committed to fostering an environment where IEHP Members receive access to quality and accessible healthcare services. IEHP is further committed to supporting a culture where IEHP's Providers, Members, and staff are treated in a professional, collegial, and caring manner. Toward these goals, IEHP maintains a Provider Disruptive Behavior Policy that prohibits any behavior that could be perceived as hostile, disruptive, inappropriate, harassing, or that does not endeavor to meet the highest standards of professionalism, prevents IEHP from complying with any statutory, regulatory, or contractual requirements, or interferes with IEHP's mission to provide its Members with quality and accessible healthcare services.

B. Provider Expectations

1. Treat all individuals encountered in the course of administering or providing healthcare services to Members (including, but not limited to, Members, Members' family members, Members' friends, and IEHP staff) with courtesy, honesty, and respect, and conduct themselves in a professional, collegial, and cooperative manner as outlined below.
2. Refrain from conduct that may reasonably be considered disruptive, inappropriate, or offensive to the workplace or Member care. Such conduct may be verbal or non-verbal.

PURPOSE:

A. The purpose of this policy is to:

1. Outline the expectations of Providers during interactions with Members, IEHP staff, and other related individuals in the course of administering or providing healthcare services;
2. Provide definitions/examples of disruptive and inappropriate conduct; and
3. List the procedures to identify and resolve any alleged disruptive or inappropriate behavior.

B. Disruptive behavior or inappropriate conduct may be grounds for disciplinary action, up to and including the termination of a contract.

C. Definitions/examples of prohibited disruptive and inappropriate conduct include, but are not limited to:

1. Profane, angry, threatening, intimidating, abusive, disrespectful, degrading, insulting, demeaning, belittling, disruptive, or inappropriate language or behavior, whether verbal

or non-verbal (including facial expressions, body language, or other non-verbal gestures or forms of bodily expression);

2. Inappropriate or similarly offensive physical acts or contact, or a threat thereof;
3. Non-constructive criticism or comments about, or the passing of severe judgment on IEHP staff or Members, in or absent their presence, that is threatening, inappropriate, insulting, intimidating, or otherwise disruptive;
4. Inappropriate or disruptive arguments or discussions with Members, Members' family members, Members' friends, or IEHP staff;
5. Language or behavior that others would describe as bullying or harassing, including but not limited to, yelling or the use of obscenities;
6. Insensitive, inappropriate, or disruptive comments or discussions, whether verbal or non-verbal, about a Member's medical condition, appearance, or situation;
7. Insensitive, inappropriate, or disruptive comments or discussions about or directed to IEHP staff or Members, whether verbal or non-verbal, regarding race, ethnicity, sexual orientation or any other protected class or group of people;
8. Any behavior or conduct that creates a hostile environment for IEHP staff or Members, disrupts the efficient and effective delivery of quality and timely access to healthcare services, or otherwise jeopardizes Member care;
9. Refusal to work collaboratively or cooperatively with IEHP staff or Members, or creating rigid or inflexible barriers to requests for assistance and/or cooperation; and
10. Any behavior or conduct that jeopardizes or denigrates IEHP's name, brand, or reputation.

PROCEDURES:

A. Alleged incidences of inappropriate or disruptive conduct may be addressed in accordance with the following procedures:

1. When an incident is reported, collegial intervention (i.e., counseling, warnings, and meetings and/or discussions with the Provider) should be the first step. However, there may be a single incident of inappropriate conduct, or the continuation of such conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in this Policy precludes the immediate action of IEHP or the elimination of any particular step in the below Procedures or Policy when dealing with a complaint or incident about inappropriate conduct.
2. Upon learning of the occurrence of an incidence of inappropriate conduct, IEHP shall request that the individual who reported the incident document it in writing.

Alternatively, IEHP may designate a member of its staff to document the incident as reported. The documentation should include as much detail as possible, including:

a. The date, time, and location of the incident(s);

b. A factual, objective description of the inappropriate or disruptive behavior(s);

c. The name of any Provider, Member, Member's family member, Member's friend, or IEHP staff who may have been involved in the incident(s), including any Provider, Member, Member's family member, Member's friend, or IEHP staff who may have witnessed the incident(s);

d. The circumstances around as well as those which specifically precipitated the incident(s);

e. The names of any other witnesses to the incident(s);

f. Consequences, if any, of the conduct as it relates to the delivery or administration of healthcare services, the prevention of IEHP from complying with any statutory, regulatory, or contractual requirements, the jeopardizing or denigration of IEHP's name, brand, or reputation, or the contribution towards a hostile environment;

g. Any responsive action(s) taken to intervene in, or remedy, the incident(s) including date, time, place, action, and the name(s) of those intervening; and

h. The name, title, signature, and date of the individual reporting and/or documenting the complaint of inappropriate conduct.

3. IEHP will review the report and may elect to meet or confer with the individual who reported the incident(s) or the individual who prepared the report, if different.

4. If, in IEHP's sole discretion, it is determined that an incident of inappropriate conduct has occurred, IEHP may proceed with any or all of the following options including, but not limited to:

   a. Notify the Provider that a complaint has been received;

   b. Meet and confer with the Provider to obtain additional information about the incident(s) or conduct in question;

   c. Send the Provider a letter of guidance about the incident(s);

   d. Send the Provider a letter of warning or reprimand;

   e. Meet and confer with the Provider and/or other individuals involved in the incident(s) in order to counsel the Provider about the concerns and the necessity to correct the conduct in question; and

   f. Terminate the Provider's contract.

5. If IEHP prepares any documentation for a Provider's file regarding the incident(s), or

IEHP's efforts to address the concerns with the Provider, the Provider shall be apprised of that documentation and an opportunity to respond in writing. The Provider's response shall be kept in the Provider's file.

6. If additional complaints are received concerning a Provider about related or unrelated conduct prohibited by the Policy, IEHP may continue to utilize the collegial steps noted above as long as IEHP believes there is a reasonable likelihood that these efforts will resolve the conduct in question. At any point, however, IEHP may elect to take immediate action or eliminate particular steps in the above Procedures or Policy when dealing with a complaint.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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18. PROVIDER NETWORK

P. Virtual Care

APPLIES TO:

A. This policy applies to Inland Empire Health Plan (IEHP) Primary Care Providers (PCPs), Specialists, and Behavioral Health Providers, as well as IEHP network Federally Qualified Health Centers (FQHC), Tribal Health Providers (THPs), Rural Health Clinics (RHCs) or Indian Health Services (IHS) sites, unless specified otherwise.

POLICY:

A. IEHP utilizes telehealth as an option for Members to obtain access to necessary health care services, except for General Surgery, Orthopedic Surgery, Physical Medicine, and Rehabilitation and Hospital.[1]

B. IEHP and its Delegates must ensure that all Providers comply with applicable state and federal laws and regulations and contractual requirements when providing telehealth services.[2]

DEFINITIONS:

A. "Virtual Care" may encompass modalities also referred to as "telemedicine" or "telehealth," and includes store-and-forward encounters, the use of live video, remote patient monitoring, and mobile health (mHealth). It is anticipated that, going forward, Virtual Care will be an expected and routine part of care delivery.

B. "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at an originating site and the Provider is at a distant site. Telehealth supports Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.[3]

C. "Asynchronous store and forward" means the transmission of a Member's medical information from an originating site to the Provider at a distant site without the presence of the Member. Consultations via asynchronous electronic transmission initiated directly by Members, including through mobile phone applications, are not covered under this policy.[4]

D. "Synchronous interaction" means a real-time interaction between a Member and a Provider located at a distant site.[5]

E. "Distant site" means a site where a Provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001 Supersedes APL 22-006, "Network Certification Requirement"
[2] DHCS APL 23-007, "Telehealth Services Policy"
[3] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth"
[4] Ibid.
[5] Ibid.

telehealth can be different from the administrative location.[6]

F. "Originating site" means a site where a Member is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates. For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the Member or by the Provider is not limited. The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the Member's home. A Provider is not required to be present at the originating site unless determined medically necessary by the Provider at the distant site.[7]

PROCEDURES:

A. Provider Requirements[8,9]

1. The Provider rendering IEHP covered benefits or services via a telehealth modality must be contracted with and credentialed by IEHP, licensed in California, enrolled as a Medi-Cal rendering Provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal Provider group. The enrolled Medi-Cal Provider group for which the Provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community.
2. The Provider rendering IEHP covered benefits or services provided via a telehealth modality must meet the requirements under California law in which the Provider is considered to be licensed, for example, Providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission for Certifying Agencies.[10]

B. Documentation Requirements

1. Providers providing covered benefits or services to IEHP Members must maintain appropriate documentation of services rendered to substantiate the corresponding technical and professional components of billed procedure codes. Documentation of benefits or services delivered via telehealth should be the same as documentation of services provided to IEHP Members in-person. This documentation should be maintained in the Member's medical record. The distant site Provider can bill for IEHP covered benefits or services delivered via telehealth using the appropriate procedure codes with the corresponding modifier (as defined by DHCS) and is responsible for maintaining appropriate supporting documentation.[11]

[6] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth"
[7] Ibid.
[8] Ibid.
[9] DHCS APL 23-007
[10] California Business and Professions Code (Bus. & Prof. Code) §2290.5(a)(3)
[11] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth"

2. Providers at the distant site must determine that the covered IEHP service or benefit being delivered via telehealth meets the procedural definition and components procedure code(s) associated with the IEHP covered benefit or service as well as any other requirements described in this section of the IEHP Provider manual.[12]
3. Providers are not required to document a barrier to an in-person visit for IEHP coverage of services provided via telehealth.[13, 14]
4. Providers at the distant site are not required to document cost effectiveness of telehealth to be reimbursed for telehealth services or store and forward services.[15,16]
5. Documentation for Asynchronous Store and Forward Services[17]
    a. For teleophthalmology, teledermatology services, or benefits delivered via asynchronous store and forward, Providers must also meet the following requirements:
        1) A Member receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant Specialist.
        2) Provider shall receive an interactive communication with the distant Specialist Provider upon request.
        3) If requested, communication with the distant Specialist Provider may occur either at the time of the consultation or within thirty (30) days of the Member's notification of the results of the consultation.
6. Member Consent[18,19,20]
    a. Providers must inform Members prior to the initial deliver of covered benefits or services via telehealth about the use of telehealth and obtain verbal or written consent from the Member for the use of telehealth as an acceptable mode of delivering health care services.
    b. If a Provider, whether at the originating site or distant site, maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of covered benefits or services, then this is sufficient for documentation of Member consent and should be kept in the Member's medical file.
    c. The consent shall be documented in the Member's medical and be available to IEHP

[12] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth"
[13] Ibid.
[14] DHCS APL 23-007
[15] Ibid.
[16] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth"
[17] California Welfare and Institutions Code (Welf. & Inst. Code) § 14132.725(b)
[18] CA Bus. & Prof. Code § 2290.5(b)
[19] DHCS APL 23-007
[20] California Health and Safety Code § 1374.13

and/or DHCS upon request.

d. In addition to documenting consent prior to initial delivery of covered benefits or services via telehealth. Providers are also required to explain the following to Members:

1) Member's right to access covered benefits or services delivered via telehealth or in-person visit;

2) That use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Member without affecting their ability to access covered benefits or services in the future;

3) The availability of Non-Medical Transportation to in-person visits; and

4) The potential limitations or risks related to receiving covered benefits or services through telehealth as compared to an in-person visit, if applicable.

7. Place of Service[21]

a. Providers are required to document the appropriate Place of Service code as defined by DHCS on the claim, which indicates that services were provided or received via a telecommunications system.

C. Establishing New Patients via Telehealth[22]

1. Members may be established as new patients via telehealth through the following ways:

a. All Providers may establish new patient relationships via synchronous video telehealth visits.

b. All Providers may establish new patient relationships via audio-only synchronous interaction only when one (1) or more of the following criteria applies:

1) The visit is related to sensitive services:

- Mental or behavioral health;
- Sexual and reproductive health;
- Sexually transmitted infections;
- Substance use disorder;
- Gender-affirming care;
- Intimate partner violence; and
- Other services.

See Policy 9E, "Access to Services with Special Arrangements" for more

[21] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth"
[22] DHCS APL 23-007

information regarding sensitive services.

2) The Member requests an audio-only modality.

3) The Member attests they do not have access to video.

2. FQHCs, including RHCs and THPs may establish new patient relationships through an asynchronous store and forward modality,[23] if the visit meets all of the following conditions:

   a. The Member is physically present at a Provider's site, or at an intermittent site of the Provider, at the time the covered service is performed;

   b. The individual who creates the Member's medical records at the originating site is an employee or subcontractor of the Provider, or other person lawfully authorized by the Provider to create a Member's medical record;

   c. The Provider determines that the billing Provider is able to meet the applicable standard of care; and

   d. A Member who receives covered services via telehealth must otherwise be eligible to receive in-person services from that Provider.

D. Reimbursable Telehealth Services[24]

1. IEHP covered benefits or services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Code System (HCPCS) codes and subject to all existing IEHP coverage and reimbursement policies, including any prior authorization requirements, may be provided via a telehealth modality, as outlined in this section, if all of the following are satisfied:[25]

   a. The treating Provider at the distant site believes that the benefits or services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;

   b. The Member has provided verbal or written consent;

   c. The benefits or services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s), as defined DHCS, associated with the IEHP covered benefits or services, as well as any extended guidelines as described in this section of the IEHP Provider manual; and

   d. The covered benefits or services provided via telehealth meet all state and federal laws regarding confidentiality of health care information and a Member's right to their own medical information.

2. IEHP must reimburse Providers at the same rate, whether a covered service is provided

[23] CA Bus. & Prof. Code § 2290.5(a)
[24] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth"
[25] DHCS APL 23-007

in-person or through telehealth, if the service is the same, unless otherwise agreed upon by IEHP and the Provider.[26]

3. IEHP must reimburse Providers for a covered service rendered via telephone or video at the same rate for in-person visits, provided that the modality by which the service is rendered (telephone versus video) is medically appropriate for the Member, unless otherwise agreed to by IEHP and the Provider.[27]
4. All Providers, with the exception of FQHCs, RHCs and THPs are allowed to be reimbursed for consultations provided via a telehealth modality.[28]
5. Covered benefits or services provided via a telehealth modality are reimbursable when billed in one of two (2) ways:
    a. For services or benefits provided via synchronous, interactive audio and telecommunications systems, the Provider bills with the appropriate modifier for this service as specified by DHCS.
    b. For services or benefits provided via asynchronous store and forward telecommunications systems, the Provider bills with the appropriate modifier for this service as specified by DHCS.
6. Examples of Services Not Appropriate for Telehealth:[29,30]
    a. Certain types of benefits or services that would not be expected to be appropriately delivered via telehealth include, but are not limited to, benefits or services that are performed in an operating room or while the Member is under anesthesia, require direct visualization or instrumentation of bodily structures, involve sampling of tissue or insertion/removal of medical devices and/or otherwise require the in-person presence of the Member for any reason.
7. Effective January 1, 2024, all Provider furnishing applicable covered benefits or services via audio-only synchronous interactions must also offer those same services via video synchronous interactions as to preserve Member choice. To preserve a Member's right to access covered services in-person, a Provider furnishing services through video synchronous interaction or audio-only synchronous interaction must do one of the following:[31]
    a. Offer those same services via in-person, face-to-face contact;
    b. Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

[26] DHCS APL 23-007
[27] Ibid.
[28] Ibid.
[29] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth"
[30] DHCS APL 23-007
[31] Ibid.

E. Billing Requirements[32]

1. Synchronous, Interactive Audio and Telecommunications Systems:

   a. Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Provider at the distant site and the Member at the originating site. The audio-video telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the procedure code billed.

   b. Evaluation and Management (E&M) and all other covered IEHP services provided at the originating site (in-person with the Member) during a telehealth transmission are billed according to standard IEHP policies (without telehealth modifiers as specified by DHCS). Please see 20A, "Claims Processing". The E&M service must be in real-time or near real-time (delay in seconds or minutes) to qualify as an interactive two-way transfer of medical data and information between the Member and Provider

   c. The presence of a Provider is not required at the originating site as a condition of payment unless the Provider at the originating site is medically necessary as determined by the Provider at the distant site.[33]

2. Asynchronous Store and Forward Telecommunications Systems:

   a. For billing purposes, Providers must ensure that the documentation, typically images, sent via store and forward be specific to the Member's condition and adequate for meeting the procedural definition and components of the procedure code that is billed. In addition, all services billed via store and forward are subject to all existing IEHP coverage and reimbursement policies, including any prior authorization requirements. Please see policy 20A, "Claims Processing".

3. Originating Site and Transmission Fees

   a. The originating site facility fee is reimbursable only to the originating site when billed with the procedure code specified by DHCS for this service (telehealth originating site facility fee). Transmission costs incurred from providing telehealth services via audio/video communication is reimbursable when billed with the procedure code specified by DHCS for this service (telehealth transmission, per minute, professional services billed separately).

   b. Originating Site and Transmission Fee Restrictions

      1) Restrictions for billing originating site and transmission costs are as follows:

[32] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth"
[33] Title 42 Code of Federal Regulations (CFR) § 410.78

- Originating site: once per day, same Member, same Provider.
- Transmission fee (at originating site and distant site): maximum of 90 minutes per day
  (1 unit = 1 minute), same Member, same Provider.
- If billing store and forward, Providers at the originating site may bill the originating site fee but may not bill for the transmission fee.

4. Claims reimbursement for FQHC and Tribal FQHC sites follow state guidelines.[34,35]

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[34] DHCS Medi-Cal Provider Manual, "Part 2 – Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)"
[35] DHCS Medi-Cal Provider Manual, "Part 2 – Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics"

18. PROVIDER NETWORK

P. Virtual Care

1. eConsult Services

APPLIES TO:

A. This policy applies to IEHP-Direct Primary Care Providers (PCPs) and Specialist Reviewers, as well as IEHP network Federally Qualified Health Centers (FQHC), Tribal Health Providers (THPs), Rural Health Clinics (RHCs) or Indian Health Services (IHS) sites.

POLICY:

A. IEHP provides an eConsult platform and workflow that allows IEHP Direct PCPs to request electronically the opinion and/or advice of another health care provider (Specialist Reviewer) with specialty expertise to assist in the diagnosis and/or management of the Member's health care.

PURPOSE:

A. To ensure that IEHP Members in need of care, as determined by their PCP, receive timely access to care.

DEFINITION:

A. eConsults - These fall under the auspice of store and forward Virtual Care. eConsults are asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant or Specialist Reviewer) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. eConsults between health care Providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. eConsults are permissible only between health care Providers.[1]

B. Specialist Reviewer - A Specialist Provider who has agreed to engage in an asynchronous dialogue with a PCP with the goals of sharing clinical expertise, providing case-based learning and improving timely access to quality specialty care.

C. "Asynchronous store and forward" - The transmission of a Member's medical information from an originating site to the health care Provider at a distant site without the presence of the Member. Consultations via asynchronous electronic transmission initiated directly by Members, including through mobile phone applications, are not covered under this policy.[2]

PROCEDURES:

[1] Department of Health Care Services (DHCS) Medi-Cal Provider Manual, "Medicine: Telehealth".
[2] Ibid[3] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth".

18. PROVIDER NETWORK

P. Virtual Care

1. eConsult Services

A. eConsult is a tool to facilitate Provider-to-Provider interaction in order to reduce Member visit wait times, unnecessary visits and improve access to Specialists.

B. All Providers, with the exception of FQHCs, RHCs, and THPs, are allowed to be reimbursed for consultations provided via eConsults.

C. Members cannot initiate eConsults as they are interprofessional interactions, and therefore eConsults may be initiated by Providers. Providers, including FQHCs, RHCs, and THPs are permitted to be reimbursed for brief virtual communications that consist of a brief communication with Member who is not physically present (face-to-face) at the Fee-for-Service rate for services requiring prior authorization. Prior authorization for proposed services or referrals call for the following:

1. Verification of Member eligibility;
2. Written documentation by the PCP or Specialist of medical necessity for service, procedure, or referral; and
3. Assessment of medical necessity and appropriateness of level of care with determination of approval or denial for the proposed service or referral.

D. Request for referrals submitted to IEHP Direct for most specialty care may first go through the eConsult process, in which the requesting Provider (typically the PCP) engages in an asynchronous dialog with a Specialty Reviewer. The workflow is described here:

1. Member is seen by their PCP and a potential need for specialty care is established.
2. PCP submits an eConsult to a Specialty Reviewer.
    a. eConsult may be submitted while the Member is in the office or once the Member has left. PCPs will have two (2) working days from the date the Member is seen to submit an eConsult along with all supporting documentation.
    b. PCP and staff members must sign into eConsult using their assigned username and password.
    c. All users must have an individual email address to access the eConsult portal and are not to share their passwords.
3. The eConsult includes the Member's medical history, chief complaint, medical details relevant to the Member's complaint, and a clinical dialog with the Specialty Reviewer.
    a. The PCP at the originating site must create and maintain the following:
        1) A record that the eConsult is the result of patient care that has occurred or will occur and relates to ongoing Member management; and
        2) A record of a request for an eConsult by the PCP at the originating site.
4. The Specialist Reviewer is required to respond to the PCP within 72 hours of receiving

the eConsult.

a. The Specialty Reviewer at the distant site must create and maintain the following:

1) A record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent; and

2) A written report of case findings and recommendations with conveyance to the originating site.

E. Outcome of the eConsult may include continued management of the Member's condition by the PCP or a recommendation that the Member be seen by a Specialist.

1. If the Specialty Reviewer recommends a coordination of care by the PCP by means of medication and/or therapeutic treatment, the PCP completes ("closes") the eConsult and manages the Member's condition accordingly.

a. PCP will contact and manage the Member's condition as recommended by the Specialist Reviewer.

2. If the Specialty Reviewer recommends a face-to-face visit with a Specialist, the PCP staff submits a referral request to IEHP. Please see 14D, "Pre-Service Referral Authorization Process."

F. Members may require a face-to-face visit with a Specialist after a clinical conversation has determined the care cannot be managed by the PCP in the primary care setting.

1. An eConsult is not separately reportable or reimbursable if any of the following are true:

a. The Specialty Reviewer saw the patient within the last 14 days;

b. The eConsult results in a transfer of care or other face-to-face service with the Specialty Reviewer within the next 14 days or next available appointment date of the Specialist Reviewer; or

c. The Specialty Reviewer did not spend at least five (5) minutes of medical consultative time, and it did not result in a written report.

2. An eConsult is not reimbursable more than once in a seven-day period for the same patient and Provider.

G. IEHP and its IPAs provide for Members a second opinion from a qualified health professional within the network at no cost to the Member or arranges for the Member to obtain a second opinion outside of the network if services are not available within the network.[3,4,5]

[3] DHCS Medi-Cal Provider Manual, "Medicine: Telehealth".
[4] California Health and Safety Code § 1383.15.
[5] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 5, Provision 1, Utilization Management.

18. PROVIDER NETWORK

P. Virtual Care

1. eConsult Services

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18. PROVIDER NETWORK

Q. Subcontractor Network Certification

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal line of business.

POLICY:

A. IEHP is required to undergo an annual Subcontractor Network Certification (SNC) as part of its Annual Network Certification.[1]

DEFINITIONS:

A. Subcontractor – Unless specified otherwise, this is hereinafter referred to as "IPA" and is defined as an individual or entity that has a Subcontractor Agreement with IEHP that relates directly or indirectly to the performance of the Plan's obligations under its contract with the Department of Health Care Services (DHCS). A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.[2]

B. Subcontractor Network Certification (SNC) – A process that entails IEHP reporting on its monitoring of IPA' and Downstream Subcontractors' Provider Networks and submitting documentation to DHCS verifying the compliance and/or noncompliance reported.

C. Subcontractor Network – A Provider Network of an IPA or Downstream Subcontractor, wherein the IPA or Downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.

D. Downstream Subcontractor – An individual or entity that has a Downstream Subcontractor Agreement with an IPA of the Plan or a Downstream Subcontractor that relates directly or indirectly to the performance of the IPA's obligations under its Subcontractor Agreement with IEHP.

PURPOSE:

A. To ensure IPA and Downstream Subcontractor Provider Networks meet state and federal network adequacy and access requirements.[3]

PROCEDURES:

A. IPA Accountability[4]

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001 Supersedes APL 21-006, "Network Certification Requirements"
[2] Title 42 Code of Federal Regulations (CFR) 438.2
[3] DHCS APL 23-006, "Delegation and Subcontractor Network Certification"
[4] Ibid.

1. IEHP delegates certain activities or obligation to its IPA whether directly or indirectly. IEHP's Delegation Agreement:
   a. Specifies any and all delegated activities, obligations, and related reporting responsibilities (See Attachment, "IPA Delegation Agreement – Medi-Cal" in Section 25);
   b. Includes the IPA's agreement to perform the delegated activities, obligations, and reporting responsibilities; and
   c. Provides for the revocation of the delegation of activities or obligations, or specifies other remedies where DHCS or IEHP determines the IPA is not performing satisfactorily.[5] Please see Policy 25A4, "Delegation Oversight – Corrective Action Plan Requirements" for more information.
2. IEHP's Delegation Agreement also states that the IPA agrees to comply with all applicable Medicaid laws and regulations, including all subregulatory guidance and Contract provision, as well as the applicable state and federal laws.[6] IEHP must maintain and communicate to its IPA's policies and procedures for monitoring its IPAs' compliance with all requirements related to all delegated activities, obligations, and related reporting responsibilities as described in APL 23-006. Plan policies and procedures are available to DHCS upon request.

B. Ownership and Control Disclosures[7]

1. To identify potential conflicts of interest, IEHP collects and reviews IPAs, First Tier Downstream and Related Entities' (FDR) ownership and control disclosures.[8,9] IEHP requires and ensures IPAs and FDRs accurately provide all required information in their disclosures. For each person with an ownership or control interest and for each managing employee, information includes the following. An officer or director of a disclosing entity that is organized as a corporations should be considered a person with control interest.[10,11,12]
   a. Date of birth; and
   b. Social Security Number.

[5] 42 CFR § 438.230 (c)(1)
[6] 42 CFR § 438.230 (c)(2)
[7] DHCS APL 23-006
[8] 42 CFR § 455.104
[9] 42 CFR § 438.608(c)
[10] 42 CFR § 455.104 (b)(1)
[11] 42 CFR § 438.608(c)(2)
[12] DHCS APL 17-004, "Subcontractual Relationships and Delegation"

2. IEHP reviews potential conflicts of interest and makes IPA and FDR ownership and control disclosures available upon request, as the information is subject to audit by DHCS. IEHP will alert Managed Care Operations Division (MCOD) Contract Manager within 10 working days upon discovery of noncompliance with these requirements, and/or if a disclosure reveals any potential violations of the ownership and control requirements.

C. Data Reporting:[13]

1. IEHP must monitor the quality and compliance of IPA data that IEHP submits to DHCS or other entities, pursuant to reporting responsibilities under state and federal laws. IPAs are required to submit complete, accurate, reasonable, and timely Network Provider encounter data to IEHP for all items and services furnished to Members either directly or through Downstream Subcontractors or other arrangements with Providers. IEHP validates its IPAs' data and reporting submission, and may request additional documentation at any time in order to confirm that the information included in the submission is accurate prior to submission to DHCS. This includes, but is not limited to,
   a. Encounter data;
   b. Monthly 274 Provider Network data files;
   c. Data reported through quarterly templates;
   d. Electronic visit verification reporting; and
   e. Any other ad hoc data requests required by DHCS.

D. Subcontractor Network Certification (SNC)[14]

1. IEHP is required to undergo an annual SNC that is separate and distinct from the submission process for the ANC. SNC is also required when:
   a. An IPA's Network experiences a significant change; and
   b. IEHP enters into a new risk-based Delegation Agreement with an IPA that expands IEHP's existing Provider Network.

   For information on block transfer and significant network changes, please see Policy 18J, "Termination of PCPs, Specialists, Vision, and Behavioral Health Providers."
2. In the event that a significant change occurs within the 90 calendar days prior to the SNC annual submission date, IEHP can document the change as part of that Reporting Year SNC filing.

E. Delegate Network Criteria[15]

[13] DHCS APL 23-006
[14] Ibid.
[15] Ibid.

1. For the annual SNC, IEHP must include all IPA Networks reported via the 274 Provider Network data file, unless the IPA's Network is exempt per the criteria listed below and the required documentation provided substantiates the exemption. In addition to service areas where IEHP only contracts directly with individual Providers and no IPA Networks exist, the following describes the IPA Networks that are exempt from SNC:
   a. IEHP only contracts with one IPA Network in the service area, and no Providers directly contract with IEHP;
   b. The IPA Network only provides specialty or ancillary services; or
   c. The IPA Network only provides care through single case agreements and is not available to all IEHP Members upon enrollment.
2. IEHP is required to submit an exemption request with the SNC submission per the instructions provided in Attachment A using the Subcontractor Network Exemptions Request Template (Attachment B). DHCS will review each exemption request and provide a formal notification of the disposition to IEHP. Approvals are valid for one (1) calendar year until the next annual SNC filing.

F. Submission[16]

1. IEHP must submit the required SNC documentation to DHCS that accurately reflects IEHP's monitoring of IPAs' Networks, no later than 45 calendar days following the RY or, if the date falls on a weekend, the next working day. IEHP submits all required SNC documentation as described in Attachment A with the correct file naming conventions through the DHCS Secure File Transfer Protocol (SFTP) site. Failure to submit complete and accurate SNC documentation by the SNC annual submission date subjects the Plan to the imposition of a Corrective Action Plan (CAP) and/or other enforcement actions.[17,18]
2. The SNC Submission consists of three (3) parts:
   a. The Subcontractor Network Exemptions Request Template (Attachment B);
   b. The Network Adequacy and Access Assurances Report (NAAAR) (Attachment C); and
   c. Verification documents.

G. Noncompliance[19]

1. All IPA Network deficiencies impacting Member access to care must result in IEHP or the IPA authorizing Covered Services from Out-of- Network (OON) Provider for Members in the deficient IPA Network, regardless of associated transportation or Provider costs until deficiency is addressed. IEHP or IPA must also ensure that the

[16] DHCS APL 23-006
[17] Welfare and Institutions Code (WIC) § 14197.7 (e)
[18] DHCS APL 22-015, "Enforcement Actions: Administrative and Monetary Sanctions"
[19] DHCS APL 23-006

deficient IPA or Downstream Subcontractor informs Members that OON access to services is available, and that IEHP or its IPA's Member Services staff are trained on Members' right to request OON access for Covered Services and transportation to Providers where the IPA or Downstream Subcontractor is unable to comply with Network adequacy or access standards.

H. Monitoring, Corrective Action, and Sanctions[20]

1. IEHP monitors regularly all delegated functional areas. IEHP also imposes corrective action and/or financial sanctions on IPAs upon discovery of noncompliance with the terms of their Delegation Agreement or any Medi-Cal requirements. For information on corrective action plan, please see Policy 25A4, "Delegation Oversight – Corrective Action Plan Requirements.
2. IEHP reports any significant instances (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their MCOD Contract Manager within three (3) working days of the discovery or imposition.
3. Upon completing the review of SNC submissions, DHCS will provide a CAP notification letter, outlining the deficiencies and specific issues of noncompliance that IEHP must address. IEHP must provide an initial CAP response, no later than 30 calendar days after the issuance of the CAP notification letter, that details IEHP's plan of action and sets forth steps to correct the deficiencies identified.
4. IEHP will have six (6) months to correct all deficiencies during which time, the Plan must provide monthly status updates that demonstrate action steps it is undertaking to address the CAP. DHCS may impose sanctions, or other appropriate enforcement actions, for failure to comply with Network adequacy and access standards at the end of the six (6) month CAP period. If monetary sanctions are to be imposed, DHCS will consider the factors set forth in the California Welfare and Institutions Code § 14197.7 (g) when assessing and determining the amount.

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[20] DHCS APL 23-006