
18. PROVIDER NETWORK

- A. Primary Care Physician
 - 1. IPA and Hospital Affiliations
-

APPLIES TO:

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

POLICY:

- A. Primary Care Physicians (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.

PROCEDURES:

- A. A PCP must spend a minimum of sixteen (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 sixteen (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 sixteen (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 as long as the PCP is contracted with an IPA that meets the criteria specified in Policies 18F, “Specialty Panel” 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 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

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A. Primary Care Physician 1. IPA and Hospital Affiliations

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 in order 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 Panel" and 18H, "Hospital Affiliations."
- G. IEHP verifies IPA and Hospital affiliation privileges and geographic distribution as stated in Policy 5B, "Hospital Privileges."

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18. PROVIDER NETWORK

A. Primary Care Physician 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 network adequacy of our Provider network to assure the required one full-time equivalent (FTE) PCP per two thousand (2,000) Member ratio. This ratio is calculated on the Plan's PCP network as a whole and is not applied to an individual PCP.
- B. IEHP's general standards for enrollment levels to ensure that our overall contracted network satisfies regulatory requirements is as follows:
- | | |
|----------------------------------|-----------|
| 1. Primary Care Physicians (PCP) | 1: 2,000 |
| 2. Physician Extenders | 1 : 1,000 |
| 3. Total Physicians | 1 : 1,200 |
- C. State regulations also require that FTE physician supervisor to non-physician medical practitioners (Physician Extenders) 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. | |
- D. IEHP has adopted the above FTE ratios for all Practitioners serving all Members.
- E. PCPs are defined as, Family Practice, Internal Medicine, Pediatrics, General Practice, Preventive Medicine or OB/GYN physicians.
- F. Non-physician medical Practitioners, also known as physician extenders, are defined as NPs, CNMs and PAs.
- G. In accordance with Title VI of the Civil Rights Act and Title 42, Code of Federal Regulations, Section 442.110, all Members must receive access to all covered services without restriction based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

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A. Primary Care Physician 2. Enrollment Capacity

- H. IEHP requires Providers to provide covered services to all Members assigned to them at an appropriate facility without imposing restrictions as listed in Policy G.
- I. IEHP ensures the participation of a broad range of safety net and traditional Providers, within its service areas by maintaining contracts with and active outreach to these Providers.
- J. IEHP will include any safety net or traditional Provider that meets credentialing and/or quality standards, and is willing to provide services under the same terms and conditions that the plan requires for similar Providers.
- K. PCPs have a general standard for an enrollment capacity of two thousand (2,000) Members to ensure access standards are met. All PCPs must be willing to accept a minimum enrollment requirement, unless otherwise approved. The general standard for PCPs increases if there is associated mid-level Providers as noted above.
- L. 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.
- M. PCPs should be located within ten (10) miles or thirty (30) minutes drive time of a Member's residence, when applicable. IEHP may approve exceptions to this standard in certain circumstances, including but not limited to PCPs located in areas that are underserved or where no medical delivery system exists.

PROCEDURES:

- A. Each PCP is listed in the IEHP data system as having a general standard for an enrollment capacity of two thousand (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.
- B. For each physician extender supervised by a PCP at the same location, the above recommended enrollment capacity can be increased by one thousand (1,000) Members per physician extender.
 - 1. IEHP must credential the physician extender which includes a copy of the Supervisory certificate and Delegation of Services Agreement between the physician and physician extender, if applicable, in order to increase the PCP's enrollment capacity.
 - 2. PCPs must meet all applicable statutory and regulatory requirements for the supervision of physician extenders.
 - 3. Only one (1) PCP can be designated the supervising physician for a physician extender at any unique Provider site. Physician extenders are allowed a maximum of two (2) unique supervisors respectively at two (2) unique locations.

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- C. As stated in Policy 9A, “Access Standards” a PCP must be physically on-site a minimum of sixteen (16) hours per week for each approved PCP site.
- D. Providers are required to offer the same hours of operation for appointments or walk in to all patients, including Medi-Cal beneficiaries, regardless of line of business.
- E. All participating Pediatric, Family Practice and General Practice PCPs must be willing to accept a minimum of five hundred (500) Members in all contracted lines of business combined, unless otherwise approved. Participating Internal Medicine PCPs must be willing to accept a minimum of two hundred fifty (250) Members in all contracted lines of business combined, unless otherwise approved. 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.
- F. PCPs are listed in the IEHP Provider Directory and receive Members through auto assignment and Member Choice, unless otherwise requested.
 - 1. PCPs requesting age restrictions outside of those listed in Policy 5A, “IEHP Practitioner Guidelines” do not receive Members through auto assignment.
- G. A PCP can limit the growth of his/her IEHP enrollment by requesting in writing to be listed in the Provider Directory as “Closed” to Member assignment if they have met the minimum enrollment requirement of Members for their specialty, unless otherwise approved. 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.
- H. Access related grievances are reported and tracked by the Grievance and Appeals department and provided to the Provider Services 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.
- I. On an ongoing basis, IEHP reviews and monitors its overall PCP capacity to ensure adequate access regardless of enrollment capacity.
- J. If IEHP is notified or otherwise becomes aware that a safety net or traditional Provider is within its service area but not currently contracted, IEHP staff actively outreaches to that Provider to obtain a contract. If the Provider meets credentialing and/or quality standards, and is willing to participate under the terms and conditions for similar Providers, IEHP will contract with that Provider.

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REFERENCE:

- A. Title VI of the Civil Rights Act and Title 42, Code of Federal Regulations, § 442.110

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18. PROVIDER NETWORK

B. Provider Directory

APPLIES TO:

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

POLICY:

- A. IEHP publishes a Provider Directory on a monthly basis.
- B. Each Provider Directory contains information on IPAs and Hospitals, Primary Care Physicians (PCPs), OB/GYNs, Specialists, Behavioral Health Providers, Behavioral Health Treatment (BHT) Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, and other Providers (e.g. Nurse Practitioners (NPs), Physician Assistants (PAs), Acupuncturists, Midwives, and Dentists) who have been credentialed and are contracted with IEHP directly or through a subcontracted agreement with network IPAs.
- C. Each PCP is listed individually in the Provider Directory to help facilitate the selection process by the Member.
- D. Based on IEHP PCP/ IPA affiliations, a PCP can be listed twice in the Provider Directory, with the exception of those Physicians who also service IEHP rural areas.
- E. 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.
- F. A listing of all contracted IPAs, Hospitals, PCPs, Specialists, OB/GYNs, Behavioral Health Providers, BHT Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, and other Providers are included in the Provider Directory.
- G. IEHP also maintains a Web-based Provider Directory including other Provider Directory links for IEHP contracted Provider Networks, referred to as the Doctor Search, to provide Members and prospective members with the most updated IEHP Provider Network including Delegated IPAs, Hospitals, PCPs, Specialists, OB/GYNs, Behavioral Health Providers, BHT Providers, Vision Providers, Urgent Care Centers, Ancillary Providers, Birth Centers, Facilities, Pharmacies, and other Providers.
- H. If a contracted Provider informs IEHP Provider Services or Contracts directly of a Provider Directory change or inaccuracy, IEHP will make that change to the IEHP internal systems or inform the delegated Provider of the inaccuracy in their Directory. When the internal systems are updated, the network updates are reflected on the web-based directory by the following day.
- I. IEHP investigates each time it receives a report of a potential Provider Directory inaccuracy. Provider Services or Contracts reaches out to the Provider within five (5) business days of the inaccuracy report for confirmation of the following:
1. Contracting Provider is no longer accepting new patients for any line of business.

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B. Provider Directory

2. Removal of Provider or Provider group who has retired, ceased to practice, or no longer under contract with IEHP for any reason.
 3. Change in Provider's practice location or update of demographic information.
 4. Any information that affects the content or accuracy of the Provider Directory.
- J. Upon confirmation of the correct Provider information, a request if needed is sent to update IEHP's internal systems. When the internal systems are updated, the network updates are reflected on the web-based directory by the following day.
- K. As part of IEHP's monitoring process, on an annual basis, IEHP requires delegated contracted entities (such as Kaiser Permanente, Delta Dental, and American Specialty Health (ASH)) provide a report of identified/reported inaccuracies and the timeframe of the correction as stated in Policy 25A2, "Delegation Oversight - Audit".

PROCEDURES:

- A. IEHP publishes the Provider Directory on a monthly basis to provide existing and potential Members with current information and changes in IEHP's network.
- B. Members, potential members or other requestors can receive the IEHP Provider Directory through the following:
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.
 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) days.
 4. Members can also access the Doctor Search online at www.iehp.org. All network updates are reflected on web-based Provider Directory the same day.
- C. The IEHP Provider Directory contains information regarding IEHP's network Practitioners, the following elements which are subject to change based on Program requirements, including but not limited to:
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);

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B. Provider Directory

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;
 9. Age Restriction;
 10. Appointment Needed;
 11. Federally Qualified Health Center (FQHC);
 12. Board Certified;
 13. Telephone Number (including area code);
 14. Affiliated Hospital;
 15. Hospital Admitting Privileges;
 16. Affiliated IPA/Clinic;
 17. IEHP Assigned Doctor Number;
 18. National Provider Identifier (NPI) Number;
 19. Languages (other than English) spoken by clinical staff including Physician;
 20. Business Hours and Days of operations;
 21. Bus Route Information;
 22. Panel Status (indication on whether a Provider is accepting new Patients, existing Patients only, not accepting new Patients at this time or if they are only available to see Patients by referral or only through a hospital or facility);
 23. Accessibility Level; and
 24. Extended Office Hours (Providers who are open before 8am, open after 5pm, or open weekends are 'bolded').
- D. The Provider Directory also includes instructions for Members on how to use the Directory for selecting a Provider.
- E. IEHP requires all contracted Providers who are not accepting new Members to direct an enrollee or potential enrollee seeking to become a new Member to IEHP for additional assistance in finding a Provider and to the California Department of Health Care Services (DHCS) to report any potential Directory inaccuracy.
- F. IEHP maintains 100% verification of the elements listed above by faxing verification requests and calling each Practitioner that doesn't respond to the written request. If IEHP can not verify a Provider's information a minimum once every three hundred sixty-five (365) days, IEHP

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will notify the Provider of pending Directory removal ten (10) business days prior to removal. Non-responsive Providers will be removed from the Directory at the next required update, except for general acute care Hospitals.

- G. 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.
- H. Due to population mix in Riverside and San Bernardino Counties, IEHP evaluates the Spanish speaking capability of Practitioner's and their staff who have indicated they have capabilities to speak Spanish, at the time of entry into the network and annually through language competency audits, before this designation is listed in the Provider Directory as outlined in Policies 9H1, "Cultural and Linguistic Services - Foreign Language Capabilities" and 9H2, "Cultural and Linguistic Services – Spanish Language Competency Audits" for more information. DHCS currently has designated Spanish as the only threshold language in Riverside and San Bernardino Counties.
- I. IEHP posts a report every six (6) months on the secure Provider website 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.
- J. Any errors in the information listed should be reported to IEHP Provider Services within five (5) days of receipt in order to update the Directory.
- K. Provider shall inform IEHP within five (5) business days when either of the following occur:
1. Provider is not accepting new patients; or
 2. If Provider had previously not accepted new patients, Provider is currently accepting new patients. (Cal. Health and Safety Code § 1367.27(j)(1).)
- L. IEHP investigates each time it receives a report of a potential Directory inaccuracy. IEHP will investigate by contacting the affected Provider within five (5) business days, and document

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the receipt, investigation and outcome of each reported potential Directory inaccuracy. IEHP will verify the accuracy of the information or update the Provider Directory within thirty (30) calendar days.

- 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.

REFERENCES:

- A. California Health and Safety Code § 1367.27.
B. Senate Bill (SB) 137.

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C. PCP, Vision and Behavioral Health Provider Network Changes

APPLIES TO:

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

POLICY:

- A. PCPs must provide sixty (60) days advance written notice to IEHP and their IPA regarding any changes in their operations including address, IPA and/or hospital affiliations.
- B. Vision and Behavioral Health Providers must provide sixty (60) days advance written notice to IEHP of any changes in their clinic operation.
- C. IPAs are required to submit coverage plans sixty (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.

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 sixty (60) days prior to the effective date of the change.
- B. IPAs have sixty (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 sixty (60) days from the effective date of the IPA affiliation change or possible termination.
- 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, the new IPA has an approved hospital link and the PCP has privileges or admitting arrangements in place at the new hospital; and a signature page of the agreement between the PCP and IPA has been submitted to IEHP by the new IPA. Once all information is verified, 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.

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C. PCP, Vision and Behavioral Health Provider Network Changes

1. A n IPA change becomes effective on the first of the month following sixty (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 sixty (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 (See Attachments, “Change in IPA Affiliation Letter” and “Change in Hospital Affiliation Letter” in Section 18).
- F. The above procedures for Member assignment may be modified due to circumstances that, in the judgement of the IEHP Chief Operating Officer or Chief Medical Officer, 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 sixty (60) days prior to the relocation.
- B. If a sixty (60) days advance notice is not received, the PCP is frozen to Member auto-assignment, not Member choice enrollment for a period of sixty (60) days from the date IEHP received notification from the IPA.
- C. When geographically appropriate, Members remain with the PCP unless the PCP moves to a different geographic area, defined as ten (10) miles, from the PCP’s old location.
- D. 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.
- E. If the PCP practiced in a hospital-based clinic, county clinic, teaching clinic, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Indian Tribal Clinic (ITC), or other site IEHP determined to function 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.
- F. 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.
- G. IPA and PCPs need to 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.

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

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C. PCP, Vision and Behavioral Health Provider Network Changes

- A. Vision and BH Providers must submit written notification to IEHP that they are relocating to another office within IEHP's geographic service area sixty (60) days prior to the relocation.
- B. Vision and BH Providers need to 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.

Vision and Behavioral Health (BH) Provider Termination

- A. Vision Providers and BH Provider no longer interested in participation in the IEHP network must submit a minimum of sixty (60) days written notice of intent to terminate.
- 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 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 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.

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D. Delegated IPA Reported Provider Changes

1. PCP Termination

APPLIES TO:

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

POLICY:

- A. All Delegated IPAs must provide IEHP with a sixty (60) days advance written notice of any significant changes in the Delegated IPA's network, including the termination of a Primary Care Physician (PCP).
- B. IEHP retains the right to obligate the Delegated IPA to provide medical services for existing Members for the entire sixty (60) days period.
- C. IEHP notifies affected Members at least thirty (30) days prior to the effective date of termination of a PCP.
- D. IEHP monitors Delegated IPA compliance with policy on an annual basis.

PROCEDURES:

- A. IEHP requires advance sixty (60) days written notification from the Delegated 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 sixty (60) days advance notification, IEHP works with the Delegated 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 Delegated 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 thirty (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 Delegated 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 (See Attachments, "Member PCP Term Notification Letter – English" and "Member PCP Term Notification Letter – Spanish" in Section 18). Notification to the Members occurs five (5) working days after IEHP approves the submitted coverage plan and submits internal notification of systems at least thirty (30) days prior to the effective date of the impending termination.

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D. Delegated IPA Reported Provider Changes

1. PCP Termination

5. Notification of the change is also sent to the Delegated IPA and PCP confirming the termination date and transfer of Members (See Attachments, “Compliant Termination Letter” and “Non-Compliant Termination Letter” in Section 18).
- B. In situations where less than sixty (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 thirty (30) days to make an alternate PCP change.
1. The Delegated 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 Delegated 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 (See Attachments, “Member PCP Term Notification Letter – English” and “Member PCP Term Notification Letter – Spanish” in Section 18). Notification to the Member occurs at least thirty (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 Delegated 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” in Section 18).
- C. IEHP monitors Delegated IPA’s compliance with the written notification required as part of the IPA Performance Evaluation Tool as stated in Policy 25A3, “Delegation Oversight – Delegated IPA Performance Evaluation.”

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D. IPA Reported Provider Changes

2. Specialty Provider Termination

APPLIES TO:

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

POLICY:

- A. All IPAs must provide IEHP with a sixty (60) day advance written notice of any significant changes in the IPA's network, including the termination of a specialty Provider.
- B. IEHP requires IPAs to notify Members in writing thirty (30) days prior to the effective date of a specialist's termination, or determination by the IPA to terminate a Specialist.
- 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 12A5, "Care Management Requirements - Continuity of Care".
- D. IEHP retains the right to obligate the PA 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 ninety (90) days, whichever is shorter. Existing care may continue beyond the ninety (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 sixty (60) day advance written notice of the termination of a specialty Provider from the IEHP network. IPAs are responsible for identifying Members currently under the care of a terming specialist, 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 twelve (12) month period, are currently under on-going care, or have an open referral, as well as a copy of the notification letter sent to Members as stated below.

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D. IPA Reported Provider Changes

2. Specialty Provider Termination

- B. IPAs must send written notification to Members thirty (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 (See Attachments, “Specialist Termed Member Notification – English” and “Specialist Termed Member notification Letter – Spanish” in Section 18). As applicable, the notice to Members must include the right of the Member to continue care under the specialist as outlined in Policy 12A5, “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 twelve (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 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 at (800) 440-4347.
- F. IEHP monitors IPA compliance with Specialist 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 Panel,” 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 – Delegated IPA Performance Evaluation.”

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E. Management Services Organization Changes

APPLIES TO:

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

POLICY:

- A. IEHP evaluates all Management Services Organizations (MSOs) that are contracted with Delegated IPAs to ensure that they can meet IEHP operational requirements and standards.
- B. Any Delegated 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 IEHP operational requirements and standards.
- C. Prior to being included in IEHP's Provider network, the Delegated IPA or MSO must meet IEHP's contractual, financial, administrative and quality standards.
- D. IEHP performs an on-site audit of the Delegated IPA or MSO to review information provided in the pre-contractual response.
- E. In the event that a Delegated IPA wishes to change MSOs the Delegated IPA must provide IEHP a ninety (90) day advance written notice of the change.
- F. The new MSO will be subject to a pre-contractual audit prior to approval.
- G. The Delegated IPA must submit a transition plan of services thirty (30) days prior to change from the existing MSO to the new MSO.
- H. If the MSO does not meet IEHP standards, the Delegated IPA is not allowed to transition to the new MSO. For new Delegated IPAs, failure to have an MSO or in-house staff and procedure that meet minimum standards will result in all contracting efforts being halted.
- I. In the event that a MSO contracted with an Delegated IPA experiences significant operational or financial failures that result in the termination of the Delegated IPA, IEHP reserves the right to eliminate the MSO or its principals for future management services for any of our currently contracted or new Delegated IPAs.
- J. If the MSO is providing management services for more than one (1) currently contracted Delegated 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 Delegated IPA.
- K. If the MSO is providing management services for more than one (1) currently contracted Delegated 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 a Delegated IPA decides to change its MSO or to bring MSO functions under

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E. Management Services Organization Changes

the umbrella of the Delegated IPA, the Delegated IPA must:

1. Provide IEHP with a ninety (90) day advance written notice if the MSO is not currently affiliated with IEHP; or
2. Provide IEHP with a sixty (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 Delegated 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 Delegated 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.

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

D. If the Delegated IPA/MSO is unable to pass the IEHP audit, the Delegated 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 Delegated IPA to comply with the above notification requirements may result in the Delegated 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 have significant ownership or officer overlap with the Delegated IPA owners or officers.

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F. Specialty Network Requirements

APPLIES TO:

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

POLICY:

- A. State Regulators mandate the types of Specialists required in IEHP’s network (See Attachment, “Specialty Panel Worksheet” in Section 18 for required specialties).
- B. All Members must receive access to all covered services without restriction based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.
- C. IEHP requires IPAs to provide covered services to all Members assigned to them at an appropriate facility without imposing restrictions as listed in Policy B.
- D. IEHP requires IPAs to submit a complete listing of their specialty network including Specialists, contracted Hospitalists, Admitters, Extenders and Ancillary Providers to identify the IPA’s current Provider network.
- E. 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.
- F. IEHP monitors the specialty network including Specialists, Hospitalists, Admitters, Extenders and Ancillaries, for each affiliated Hospitals on a semi-annual basis.
- G. Prior to establishing a “link” to a network Hospital and prior to receiving enrollment in a given geographic area:
1. All IPAs must submit a complete IPA Hospital Link Responsibility Grid in the format required by IEHP (See Attachment, “IPA Hospital Link Responsibility Grid – Medi-Cal” in Section 18) Hospitalists or Admitters and Ancillary Providers, contracted and credentialed, that have privileges at IEHP contracted Hospitals. Upon receipt of a complete IPA Hospital Link Responsibility Grid, IEHP will schedule the review of the data according to the current needs of the plan as they relate to access and network adequacy.
 2. A complete specialty network of Physicians is defined as consisting of a minimum of two (2) unique Providers for every specialty listed in this policy and two (2) unique Provider contracts with the IPA in every specialty in each local geographic service area as it relates to Hospital affiliation. A Specialist Provider who has offices in several geographic regions counts as one (1) unique Specialist regardless of the number of Hospitals at which the Specialist has privileges.

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F. Specialty Network Requirements

3. IEHP requires IPAs to have all mandated California Department of Health Care Services (DHCS) Specialists under contract within thirty (30) miles or sixty (60) minutes of a Member's residence, via public or private transportation.
- H. IEHP has identified its high-volume Specialists based on demographics and number of encounters. To ensure that Members have adequate access to such high-volume Specialists, IEHP and the IPA (when applicable) must maintain the following minimum ratios of high-volume specialty Providers to Members:
- | | |
|-----------------------|----------|
| 1. OB/GYNs | 1:10,000 |
| 2. Physical Therapist | 1:10,000 |
| 3. Orthopedic Surgery | 1:15,000 |
| 4. Ophthalmology | 1:15,000 |
| 5. Cardiology | 1:10,000 |
| 6. Pain Management | 1:25,000 |
- I. IEHP has identified its high impact Specialists based on Utilization data such as Claims and encounters on an annual basis. To ensure that the Members have adequate access to such highly impacted Specialists, IEHP maintains the following minimum ratios of high-impact specialty Providers to Members.
- | | |
|---------------|----------|
| 1. Hematology | 1:25,000 |
| 2. Oncology | 1:25,000 |
- J. IEHP has identified its high-volume Behavioral Health Providers based on demographics and number of encounters. To ensure that the Members have adequate access to such high-volume Behavioral Health Providers, IEHP maintains the following minimum ratios of high-volume Behavioral Health Providers to Members:
- | | |
|--|----------|
| 1. Mental Health Practitioners | 1:15,000 |
| 2. Marriage and Family Therapist | 1:15,000 |
| 3. Licensed Clinical Social Worker | 1:15,000 |
| 4. Psychiatrists | 1:15,000 |
| 5. Psychologists | 1:15,000 |
| 6. Behavioral Health Treatment Providers | 1:15,000 |

DEFINITIONS:

- A. A Specialist is defined as a Physician who is board certified or has training that meets American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) requirements as applicable in the specialty of medical care provided.

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F. Specialty Network Requirements

- B. A high-volume Specialist is defined as a Physician located in an expected high-volume geographic area or in high-volume specialties or both and most likely provides services to the largest segment of the membership.
- C. A high-impact Specialist is defined as a Physician that treats conditions that have mortality and morbidity rates and where treatment requires significant resources.

PROCEDURES:

- A. In order for an IPA to establish a link (affiliation) at an IEHP contracted Hospital, the IPA must submit via the format approved by IEHP the following DHCS Core Specialty network of Physicians for both pediatric and adult populations, contracted and credentialed, and at a minimum two (2) unique Physicians and two (2) unique Physician contracts for each specialty in place that have admitting privileges at the designated Hospital (unless other inpatient coverage as delineated in Policy 5B “Hospital Privileges”):
 - 1. Cardiology;
 - 2. Dermatology;
 - 3. Endocrinology;
 - 4. Gastroenterology;
 - 5. General Surgery;
 - 6. Infectious Disease/HIV Specialist;
 - 7. Nephrology;
 - 8. Neurology;
 - 9. OB/GYN;
 - 10. Orthopedics Surgery;
 - 11. Otolaryngology (ENT);
 - 12. Ophthalmology;
 - 13. Oncology/Hematology;
 - 14. Physical Medicine and Rehabilitation; and
 - 15. Pulmonary Medicine.
- B. Prior to receiving enrollment and activation at this established link the IPA must ensure that the following specialty network of Physicians, consisting of a minimum of two (2) unique Providers and two (2) unique Provider contracts per specialty are contracted and credentialed within the local geographic service area of the linked Hospital (See Attachment, “Hospital Geographic Service Areas” in Section 18 for geography coverage):

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F. Specialty Network Requirements

1. Allergy and Immunology;
 2. Bariatric Surgery
 3. Cardiac/Thoracic Surgery;
 4. Genetics
 5. Neurosurgery (if the Hospital provides this service);
 6. Pain Management
 7. Pediatric Subspecialties;
 - a) Pediatric Cardiology
 - b) Pediatric Gastroenterology
 - c) Pediatric Ophthalmology
 - d) Pediatric Neurology
 - e) Pediatric Orthopedics
 8. Pediatric Surgery;
 9. Physical and Speech Therapy;
 10. Plastic Surgery;
 11. Podiatry;
 12. Rheumatology;
 13. Urology; and
 14. Ancillary Providers.
 - a) Audiology
 - b) Diagnostic Radiology
 - c) DME
 - d) Home Health
 - e) Home Infusion Agency
 - f) Imaging/Diagnostic/X-Ray
 - g) Laboratory
 - h) Radiology
- C. If the network Hospitals within the affiliated Hospital's local geography do not offer these services, the IPA is not required to have the corresponding specialty in place as outlined above, but must make regionally appropriate arrangements with other Hospitals in the IEHP network.

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F. Specialty Network Requirements

IEHP will verify availability of Specialists before approving regionally appropriate arrangements.

- D. After receiving the complete specialty network presented by the IPA, the Director of Provider Relations will determine the scheduling of the network review and approval in accordance with access and network adequacy requirements. Once confirmed, the Provider Relations Manager or Provider Services Representative will advise the IPA when the specialty network will be reviewed and provide an estimate of an effective date of the new affiliation, dependent upon the completeness of the specialty network presented.
- E. In the event that a Member is at the linked or non-linked Hospital and requires a consult from a specialty Physician that the IPA does not have under contract at that Hospital, the IPA must arrange and pay the Specialist for the consulting services rendered at the rate required by the Specialist.
- F. 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 preferred that the IPA contract with the Hospitalist group contracted with IEHP Direct, the IPA may chose 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 particular Hospital the IPA can contract with Admitters to admit their assigned Members.
- G. Specialists are required to offer the same hours of operation for appointments or walk in to all patients, including Medi-Cal beneficiaries, regardless of line of business.
- H. In the event that a Member must be transferred to another Hospital due to a lack of a contracted Specialist that is available at the Hospital, the IPA will be financially responsible for the transfer transportation costs.
- I. In certain instances when services required are unavailable within the IEHP network, the IPA must arrange for the provision of specialty services from Providers outside the contracted network to ensure uninterrupted care to Members and timely access as outlined in Policy 9A, "Access Standards." IPA must initiate and execute a Letter of Agreement (LOA) for services rendered outside the network. IPA must ensure that the cost to the Member should be no greater than it would be if the services were provided in-network.
- J. IEHP shall provide for the completion of covered services by a terminated or out-of network Provider at the request of Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96.
- K. For newly enrolled beneficiaries who request continued access, IEHP shall provide continued access for up to twelve (12) months to an out-of-network Provider with whom they have ongoing relationship provided there are no quality of care issues with the Provider and the

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F. Specialty Network Requirements

Provider will accept IEHP or Medi-Cal FFS rates, whichever is higher in accordance with W & I Code 14182(b) (13) and (14). An ongoing relationship shall be determined by IEHP's identifying a link between a newly enrolled beneficiary and an out-of-network Provider using FFS utilization data provided by DHCS.

- L. On a semi-annual basis, IEHP posts the IPA's specialty network roster on its secure Provider website including adult/Pediatric Hospitalists, adult/Pediatric Admitters, Extenders, and Ancillary Providers submitted previously by the IPA to IEHP that identifies the IPA's current Provider network that includes:
1. Practitioner name;
 2. Address;
 3. Phone number;
 4. License number;
 5. Specialty type;
 6. Hospital affiliations;
 7. IPA credentialing committee dates;
 8. For obstetricians only, the Hospitals they deliver; and
 9. IPAs are required to verify and update the above information. Specific reporting requirements are delineated in Policy 25B10, "Credentialing Quality Oversight of Delegates."
- M. IPAs are required to update all information located on the secure Provider website, within thirty (30) days of the information being made available online.
- N. Failure of the IPA to complete the required updates in a timely manner including written termination notifications of Specialist as stated in Policy 18D2, "IPA Reported Provider Changes - Specialty Provider Termination" may result in freezing the IPA for a period up to sixty (60) days.
- O. IEHP reviews the information provided by the IPA and tracks the specialty network including adult/Pediatric Hospitalists, adult/Pediatric Admitters, Extenders, and Ancillary Providers of each IPA geographically to identify any "holes," missing required Specialist(s) or lacking Hospital or geographic coverage.
- P. Upon identification of such deficiencies, IEHP has thirty (30) days to respond to the IPA outlining the deficiencies and specifying the timeframe to cure those deficiencies.
- Q. Depending on the impact to either the Member or Hospital, IEHP may immediately freeze the affected IPA/Hospital link or the IPA from receiving any new enrollment until such deficiencies are corrected.

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F. Specialty Network Requirements

- R. If the IPA is unable to correct the deficiencies within the allotted timeframe, IEHP may transfer the existing enrollment from the affected IPA to other IPAs that have adequate specialty networks and terminate linkage.
- S. No enrollment is given to any new PCP until the IPA's specialty network at the affiliated Hospital has been approved by IEHP.

REFERENCES:

- A. California Welfare and Institutions Code 14182(b) (13) and (14).
- B. California Health and Safety Code Section 1373.96.
- C. Final Rule Mega Reg 81 FR 27498 § 438.68.

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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. Care Management Teams
 3. IEHP Provider Relations Team
 4. Nurse Educators
 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 Delegated IPAs to communicate IEHP's policies and procedures to contracted PCPs and Specialists. In most cases, IEHP sends correspondence directly to Delegated 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 Delegated 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, Delegated IPAs, and Hospitals concurrently. Prior notification is not provided by IEHP in these cases.
- F. On 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. Provider Services Admin Team maintains an exception table list of these Providers with their mailing address or email address.

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G. Provider Resources

G. It is crucial to the success of each Provider 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 Delegated IPA at a minimum annually.
3. Periodically, JOMs focusing on Delegated IPA/hospital coordination and communication are held (when necessary or as requested with each Delegated 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 Care Management Teams that serve as a resource for IEHP Team Members, Providers, and contracted Delegated 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. Care Management Teams are comprised of Care Management Nurses and Coordinators.
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 anytime 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 Care Management Teams. These issues may include:
 - a. Access issues

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G. Provider Resources

- 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 nonparticipating), contracted Delegated IPAs, Hospitals and Ancillary Providers.
2. The IEHP Provider Relations Team is comprised of Provider Services Representatives and Provider Call Center Representatives.
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

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G. Provider Resources

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 Delegated 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)
 - Electronic Referrals
 - Health Education Referrals
 - Care Plans
 - Member Health Records
 - Online formulary search
 - Staying Healthy Assessment (SHA)
 - IEHP Guidelines for Care Management
 - Member Preventive Care Rosters
 - ICD Code Training
 - 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

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G. Provider Resources

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

D. IEHP Contracts Service Team

1. Provider Contracting Services Representatives (PCSRs):

- a. IEHP PCSRs are trained in accordance with regulations set forth by the State Programs Regulations.
- b. IEHP PCSRs provide detailed information about IEHP benefits, IEHP programs, and managed care concepts to IEHP Ancillary Providers and Hospitals, and serve as the focal point for staff to obtain information about IEHP programs, DHCS, CMS and other regulatory issues, as applicable.
- c. For the purposes of visits, the PCSRs are assigned geographic areas to visit IEHP Ancillary Providers and Hospitals.
- d. On an initial, periodic and Provider requested basis, PCSRs provide training to IEHP Ancillary Providers and their staff covering an array of topics, including but not limited to:
 - 1) Prior Authorization Requests
 - 2) Member Eligibility
 - 3) Website Tools
 - Electronic Referrals
 - Care Plans
 - Member Health Records
 - Online formulary search
 - IEHP Guidelines for Care Management
 - Compliance Training and Fraud, Waste and Abuse (FWA)
 - ICD Code Training
 - Provider Orders for Life-Sustaining Treatment (POLST) Registry
 - 4) Claims
 - Claim Status
 - Clean Claim requirements
 - Provider Dispute Resolution (PDR) Process
 - Correct Billing Entities and Division of Financial Responsibility

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G. Provider Resources

- 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 ask questions with their IEHP PCSRs, especially to help the staff understand complex State regulations concerning Medi-Cal Program beneficiaries.

E. Nurse Educators

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 Physicians (PCPs).

F. IEHP University:

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

G. Provider Newsletter (The Heartbeat)

1. The Heartbeat is a newsletter that is distributed by mail to all IEHP on a bi-annual basis.
2. The Provider Newsletter informs Providers of any policy, benefit, service, program or regulatory changes.
3. The Provider Newsletter also informs Providers of featured health education programs available to Members, results of quality studies or other quality of care related information.

H. Provider Staff Newsletter (ScrubTalk)

1. Scrub Talk is a newsletter distributed by mail to all IEHP Provider staff on a bi-annual basis.
2. The purpose of the Scrub Talk Newsletter is to establish an important link with office staff to foster network cohesiveness and stability.

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G. Provider Resources

3. Scrub Talk features articles and helpful tips to assist Provider staff with information or services that are available to them.
4. Scrub Talk features “Stress Busters” to help Provider staff to be more productive in the performance of their daily duties.

I. 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 Services Department determines the need for such special notices.

J. IEHP Website – www.iehp.org

1. IEHP’s website is a valuable business tool created to provide our Providers with twenty-four (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. To monitor compliance, each month IEHP’s Application Support Team generates Website Statistics Report for management review. It provides online activity summary of Providers who have accessed various pages of the website. The Director of Provider Services distributes the report to the appropriate Provider Services staff to analyze data and propose follow up actions as needed.
5. 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 Provider
 - 2) Provider Login
 - 3) Pay for Performance (P4P)
 - P4P Program
 - Global Quality P4P Program
 - Hospital P4P Program
 - OB/GYN P4P Program
 - 4) Plan Updates
 - Correspondence

18. PROVIDER NETWORK

G. Provider Resources

- IEHP Holiday Schedule
 - Medicare Beneficiary Identifier (MBI)
 - Newsletters
 - The Heartbeat
 - ScrubTalk
 - Proposition 56
 - Public Health Advisory
 - Riverside County Public Health System
 - San Bernardino County Public Health System
 - Regulatory Updates
 - Medicare Outpatient Observation Notice (MOON)
 - Updates
 - Cal MediConnect Quality Withhold Measures
 - Flu Updates
 - Preventive Services
- 5) Provider Resources
- Compliance
 - Code of Business Conduct and Ethics
 - Forms
 - Training
 - Contact the OIG
 - Fraud Prevention
 - Guidelines for Care Management Training
 - Nondiscrimination Language
 - Online Cultural Competency Training
 - Frequently Asked Questions (FAQs)
 - Claims
 - Medi-Cal Learning Portal
 - Medi-Cal Rates and Codes

18. PROVIDER NETWORK

G. Provider Resources

- Medicare Physician Fee Schedule
- Educational Opportunities
 - Specialty Mental Health Care Coordination
 - Staying Health Assessment (SHA) Training
- Forms
 - Behavioral Health
 - Claims
 - Compliance
 - Delegation Oversight Audit (DOA)
 - ERA 835 Enrollment Medicare
 - Grievance
 - Growth Chart
 - Historical Data Form
 - Perinatal
 - Pharmacy
 - Provider Preventable Conditions (PPC)
 - Staying Health Assessment
 - UM/CM
 - Medi-Cal Letter Templates
 - Medicare-Medicaid Plan Letter Templates
 - Vision
 - Other
- Health Education
 - Activities
 - Brochures
 - Educational Resources
- Manuals
 - Benefits
 - Electronic Data Interchange (EDI)
 - Provider Manuals

18. PROVIDER NETWORK

G. Provider Resources

- POLST Registry
 - Pharmacy Services
 - Quality & Clinical Resources and Tools
 - Clinical Practice Guidelines Library
 - Staying Healthy
 - After Hours Care, Urgent Care Facilities & LabCorp Locations
 - After Hours Care
 - LabCorp Locations
 - Urgent Care Clinics
 - Utilization Management Criteria
 - Behavioral Health
 - Diagnostic Testing
 - DME and Medical Supplies
 - ENT
 - Gynecology and Obstetrics
 - Neurology
 - Oncology
 - Orthopedic
 - Pain Management
 - Pediatric
 - Surgical Procedures
 - Other
- 6) Pharmacy Services
- Academic Detailing
 - Cal MediConnect
 - Clinical Information
 - Drug MAC
 - Formulary
 - Pharmacy Forms

18. PROVIDER NETWORK

G. Provider Resources

- Pharmacy Network Lists
 - Pharmacy P4P Program
 - Pharmacy Quality Ratings
 - Provider Communications
- 7) Special Programs
- Alcohol Misuse Screening and Counseling
 - Baby-N-Me
 - California Children Services
 - Health Homes Program
 - 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
 - MyPath
 - Neuro Vitality Center
 - Services for Teen Patients
 - Tobacco Cessation Services
- 8) Join Our Network
- Ancillary
 - Behavioral Health
 - Behavioral Health Integration Initiative (BHI-I)
 - Behavioral Health Forms
 - Frequently Asked Questions (FAQs)
 - Hospitals

18. PROVIDER NETWORK

G. Provider Resources

- IPA
 - PCP and Specialists
 - Provider Network Expansion Fund
 - Screening and Enrollment
 - Vision
- b. Secure Site Login
- 1) Home (Landing Page)
 - Updates
 - Provider Network Expansion Fund
 - Department of Public Health
 - Department of Social Services Requirements
 - Forms
 - Special Programs
 - Events and Training
 - AMSC (formerly known as SBIRT) Services
 - Global Quality P4P Program (For PCPs Only)
 - 2) Eligibility
 - 3) Rosters
 - Assigned Roster
 - CCS
 - Direct Ancillary (For Direct Contracted Providers only)
 - Direct Specialty (For Direct Contracted Providers only)
 - DocOnline
 - Early Start Roster
 - Health Management
 - Asthma Roster
 - Care Plans and HRAs
 - Diabetes Roster
 - Initial Health Assessment

18. PROVIDER NETWORK

G. Provider Resources

- NEMT PCS Roster
- Nurse Advice Line
- Preventive Care
 - ADHD Medication (Follow-up Care)
 - Annual Monitoring for Patients on Persistent Medications
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
 - Breast Cancer Screen
 - Cervical Cancer Screen
 - Childhood Immunizations
 - Diabetes Care
 - DualChoice Annual Visit
 - Immunizations for Adolescents
 - Medication Management for People with Asthma
 - Prenatal and Postpartum Care
 - Weight Assessment and Counseling Nutrition and Physical Activity
 - Well Care (0-15 Months)
 - Well Care (3-6 Years)
 - Well Care (Adolescent)
 - Yellow Card
- 4) Encounter
- 5) Pharmacy
 - Rx PA/CD Auth Request
 - Medi-Cal Formulary
 - CMC Formulary
 - Prior Authorization Criteria
 - Pharmaceutical Services
- 6) Claims Status
- 7) Behavioral Health
 - Referral Request Form

18. PROVIDER NETWORK

G. Provider Resources

- BHICCI Program
 - Roster
 - Reporting Dashboard
- 8) Referrals
 - Status
 - Request (Direct Contracted Providers only)
- 9) Finance
 - Capitation Reports
 - Claims Remittance Advice (RAs)
 - P4P RAs
 - Prop 56 RAs
- 10) Pay for Performance (P4P)
 - P4P Entry
 - P4P Status
- 11) Health Education
 - Request
- 12) Clinical Resources and Tools
- 13) Vision Providers Only
 - Claims Entry
 - Vision Referral Request
 - Claims Status
 - Referrals
 - Status
 - Request
 - Finance
 - Claims RAs
 - Prop 56 RAs
- 14) Pharmacy Providers Only
 - Medi-Cal Formulary

18. PROVIDER NETWORK

G. Provider Resources

- CMC Formulary
- Prior Authorization Criteria
- Pharmaceutical Services

15) Behavioral Health Providers Only

- Referral Request Form
- Claims Submission
- Coordination of Care Treatment Plan
- BHICCI Program
 - Roster
 - Reporting Dashboard

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	September 1, 1996
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2020

18. PROVIDER NETWORK

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) PCPs and must, as a group, be capable of providing care to Members of all ages and genders and, who admit to the designated Hospital or have an admitting arrangement. The PCPs must be contracted and credentialed by the IPA who links to the contracted Hospital, as delineated in Policy 18F, “Specialty Panel.”
- B. IEHP may choose to approve an IPA to have less than the minimum five (5) individual PCP requirements due to geographic needs of Members and/or to avoid the potential monopolistic situation with its 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 fifteen (15) miles or thirty (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 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, are capable of providing 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 Panel.”
- 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:

18. PROVIDER NETWORK

H. Hospital Affiliations

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. Have IEHP pend the PCP 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 sixty (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 on a monthly basis. 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 ninety (90) days. If the IPA/Hospital link is not compliant within a ninety (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 or the Chief Operating Officer 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.

18. PROVIDER NETWORK

H. Hospital Affiliations

3. In the situation where a dedicated adult Hospitalist group does not exist at a particular 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		
Chief Approval: <i>Signature on file</i>	Original; Effective Date:	March 9, 1998
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2020

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 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 (See Attachment, “IEHP PCP Leave of Absence Coverage Form” in Section 18).
- D. In general, leaves of absence by PCPs greater than ninety (90) days require transfer of assigned Members to another PCP.
- E. 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 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 sixteen (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 sixty (60) days in advance.
- 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.

18. PROVIDER NETWORK

I. Leave of Absence

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 ninety (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 of the above 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.

INLAND EMPIRE HEALTH PLAN		
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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 thirty (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 thirty (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 12A5, "Care Management Requirements - Continuity of Care."

DEFINITION:

- A. Block Transfer: This is required if a contract termination constitutes a change in the availability or location of covered services.
 - 1. Clinic and PCP terminations that result in more than five hundred (500) Members having to transfer require a block transfer.
 - 2. All IPA, medical group, and hospital contract terminations require a block transfer.

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" in Section 18). A copy of the notification to the PCP is sent to the IPA.
- B. IEHP sends affected Members a letter notifying them of the PCP termination no later than thirty (30) days prior to the effective date (See Attachments, "Member PCP Termination Notification Letter – English" and "Member PCP Termination Notification Letter – Spanish")

18. PROVIDER NETWORK

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

in Section 18). The letter provides the Member with the opportunity to contact IEHP to select a different PCP at least thirty (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 affected IPA's network. The final decision regarding Member transfers rests with IEHP.
- D. If Members cannot be transferred within the IPA network due to age limitations or geographic location, 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.
- 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" in Section 18).
 2. Sends the affected Members a letter notifying them of the change in PCP thirty (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" in Section 18). 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" in Section 18).
- 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 thirty (30) days prior to the effective date and must include the option for Members to continue care with their existing Provider for up to ninety (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" in Section 18.

Vision Provider Termination

18. PROVIDER NETWORK

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

- 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 is being terminated from participation in the IEHP network and the effective date of the termination (See Attachment, “Peer Review Termination Letter” in Section 18).

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” in Section 18).
- 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

- A. Block Transfers - In the event of the termination of a Provider contract that could involve the block transfer of Members, IEHP may do one or all of the following:
1. Provide all assigned Members with a written notice thirty (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 fifteen (15) mile radius 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 into a new contract or to not terminate their contract prior to the termination date, IEHP return 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.

18. PROVIDER NETWORK

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

INLAND EMPIRE HEALTH PLAN		
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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. Prior to contracting, IEHP verifies the services available, accreditation status and/or Centers for Medicare and Medicaid Services (CMS) survey site survey, license, and standing with regulatory bodies in compliance with the most current NCQA standards, CMS and regulatory requirements prior to contracting with such organization.
- C. IEHP reconfirms the status of all contracted hospitals concurrently upon expiration and every contract renewal period, but no less than every three (3) years.
- D. IEHP maintains the appropriate records to document the verification process for contracted hospitals per the most recent NCQA and CMS guidelines and IEHP requirements.
- E. 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.
- F. IEHP does not contract with Hospitals if they appear on the list of indicted 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.

PROCEDURES:

- A. 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, license and most recent regulatory audit results satisfy this requirement.
- B. 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;

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

- 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 approval.
- C. If Hospital offers Behavioral Health services, the following applies:
1. Inpatient Services
- 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.
- D. The Hospital must be accredited by one of the following accrediting agencies:
- 1. The Joint Commission (TJC);
 - 2. Healthcare Facilities Accreditation Program (HFAP);
 - 3. Behavioral Health - Commission on Accreditation of Rehabilitation Facilities (CARF);
 - 4. Det Norske Veritas Healthcare (DNV); and
 - 5. Center for Improvement in Healthcare Quality (CIHQ).
- E. If a Hospital is 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 site review and/or a CMS site survey of the Hospital, as applicable, in addition to meeting other standards as defined by IEHP.

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

- F. 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:
1. A current and unencumbered license;
 2. Current certification from The Joint Commission, HFAP, CARF, DNV, CIHQ as applicable, or an alternative accreditation or site review as determined by IEHP; and
 3. No Medicare/Medicaid sanctions against them.
- G. 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 thirty (30) days following the expiration of the license and accreditation.
- H. On a monthly basis, the Contracts Administration Coordinator, or designee reviews the Medical Suspended and Ineligible list to verify Hospitals contracted with the Plan have no Medicaid sanctions and/or uses the sanction screening service OIG Compliance Now or via the following website: <http://www.medi-cal.ca.gov/default.asp>.
- I. Additionally, once a month, the Contracts Administration Coordinator, or designee, researches the authorized government websites and/or uses the sanction screening service OIG Compliance Now to verify hospitals contracted with the Plan have no Medicare/Medicaid sanctions or via the following website: <http://www.sam.gov> for System for Award Management (SAM).
- J. 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.
- K. IEHP reserves the right to perform facility site audits when quality of care issues arise and to deny hospital's participation in the IEHP network if IEHP requirements are not met.
- L. If during the contract period, IEHP becomes aware of a change in the accreditation and/or CMS site survey, license or certification status, or sanctions, fraudulent activity or other legal or remedial actions have been taken against any hospital, the Contract Coordinator notifies the Contracts Manager, Medical Director and the Compliance Department at DGStateProgram@IEHP.org within five (5) days of discovering our Provider/Hospital has been added to a disciplinary list. 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 reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Agreement.

18. PROVIDER NETWORK

K. Hospital Network Participation Standards

REFERENCE:

- A. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-001 and supersedes (APL) 06-007, “Medi-Cal Provider and Subcontract Suspensions, Terminations, and Decertifications.”

INLAND EMPIRE HEALTH PLAN		
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Chief Title: Chief Operating Officer	Revision Date:	January 1, 2020

18. PROVIDER NETWORK

L. Providers Charging Members

APPLIES TO:

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

POLICY:

- 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.
- B. 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.
- C. 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 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.
- D. According to California Health and Safety Code, Section 123110.b (See Attachment, “California Health and Safe Code 123110” in Section 18), 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 twenty-five cents (\$0.25) per page or fifty cents (\$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 fifteen (15) days after receiving the written request.
- E. In circumstances where charging a Member for completion of a form is allowed, fees should be nominal and not to exceed twenty-five (\$0.25) cents per page with a maximum charge allowed of twenty dollars (\$20).
- F. 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.
- G. Any contracted Health Care Provider who is 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.

18. PROVIDER NETWORK

L. Providers Charging Members

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

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. 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 anytime 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;
 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;

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L. Providers Charging Members

8. In-Home Support Services (IHSS) Medical Certification Form SOC 873; and
 9. Any forms related to Long-Term Services and Supports (LTSS) benefits including Community Based Adult Services (CBAS).
- 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.

REFERENCES:

- A. California Health and Safety Code, Section 123110.b.
- B. California Code of Regulations (CCR), Title 22, §51002.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on file</i>	Original Effective Date:	September 1, 1996
Chief Title: Chief Operating Officer	Revised Date:	January 1, 2020

18. PROVIDER NETWORK

M. Outsourcing Standards and Requirements

APPLIES TO:

- A. This policy applies to all Medi-Cal Delegated IPAs in IEHP's network who outsource: 1) services requiring the use and/or disclosure of IEHP protected health information ("PHI") or personally identifiable information ("PII"), as those terms are defined under Health Insurance Portability and Accountability Act ("HIPAA") and/or California law; and 2) services requiring physician licensure, in providing services to IEHP.

POLICY:

- A. Outsourcing is a business practice where a service is performed from an outside organization either offshore or onshore. The outsourced vendor provides services to contracted Delegated IPAs in IEHP's network.
1. Onshore Outsourcing: obtaining services from a third-party outside the Delegated IPA or IEHP but within the United States.
 2. Offshore Outsourcing: obtaining services from a third-party outside the Delegated IPA or IEHP and outside of the United States.
- B. Delegated IPAs or IEHP are prohibited from outsourcing any services that involve PHI and/or PII to offshore vendors.
- C. With respect to the onshore outsourcing of IEHP PHI and/or PII, the Delegated 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 Delegated 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 Delegated IPA is not permitted to outsource any of the work outlined in the IPA Agreement. If services were ongoing prior to the Delegated IPA's contract with IEHP, the Delegated IPA shall seek immediate approval by IEHP to apply retrospectively.
 2. Delegated 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.
- D. With respect to the onshore outsourcing of physician services (i.e. utilization management services), the Delegated IPAs must ensure compliance with all State of California requirements regarding in-state physician 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, Medicare and other lines-of-business in which IEHP may choose to participate. As a result, Delegated IPAs outsourcing services involving IEHP PHI and/or PII, or physician services,

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M. Outsourcing Standards and Requirements

are expected to respect and comply, and also 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 one of the fifty (50) U.S. States, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands).

PROCEDURES:

- A. As to outsourcing of business services/activities involving IEHP PHI and/or PII: Delegated IPAs seeking to obtain approval of a vendor who will use and/or disclose IEHP PHI and/or PII shall submit a written request to approve same to IEHP.
1. IEHP will approve or deny the vendor within thirty (30) days of receiving the information detailed in **POLICY**, Section C.
 2. Once IPA has conducted the due diligence outlined below, the Delegated IPA shall submit a written report detailing the findings.
 3. The Delegated 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. Any subcontracted or outsourced activities provided or currently being provided to comparable entities.
 - c. 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.
 4. Should vendor pass the step outlined in subsection **POLICY**, above, the Delegated 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:
 - a. Review of the entity's current data security and compliance 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.
 - d. Review of company's policy on fraud, waste and abuse ("FWA").
 5. If the vendor's ability to maintain data security has been successfully assessed, the Delegated 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 Delegated IPA.

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M. Outsourcing Standards and Requirements

- 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.
 6. Decisions to accept the vendor to whom the Delegated IPA wishes to onshore outsource business services/activities involving IEHP PHI and/or PII are subject to review by the IEHP Compliance Department and approval by IEHP’s Chief Network Officer and/or Executive Director Health and Provider Services.
- B. As to outsourcing of physician services: Delegated IPAs shall be required to ensure compliance of all vendors as outlined under “**POLICY**, Section C” and shall demonstrate such compliance if requested by IEHP.
- C. Final Decision:
1. IEHP reserves the right to request, modify or terminate the Delegated IPA agreement at any time if the Delegated IPA is non-compliant with IEHP’s requirements under this policy.

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18. PROVIDER NETWORK

N. IPA Medical Director Standards

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 Delegated 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 Delegated 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. The Medical Director identifies Delegated IPA network gaps in primary and specialty care coverage and ensures access to care for IEHP Members. He or she maintains an open professional relationship with the Delegated IPA Physician network.
- D. 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.
- E. The Medical Director serves as the physician liaison between the Delegated IPA, IEHP, Skilled Nursing Facilities (SNFs), Hospitals and other network Providers.
- F. The Medical Director should be involved in tracking and trending of potential fraud, waste and abuse involving IEHP Members and Providers.
- G. 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.
- H. Preference should be given to hiring Medical Directors with Primary Care experience.

PROCEDURES:

Utilization Management

- A. The Medical Director timely and personally reviews all potential authorization denials and partial approvals (modifications) for:
 - 1. Correct clinical decision-making;
 - 2. Correct application of IEHP-approved criteria using the hierarchy appropriate to the line of business per Policy 25E1, "Utilization Management Delegation and Monitoring"; and
 - 3. Use of denial language that is simple and at the appropriate grade level, ensuring that both the denial reason and specific criteria not met are understood by the IEHP Member.

18. PROVIDER NETWORK

N. IPA Medical Director Standards

- B. The Medical Director provides his or her signature on all denials and partial approvals (modifications).
- C. The Medical Director is immediately available for any urgent or expedited decisions.
- D. The Medical Director provides clinical expertise for Members requiring complex medical care, higher level of care and out-of-network services.
- E. The Medical Director consults with Delegated IPA physicians to ensure correct utilization of UM criteria and initiates outreach to Providers showing a pattern of inappropriate authorization requests.
- F. The Medical Director ultimately ensures that IEHP Members receive any medically necessary services including cases when criteria language appears vague or non-specific.

Quality and Care Management

- A. The Medical Director:
 - 1. Is immediately available to consult on all complex care management and care coordination cases as needed;
 - 2. Reviews all Provider and Delegated IPA grievances for adverse trends or Potential Quality Incidents (PQIs);
 - 3. Reaches out to Providers as necessary to ensure timely response to grievance inquiries;
 - 4. Has an understanding of community standards for medical care and provides input on all PQI cases;
 - 5. Has oversight of the Delegated IPA Quality Improvement process, policy and strategy; and
 - 6. Has fundamental understanding of National Committee on Quality Assurance (NCQA) metrics, Medi-Cal regulations and is involved in the Delegated IPA metric improvement strategy.

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N. IPA Medical Director Standards

REFERENCES:

- A. Title 22, California Code of Regulations §53857.
- B. DHCS Final Rule Contract Amendment January 2018, Exhibit A, Attachment 1, Organization and Administration of the Plan.
- C. DMHC Technical Assistance Guide, Quality Management, QM-002.
- D. DMHC Technical Assistance Guide, Utilization Management.

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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:

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O. Provider Disruptive Behavior

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

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O. Provider Disruptive Behavior

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);

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- 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.

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Chief Title: Chief Operating Officer	Revision Date:	

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P. Virtual Care

APPLIES TO:

- A. This policy applies to Inland Empire Health Plan (IEHP) Primary Care Providers (PCPs), Specialists, and Behavioral Health Providers serving IEHP Members.
- B. This policy does not apply to IEHP network Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Indian Health Services (IHS) sites. For originating site policy and billing information specific FQHCs, RHCs or IHS – Memorandum of Agreement (IHS-MOA) 638, Clinics, refer to the Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) and Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics sections in the appropriate Part 2 Department of Health Care Services (DHCS) manual.

POLICY:

- A. This policy describes procedures related to modalities of Virtual Care offered by eligible IEHP Providers to IEHP Members.

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 health care 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.
- C. “Asynchronous store and forward” means 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.
- D. “Synchronous interaction” means a real-time interaction between a Member and a health care Provider located at a distant site.
- E. “Distant site” means a site where a health care Provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.

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P. Virtual Care

- 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 health care 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 health care Provider is not required to be present at the originating site unless determined medically necessary by the Provider at the distant site.

PROCEDURES:

A. Provider Requirements

1. The health care 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 health care 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 health care Provider rendering IEHP covered benefits or services provided via a telehealth modality must meet the requirements of *Business and Professions Code* (B&P Code), Section 2290.5(a)(3), or equivalent 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.

B. Documentation Requirements

1. All Health Care Practitioners 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.
2. Health Care 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 service or benefit as well as any

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P. Virtual Care

other requirements described in this section of the IEHP Provider manual.

3. Health care Providers are not required to document a barrier to an in-person visit for IEHP coverage of services provided via telehealth.
4. Health care 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.
5. Documentation for Asynchronous Store and Forward Services
 - a. For teleophthalmology, teledermatology services, or benefits delivered via asynchronous store and forward, health care 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. Consent
 - a. In addition, Health Care Providers must also inform the Member 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 Health Care 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 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 upon request.
7. Place of Service
 - a. Health care 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.

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C. Reimbursable Telehealth Services

1. IEHP covered benefits or services, identified by CPT or 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:
 - a. The treating health care 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 benefits or services delivered via telehealth meet the procedural definition and components of the procedure codes, as defined DHCS, associated with the IEHP covered service or benefit, as well as any extended guidelines as described in this section of the IEHP Provider manual; and
 - c. The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a Member's right to their medical information.
2. 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 health care 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 health care Provider bills with the appropriate modifier for this service as specified by DHCS.
3. Examples of Services Not Appropriate for Telehealth:
 - 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.

D. Billing Requirements

1. Synchronous, Interactive Audio and Telecommunications Systems:

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P. Virtual Care

- a. Health care Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the health care 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). 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 health care Provider
 - c. The presence of a health care Provider is not required at the originating site as a condition of payment unless the health care Provider at the originating site is medically necessary as determined by the health care Provider at the distant site.
2. Asynchronous Store and Forward Telecommunications Systems:
 - a. For billing purposes, health care 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.
 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 services (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:
 - Originating site: once per day, same Member, same Provider.

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P. Virtual Care

- 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.

REFERENCES:

- A. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009, “Telehealth Services Policy”.
- B. DHCS Provider Manual, Medicine: Telehealth, August 2019.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: <i>Signature on File</i>	Original Effective Date:	
Chief Title: Chief Operating Officer	Revision Date:	January 1, 2020

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- P. Virtual Care
 - 1. eConsult Services
-

APPLIES TO:

- A. This policy applies to all IEHP Direct Contracted Primary Care Providers (PCPs) and Specialist Reviewers.
- B. This policy does not apply to IEHP network Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Indian Health Services (IHS) sites. For originating site policy and billing information specific FQHCs, RHCs or IHS – Memorandum of Agreement (IHS-MOA) 638, Clinics, refer to the Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) and Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics sections in the appropriate Part 2 Department of Health Care Services (DHCS) manual.

POLICY:

- A. IEHP has implemented an eConsult platform and workflow that allows 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.
- B. eConsult is a secure online platform that allows for asynchronous Provider-to-Provider communication to ensure access to high-quality, patient-centered, and coordinated specialty care for IEHP Members.
- C. 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.
- D. 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.

PURPOSE:

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

DEFINITION:

- A. eConsults fall under the auspice of store and forward. 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,

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advisory opinions and recommendations of care. eConsults are permissible only between health care Providers.

- B. A Specialist Reviewer is 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” means 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.

PROCEDURES:

- A. eConsults may be initiated for services requiring prior authorization; they may be initiated by PCPs or Specialists. 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.
- B. 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 Specialist Reviewer. The workflow is described here:
 - 1. Member is seen by their PCP and a potential specialty care need is established.
 - 2. PCP submits an eConsult to a Specialist Reviewer.
 - a. eConsult may be submitted while the Member is in the office or once the Member has left. Same day submission is required.
 - 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 Specialist Reviewer.

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4. The Specialist Reviewer is required to respond to the PCP within seventy-two (72) hours.
- C. 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.
 3. IEHP will provide authorization and send an approval letter to the Member.
 4. Member will contact the assigned Specialist to schedule a face-to-face appointment.
- D. PCPs, Specialists, and Members (if the Provider refuses) or their representative, have the right to request an opinion regarding proposed medical or surgical treatments from an appropriately qualified participating health care professional acting within their scope of practice who possesses a clinical background, including training and expertise, related to the particular illness, disease condition or conditions associated with the request for a second opinion.

REFERENCES:

- A. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009, “Telehealth Services Policy”.
- B. DHCS Provider Manual, Medicine: Telehealth, August 2019.

INLAND EMPIRE HEALTH PLAN		
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Attachments

<u>DESCRIPTION</u>	<u>POLICY CROSS REFERENCE</u>
California Health and Safe Code 123110	18L
Change in Hospital Affiliation Letter	18C
Change in IPA Affiliation Letter	18C
Compliant Termination Letter	18D1, 18I, 18J
Frozen Enrollment Change Status	18A2
Hospital Geographic Service Areas	18F
Limited Enrollment Change Status	18A2
IPA Hospital Link Responsibility Grid – Medi-Cal	18F
IEHP PCP Leave of Absence Coverage Form	18I
Member PCP Term Notification Letter – English	18D1, 18I, 18J
Member PCP Term Notification Letter – Spanish	18D1, 18I, 18J
Non Compliant Termination Letter	18D1, 18I, 18J
Over Enrollment Change Letter	18A2
Peer Review Termination Letter	18J
Specialty Panel Worksheet – Medi-Cal	18F
Specialist Term Member Notification - English	18D2, 18J
Specialist Term Member Notification- Spanish	18D2, 18J



HEALTH AND SAFETY CODE - HSC

DIVISION 106. PERSONAL HEALTH CARE (INCLUDING MATERNAL, CHILD, AND ADOLESCENT) [123100 - 125850] (*Division 106 added by Stats. 1995, Ch. 415, Sec. 8.)*

PART 1. GENERAL ADMINISTRATION [123100 - 123223] (*Part 1 added by Stats. 1995, Ch. 415, Sec. 8.)*

CHAPTER 1. Patient Access to Health Records [123100 - 123149.5] (*Chapter 1 added by Stats. 1995, Ch. 415, Sec. 8.)*

123110. (a) Notwithstanding Section 5328 of the Welfare and Institutions Code, and except as provided in Sections 123115 and 123120, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient's personal representative shall be entitled to inspect patient records upon presenting to the health care provider a request for those records and upon payment of reasonable costs, as specified in subdivision (k). However, a patient who is a minor shall be entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. A health care provider shall permit this inspection during business hours within five working days after receipt of the request. The inspection shall be conducted by the patient or patient's personal representative requesting the inspection, who may be accompanied by one other person of his or her choosing.

(b) (1) Additionally, any patient or patient's personal representative shall be entitled to a paper or electronic copy of all or any portion of the patient records that he or she has a right to inspect, upon presenting a request to the health care provider specifying the records to be copied, together with a fee to defray the costs of producing the copy or summary, as specified in subdivision (k). The health care provider shall ensure that the copies are transmitted within 15 days after receiving the request.

(2) The health care provider shall provide the patient or patient's personal representative with a copy of the record in the form and format requested if it is readily producible in the requested form and format, or, if not, in a readable paper copy form or other form and format as agreed to by the health care provider and the patient or patient's personal representative. If the requested patient records are maintained electronically and if the patient or patient's personal representative requests an electronic copy of those records, the health care provider shall provide them in the electronic form and format requested if they are readily producible in that form and format, or, if not, in a readable electronic form and format as agreed to by the health care provider and the patient or patient's personal representative.

(c) Copies of X-rays or tracings derived from electrocardiography, electroencephalography, or electromyography need not be provided to the patient or patient's personal representative under this section, if the original X-rays or tracings are transmitted to another health care provider upon written request of the patient or patient's personal representative and within 15 days after receipt of the request. The request shall specify the name and address of the health care provider to whom the records are to be delivered. All reasonable costs, not exceeding actual costs, incurred by a health care provider in providing copies pursuant to this subdivision may be charged to the patient or representative requesting the copies.

(d) (1) Notwithstanding any provision of this section, and except as provided in Sections 123115 and 123120, a patient, former patient, or the personal representative of a patient or former patient, is entitled to a copy, at no charge, of the relevant portion of the patient's records, upon presenting to the provider a written request, and proof that the records or supporting forms are needed to support a claim or appeal regarding eligibility for a public benefit program. These programs shall be the Medi-Cal program, the In-Home Supportive Services Program, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, social security disability insurance benefits, Supplemental Security Income/State Supplementary Program for the Aged, Blind and Disabled (SSI/SSP) benefits, federal veterans service-connected compensation and nonservice connected pension disability benefits, and CalFresh.

(2) Although a patient shall not be limited to a single request, the patient or patient's personal representative shall be entitled to no more than one copy of any relevant portion of his or her record free of charge.

(3) This subdivision shall not apply to any patient who is represented by a private attorney who is paying for the costs related to the patient's claim or appeal, pending the outcome of that claim or appeal. For purposes of this subdivision, "private attorney" means any attorney not employed by a nonprofit legal services entity.

(e) If the patient's appeal regarding eligibility for a public benefit program specified in subdivision (d) is successful, the hospital or other health care provider may bill the patient, at the rates specified in subdivisions (b) and (c), for the copies of the medical records previously provided free of charge.

(f) If a patient or his or her personal representative requests a record pursuant to subdivision (d), the health care provider shall ensure that the copies are transmitted within 30 days after receiving the written request.

(g) This section shall not be construed to preclude a health care provider from requiring reasonable verification of identity prior to permitting inspection or copying of patient records, provided this requirement is not used oppressively or discriminatorily to frustrate or delay compliance with this section. Nothing in this chapter shall be deemed to supersede any rights that a patient or personal representative might otherwise have or exercise under Section 1158 of the Evidence Code or any other provision of law. Nothing in this chapter shall require a health care provider to retain records longer than required by applicable statutes or administrative regulations.

(h) This chapter shall not be construed to render a health care provider liable for the quality of his or her records or the copies provided in excess of existing law and regulations with respect to the quality of medical records. A health care provider shall not be liable to the patient or any other person for any consequences that result from disclosure of patient records as required by this chapter. A health care provider shall not discriminate against classes or categories of providers in the transmittal of X-rays or other patient records, or copies of these X-rays or records, to other providers as authorized by this section.

Every health care provider shall adopt policies and establish procedures for the uniform transmittal of X-rays and other patient records that effectively prevent the discrimination described in this subdivision. A health care provider may establish reasonable conditions, including a reasonable deposit fee, to ensure the return of original X-rays transmitted to another health care provider, provided the conditions do not discriminate on the basis of, or in a manner related to, the license of the provider to which the X-rays are transmitted.

(i) Any health care provider described in paragraphs (4) to (10), inclusive, of subdivision (a) of Section 123105 who willfully violates this chapter is guilty of unprofessional conduct. Any health care provider described in paragraphs (1) to (3), inclusive, of subdivision (a) of Section 123105 that willfully violates this chapter is guilty of an infraction punishable by a fine of not more than one hundred dollars (\$100). The state agency, board, or commission that issued the health care provider's professional or institutional license shall consider a violation as grounds for disciplinary action with respect to the licensure, including suspension or revocation of the license or certificate.

(j) This section prohibits a health care provider from withholding patient records or summaries of patient records because of an unpaid bill for health care services. Any health care provider who willfully withholds patient records or summaries of patient records because of an unpaid bill for health care services is subject to the sanctions specified in subdivision (i).

(k) (1) Except as provided in subdivision (d), a health care provider may impose a reasonable, cost-based fee for providing a paper or electronic copy or summary of patient records, provided the fee includes only the cost of the following:

(A) Labor for copying the patient records requested by the patient or patient's personal representative, whether in paper or electronic form.

(B) Supplies for creating the paper copy or electronic media if the patient or patient's personal representative requests that the electronic copy be provided on portable media.

(C) Postage, if the patient or patient's personal representative has requested the copy, or the summary or explanation, be mailed.

(D) Preparing an explanation or summary of the patient record, if agreed to by the patient or patient's personal representative.

(2) The fee from a health care provider shall not exceed twenty-five cents (\$0.25) per page for paper copies or fifty cents (\$0.50) per page for records that are copied from microfilm.

(Amended by Stats. 2017, Ch. 626, Sec. 1.5. (SB 575) Effective January 1, 2018.)



INLAND EMPIRE HEALTH PLAN

[Date]

[DOCTOR NAME]

[ADDRESS]

[CITY, CA ZIP]

RE: Change in Hospital Affiliation

Dear [PCP Name]:

This letter is to acknowledge receipt of your letter dated [Date] requesting a hospital affiliation change from [Old Hospital Name] to [New Hospital Name].

In compliance with IEHP's Provider Policy and Procedure Manual, your affiliation with [New Hospital Name] will become effective [Date]. According to IEHP Provider Policy and Procedure Manual, this change is considered compliant.

If you need assistance or clarification, please feel free to contact me at [Phone #].

Sincerely,

[PSR Name]

Provider Services Representative

cc: [Hospital]

[IPA]

[First Name, Last Name], Chief Operating Officer, IEHP

[First Name, Last Name], Director of Provider Relations, IEHP

[IPA File]

[PCP File]



INLAND EMPIRE HEALTH PLAN

[Date]

[DOCTOR NAME]
[ADDRESS]
[CITY, CA ZIP]

RE: Change in IPA Affiliation

Dear Dr. [PCP Name]:

This is to acknowledge receipt of your letter dated [Date of Letter], requesting that your IPA affiliation be changed to [New IPA Name].

In compliance with IEHP Provider Policy and Procedures, provided there are no credentialing or contract issues, this change will be made effective on the 1st of the month following 60 days from notification - [Effective Date]. Please be advised that though this is an IEHP Policy (18C), you may have different commitments under your contractual agreement with [Old IPA Name].

Administrative issues will remain the responsibility of [Old IPA Name] through [End Date].

If you have questions or concerns, please contact me at [PSR Phone Number].

Sincerely,

[PSR Name]
Provider Services Representative

cc: [Old IPA Name]
[New IPA Name]
[First Name Last Name], Chief Operating Officer , IEHP
[First Name Last Name], Director of Provider Relations, IEHP
[IPA File]
[PCP File]



INLAND EMPIRE HEALTH PLAN

[Date]

[IPA NAME]
[ADDRESS]
[CITY, STATE ZIP]

RE: [PCP Name] TERMINATION

Dear [IPA Contact Name]:

This letter is to acknowledge receipt of your letter dated [Date] requesting the termination of Dr. [Doctor Name] from the IEHP network. Dr. [Doctor Name] will be terminated as an IEHP PCP within [IPA Name] effective [Date] and [his/her] patients will be reassigned to Dr. [New Doctor Name], effective [Date].

Under IEHP Policy 18D, the IPA is required to give IEHP a 60-day advance written notice. This notification of termination is compliant since a 60-day advance written notice was provided.

If you have any questions or concerns, please call me at [PSR Phone #]

Sincerely,

[PSR Name]
Provider Service Representative

cc: [PCP Name]

[First Name Last Name], Chief Operating Officer, IEHP
[First Name Last Name], Director of Provider Relations, IEHP
[PCP File]



[DATE]

[IPA Contact Name] or [Provider Name]
[IPA NAME]
[Address]
[CITY, STATE ZIP]

RE: [PCP NAME] – Enrollment Status Change

Dear [IPA Contact Name/Provider Name]:

This letter is to inform you that [PROVIDER NAME] PCP status has been changed to “Frozen” for Member enrollment due to [REASON FOR FREEZE]. This change will become effective as of [EFFECTIVE DATE]. This freeze applies only to Auto Assignment, HCO Enrollment, Family Assignment and Member Choice.

If you have any questions or concerns, please call me at [PSR PHONE #].

Sincerely,

[PSR NAME]
Provider Services Representative

cc: PCP
IPA
[FIRST NAME LAST NAME], Chief Operating Officer, IEHP, 130.d
[FIRST NAME LAST NAME], Director of Provider Relations, IEHP
PCP File

HOSPITAL GEOGRAPHIC SERVICE AREAS

Hospital Name	Service Area
Community Hospital of San Bernardino	S1
St. Bernardine Medical Center	S1
Hemet Valley Medical Center	R3
John F. Kennedy Memorial Hospital	R2
Menifee Valley Medical Center	R3
Kaiser Foundation Hospital MVH	R1
Desert Regional Medical Center	R2
Loma Linda University Medical Center - Murrieta	R3
Loma Linda University Medical Center	S1
Temecula Valley Hospital Inc	R3
Loma Linda University Children's Hospital	S1
Arrowhead Regional Medical Center	S1
Parkview Community Hospital Medical Center	R1, R3
Kaiser Fontana	S1
Kaiser Riverside	R1, R3
Corona Regional Medical Center	R3
Riverside University Health Care System	R1, R3
Victor Valley Global Medical Center	S3
Riverside Community Hospital	R1, R3
Pomona Valley Hospital Medical Center	S2
Rancho Springs Medical Center	R3
Inland Valley Regional Medical Center	R3
Redlands Community Hospital	S1
San Geronio Memorial Hospital	S1
Montclair Hospital Medical Center	S2
Barstow Community Hospital	S3
Mountains Community Hospital	S1
Eisenhower Medical Center	R2
St Mary Medical Center	S3

Chino Valley Medical Center	S2
Desert Valley Hospital	S3
Bear Valley Community Healthcare	S1
Hi Desert Medical Center	S3
San Antonio Community Hospital (Medicare only)	S2

HOSPITAL GEOGRAPHIC SERVICE AREAS

R1 Riverside Proper

Moreno Valley, Nuevo, Perris, Riverside

R2 Low Desert

Amboy, Cathedral City, Coachella, Desert Hot Springs, Indian Wells, Indio, Joshua Tree, La Quinta, Landers, Marine Corp Base, Mecca, Morongo Valley, North Palm Springs, Palm Desert, Palm Springs, Pioneer Town, Rancho Mirage, Thermal, Thousand Palms, Twenty-nine Palms, Whitewater, Yucca Valley

R3 Corona/Temecula/Hemet Region

Aguanga, Anza, Corona, Fallbrook, Hemet, Homeland, Idyllwild, Lake Elsinore, Menifee, Mira Loma, Mountain Center, Murrieta, Norco, San Jacinto, Sun City, Temecula, Wildomar, Winchester

S1 San Bernardino Proper

Angelus Oaks, Banning, Beaumont, Big Bear City, Big Bear Lake, Bloomington, Blue Jay, Bryn Mawr, Cabazon, Calimesa, Cedar Glen, Cedarpines Park, Colton, Crest Park, Crestline, Fawnskin, Fontana, Forest Falls, Grand Terrace, Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Loma Linda University, Mentone, Patton, Redlands, Rialto, Rimforest, Running Springs, San Bernardino, Sky Forest, Sugar Loaf, Twin Peaks, Veteran's Hospital, Yucaipa

S2 West San Bernardino

Chino, Chino Hills, Claremont, Guasti, Hacienda Heights, La Verne, Montclair, Mount Baldy, Ontario, Pomona, Rancho Cucamonga, Upland

S3 High Desert

Adelanto, Apple Valley, Baker, Barstow, Daggett, Fort Irwin, Helendale, Hesperia, Hinkley, Lucerne Valley, Ludlow, Lytle Creek, Newberry

Springs, Oro Grande, Phelan, Pinon Hills, Victorville, Wrightwood,
Yermo

99 Out of Area

Big River, Blythe, Cima, Desert Center, Essex, Mountain Pass, Needles,
Nipton, Parker Dam, Red Mountain, Roland Heights, Trona.



IEHP PCP Leave of Absence Coverage Form

In compliance with IEHP Provider Policy **18.I Leave of Absence**, which requires an adequate coverage plan for all leaves of absence from my practice greater than two (2) weeks,

I, _____, have entered into an Agreement with
(PCP Name)
_____ who will be available to my
(Covering Provider's Name /or Group Name)
IEHP patients for direction of care during my absence.

_____ can be reached at _____,
(Covering Provider's Name/ Group Name) (Telephone #)
located at _____
(Address)

In the event I enter into a different Agreement for coverage during a leave of absence, I will provide IEHP sixty (60) days advance written notification who the covering Provider will be during any future leaves of absence.

I understand the information provided above will be utilized by IEHP when directing my IEHP patients during any leave of absences greater than two (2) weeks. If IEHP does not receive notification of coverage for a leave of absence greater than two (2) weeks, my panel may be frozen until a coverage plan is received or pending my return. A leave of absence greater than ninety (90) days could result in a transfer of assigned Members to another PCP.

Physician Name

Date



[DATE]

[IPA Contact Name] or [Provider Name]
[IPA NAME]
[Address]
[CITY, STATE ZIP]

RE: [PCP NAME] – Enrollment Status Change

Dear [IPA Contact Name/Provider Name]:

This letter is to acknowledge the offices request dated [DATE] requesting that [PCP NAME] status be changed from [CURRENT STATUS] member enrollment to “Limited” member enrollment.

Limited meaning PCP does not receive new Member enrollment through auto-assignment. PCP will receive minimum enrollment only through Member requests, HCO enrollment, or family link or PCP receives reinstated Members. This change will become effective [EFFECTIVE DATE].

If you have any questions or concerns, please call me at [PSR PHONE NUMBER].

Sincerely,

[PSR NAME]
Provider Services Representative

cc: PCP
IPA
[FIRST NAME LAST NAME], Chief Operating Officer, IEHP, I.130.d
[FIRST NAME LAST NAME], Director of Provider Relations, IEHP
PCP File

«IEHP_ID»
«Med_Name»
«Add_2» «Add_1»
«City», «STATE» «Zip_code»

September 10, 2019

Dear «Greeting02»,

We're writing to let you know that your current Primary Care Doctor, Dr. «Oldpcpname», located at «Oldpcpadd», «Oldpcpcity» will be leaving IEHP as of «mleffec».

What does this change mean to you?

To make sure there will be no break in your care, IEHP has assigned a new Primary Care Doctor, Dr. «Newpcpname». If you wish to change your new Doctor, please go to My IEHP Health Account at www.iehp.org or call IEHP Member Services.

Listed below are Dr. «Newpcpname»'s office location, and the name and address of the hospital where you should go to get care.

<u>Dr. «Newpcpname»</u>	<u>«Newhos»</u>
«Newpadd»	«Newhosadd»
«Newpcity», «NewPState» «NewPZip»	«Newhoscity», «NewHosSte» «NewHosZip»
«NewPPhone»	«NewHosPhne»

We will mail you a new IEHP Member Card. When you get the new card, destroy the old one. If you do not get the new card, please call IEHP Member Services at 1-800-440-IEHP (4347), Monday – Friday, 8am – 5pm. TTY users should call 1-800-718-4347.

Be assured – all your Medi-Cal benefits will stay the same.

If you are receiving care for one of the items on the list below or have certain services already scheduled after «mleffec», you can request permission to continue receiving those medical services. To learn more about continuity of care and eligibility qualifications, please call IEHP Member Services at 1-800-440-IEHP (4347), Monday – Friday, 8am – 5pm. TTY users should call 1-800-718-4347.

- Pregnancy
- Treatment for a serious chronic condition
- Treatment for an acute chronic condition
- Treatment that may require prompt medical attention
- Care of a newborn child up to 36 months of age
- Terminal illness
- Surgery or procedure that IEHP authorized

California Department of Managed Health Care

If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact IEHP Member Services, and if you have further questions, you are encouraged to contact the **Department of Managed Health Care**, which protects HMO consumers, by telephone at its toll-free number, **1-888-HMO-2219 (1-888-466-2219)**, or at a TTY number for the hearing impaired at **1-877-688-9891**, or online at **www.hmohelp.ca.gov**.

California Department of Health Care Services (DHCS) Office of the Ombudsman

For help with Medi-Cal, you may call the California Department of Health Care Services (CDHCS) Ombudsman Office at 1-888-452-8609. The Ombudsman Office helps people with Medi-Cal make use of their rights and responsibilities.

Thank you for trusting IEHP to take care of your health care needs.

Sincerely,

Member Services
Inland Empire Health Plan

MK-18-1169772

«IEHP_ID»
«Med_Name»
«Add_2» «Add_1»
«City», «STATE» «Zip_code»

10 de septiembre de 2019

Estimado «Greeting02»:

Le escribimos para informarle que su Doctor de Cuidado Primario, el Dr. «Oldpcpname», ubicado en «Oldpcpadd», «Oldpcpcity» dejará a IEHP a partir del «mleffec».

¿Qué significa esto para usted?

Para asegurarnos de que no haya interrupción en su atención médica, le hemos asignado un nuevo Doctor de Cuidado Primario, el Dr. «Newpcpname». Si desea cambiar a un Doctor diferente del que le hemos asignado, por favor vaya a Mi Cuenta de Salud de IEHP en www.iehp.org o llame a Servicios Para Miembros de IEHP.

Abajo se encuentra el domicilio y número de teléfono del Dr. «Newpcpname», así como el nombre y domicilio del hospital «Greeting04», a donde debe acudir para recibir atención médica.

<u>Dr. «Newpcpname»</u>	<u>«Newhos»</u>
«Newpadd»	«Newhosadd»
«Newpcity», «NewPState» «NewPZip»	«Newhoscity», «NewHosSte» «NewHosZip»
«NewPPhone»	«NewHosPhne»

Le enviaremos por correo su nueva Tarjeta para Miembros de IEHP. Cuando reciba la tarjeta nueva, destruya la anterior. Si no recibe la tarjeta nueva, por favor llame a Servicios para Miembros de IEHP al «MbrSvcPhn», lunes – viernes, 8am – 5pm. Los usuarios de TTY deben llamar al 1-800-718-4347.

Puede estar seguro de que todos los beneficios de Medi-Cal seguirán siendo los mismos.

Si está recibiendo atención para uno de los artículos de la lista a continuación o tiene ciertos servicios ya programados después de «mleffec», puede solicitar permiso para continuar recibiendo esos servicios médicos. Para obtener más información sobre la continuidad de atención médica y requisitos de elegibilidad, llame a Servicios para Miembros de IEHP al 1-800-440-IEHP (4347), lunes – viernes, 8am – 5pm. Los usuarios de TTY deben llamar al 1-800-718-4347.

- Embarazo
- Tratamiento para una condición crónica grave.
- Tratamiento para una afección crónica aguda.
- Tratamiento que puede requerir atención médica inmediata.
- Cuidado de un recién nacido hasta los 36 meses de edad.
- Enfermedad terminal
- Cirugía o procedimiento autorizado por IEHP.

Departamento de Atención Médica Coordinada (Department of Managed Health Care)

Si usted ha estado recibiendo servicios de algún proveedor de atención médica, entonces podría tener derecho a continuar atendiéndose con su proveedor por un periodo de tiempo designado. Por favor, comuníquese con Servicios para Miembros de IEHP, y si tiene preguntas adicionales, no dude en comunicarse con el **Departamento de Atención Médica Coordinada (Department of Managed Health Care)**, el cual protege a los usuarios de HMO, a la línea telefónica gratuita al **1-888-HMO-2219 (1-888-466-2219)**, o al número de TTY para personas con dificultades auditivas al **1-877-688-9891**, o en línea en **www.hmohelp.ca.gov**.

Oficina de Defensoría del Departamento de Servicios de Atención Médica (Department of Health Care Services [CDHCS] Ombudsman Office)

Para obtener ayuda con respecto a asuntos de Medi-Cal, usted puede llamar a la Oficina de Defensoría del Departamento de Servicios de Atención Médica (Department of Health Care Services [CDHCS] Ombudsman Office) al 1-888-452-8609. La Oficina de Defensoría ayuda a que las personas con Medi-Cal hagan uso de sus derechos y responsabilidades.

Gracias por confiar en IEHP para atender sus necesidades de atención médica.

Sinceramente,

Servicios para Miembros
Inland Empire Health Plan

MK-18-1169772S



[Date]

[IPA Contact Name]
[IPA Name]
[ADDRESS]
[City, State Zip]

RE: [PCP NAME] TERMINATION

Dear [IPA Contact Name]:

This letter is to acknowledge receipt of your letter dated [Date] requesting the termination of [PCP Name] as a PCP from [PCP Address]. Dr. [PCP Name] membership will be reassigned to Dr. [New PCP Name] to the same location effective [Date].

Under IEHP Policy 18.D, the IPA is required to give IEHP a 60-day advance written notice. This notification of termination is non-compliant due to no 60-day advance written notice was provided.

Because of this requirement IEHP retains the right to obligate the IPA to provide medical services for the PCP's existing patients at the former PCP practice location for up to 60 days. If patient care becomes an issue, efforts will be made to reassign the patients to another PCP; however, there is no guarantee that all patients will remain within your network.

If you have any questions or concerns, please call me at (PHONE NUMBER

Sincerely,

PSR Name
Provider Services Representative

cc: PCP Name
[First Name Last Name], Chief Operating Officer, IEHP
[First Name Last Name], Director of Provider Relations, IEHP
PCP File



[DATE]

[IPA Contact Name] or [Provider Name]
[IPA NAME]
[Address]
[CITY, STATE ZIP]

RE: [PCP NAME] – Enrollment Status Change

Dear [IPA Contact Name/Provider Name]:

This letter is to inform you that Dr. [PCP NAME] PCP status has been changed to “Closed” for Member enrollment. This change will become effective as of [DATE].

Under IEHP Policy 18 A2, the maximum amount of enrollment that Dr. [PCP NAME] is eligible for is [NUMBER] Members. Currently Dr. [PCP NAME] has [NUMBER] Members and [NUMBER] physician extenders in IEHP’s system. If Dr. [PCP NAME] has additional physician extenders who have not been credentialed, please submit their credentialing applications to increase Dr. [PCP NAME] Member capacity. A maximum of four supervised mid-levels is allowed per PCP to increase capacity to a maximum of 6000 Members.

IEHP will continue to monitor Dr. [PCP NAME]’s enrollment numbers. If Dr. [PCP NAME]’s membership should drop below the maximum amount allowable, IEHP will open Dr. [PCP NAME] to enrollment. This would include Auto Assignment, HCO Enrollment, Family Assignment and Member Choice.

If you have any questions or concerns, please contact me at (909) 890-XXXX.

Sincerely,

PSR NAME
Provider Services Representative

cc: PCP
IPA
[FIRST NAME LAST NAME], Chief Operating Officer, IEHP
[FIRST NAME LAST NAME], Director of Provider Relations, IEHP
PCP File

DATE

SENT VIA FEDEX

PROVIDER FIRST NAME M.I. LAST NAME SUFFIX, DEGREE
c/o PRACTICE NAME
ADDRESS
CITY, STATE ZIP

RE: IEHP PEER REVIEW SUBCOMMITTEE DECISION

Dear PROVIDER NAME:

Inland Empire Health Plan (IEHP)'s Peer Review Subcommittee met on (DATE), and reviewed (REASON FOR REVIEW).

Due to evidence documenting (EVIDENCE FOUND), the IEHP Peer Review Subcommittee has made the recommendation to terminate your participation with IEHP.

You have the right to appeal this decision and request a first level appeal, which is held before the IEHP Peer Review Subcommittee. If you wish to request an appeal, your written request must be received within thirty (30) days of receipt of this letter. In a Level I appeal, you will have the right to be present and participate in the proceedings. If you request an appeal, please provide me with copies of any additional information, which you would like to have presented at the Peer Review Subcommittee meeting for your appeal. In addition, please let me know if you wish to be present at the meeting.

If your written request for appeal is not received within thirty (30) days of your receipt of this notice, your rights will be considered waived, and any action recommended by the Peer Review Subcommittee will be presented to the Governing Board of IEHP for final action.

A copy of the IEHP Peer Review (Level I) and Credentialing Policy and Procedures is enclosed for your information and further clarification of your rights in the Level I appeal process.

IEHP will report the final decision of the IEHP Governing Board, to the Medical Board of California and/or the National practitioner Data Bank, as required under California business and professions Codes subsection 805 and 45 of Federal Regulations, Part 60.

PHYSICIAN NAME

DATE

Page 2

Should you wish to discuss this matter further, please feel free to contact me at (909)
(PHONE NUMBER)

Sincerely,

IEHP MEDICAL DIRECTOR'S NAME

Medical Director, IEHP

Peer Review Subcommittee Chairperson

cc: IPA MEDICAL DIRECTOR'S NAME, IPA NAME
[NAME], Chief Operating Officer, IEHP
[NAME], Director of Provider Relations, IEHP
[NAME], Medical Director, IEHP
[NAME], Director of Quality Management
[NAME], Provider Services Representative, IEHP
[NAME], Credentialing Manager, IEHP
[NAME], Credentialing Contact Title, IPA NAME
Provider File

«IEHP_ID»
«FISRT_NAME» «LAST_NAME»
«ADDRESS_1» «ADDRESS_2»
«CITY», «STATE» «ZIP_CODE»

September 10, 2019

Dear «FirstName»,

A change in our Provider Network might affect your health care. Dr. «SpecName», «PDDESC2» Specialist, located at «PAdd1» «PAdd2», «PCity», will no longer be serving IEHP Members as of «MLEffec».

To make sure there is no break in your health care, please call your Primary Care Doctor right away for help finding a new «PDDESC2» Specialist if you need one.

If you are getting care now, you may be able to keep seeing Dr. «SpecName» until your Doctor can help you find a new «PDDESC2» Specialist. It is very important that you talk about this with your Doctor as soon as you can.

Please do not wait. This change may affect your care. Call your Doctor today.

If you have any questions, call IEHP Member Services at 1-800-440-IEHP (4347). TTY users should call 1-800-718-4347.

You can be sure; all your benefits will stay the same. Thank you for trusting IEHP with your health care needs.

Sincerely,

IEHP Member Services
OPS_25_EA_SPT_«SpecialistID»

IMPORTANT INFORMATION about Billings, Authorizations for Services, and your right to Continued Care is printed on the back of this letter. Please be sure to read it.

¿Prefiere esta información en Español? Llame a Servicios para Miembros de IEHP al «Member_Services_Phn».

«IEHP_ID»
«FISRT_NAME» «LAST_NAME»
«ADDRESS_1» «ADDRESS_2»
«CITY», «STATE» «ZIP_CODE»

10 de septiembre de 2019

Estimado/a «FirstName»:

Un cambio en nuestra Red de Proveedores podría afectar su atención médica. El/la Dr./Dra. «SpecName», Especialista en «PDDESC2», ubicado/a en «PAdd1» «PAdd2», «PCity», ya no atenderá a los Miembros de IEHP a partir del «MLEffec».

Con el propósito de asegurarnos de que no se interrumpa su atención médica, por favor llame a su Doctor de Cuidado Primario de inmediato para que le ayude a encontrar un nuevo Especialista en «Pddesc2» si lo necesita.

Si actualmente está recibiendo atención, es posible que pueda seguir acudiendo con el/la Dr./Dra. «SpecName» hasta que su Doctor/a pueda ayudarle a encontrar un nuevo Especialista en «PDDESC2». Es muy importante que hable acerca de esto con su Doctor/a lo más pronto que pueda.

Por favor no espere. Este cambio puede afectar su atención médica. Llame a su Doctor hoy mismo.

Si tiene alguna pregunta, comuníquese a Servicios para Miembros de IEHP al 1-800-440-IEHP (4347). Los usuarios de TTY deben llamar al 1-800-718-4347.

Puede estar seguro/a de que todos los beneficios de usted seguirán siendo los mismos. Gracias por confiar en IEHP para atender sus necesidades de atención médica.

Atentamente,

Servicios para Miembros de IEHP
OPS_25_SA_SPT_«SpecialistID»

Al reverso de esta carta encontrará INFORMACIÓN IMPORTANTE sobre Facturación, Autorización de Servicios y su derecho a Continuidad de la Atención Médica. Por favor, asegúrese de leerla.

¿Prefiere esta información en inglés? Llame a Servicios para Miembros de IEHP al «Member_Services_Phn».

Specialty Network Review

<<IPA Name>> | <<Hospital Name>>

CORE SPECIALTY NETWORK				
SPECIALTY	TOTAL # OF PROVIDERS	# OF PROVIDERS ON UNIQUE CONTRACTS	STATUS	NOTES
Cardiology				
Dermatology***				
Endocrinology				
Gastroenterology				
General Surgery				
Infectious Disease/HIV Specialist				
Nephrology				
Neurology				
OB/GYN				
Orthopedics Surgery				
Otolaryngology (ENT)				
Ophthalmology				
Oncology/Hematology				
Physical Medicine and Rehabilitation				
Pulmonary Medicine				

GEOGRAPHIC SPECIALTY NETWORK				
SPECIALTY	TOTAL # OF PROVIDERS	# OF PROVIDERS ON UNIQUE CONTRACTS	STATUS	NOTES
Allergy and Immunology***				
Cardiac/Thoracic Surgery				
Neurosurgery (if the hospital provides this service)				
Pain Management				
Pediatric Subspecialties**				
1. Pediatric Cardiology				
2. Pediatric Gastroenterology				
3. Pediatric Ophthalmology				
4. Pediatric Neurology				
5. Pediatric Orthopedics				
Pediatric Surgery				
Physical & Speech Therapy***				
Plastic Surgery				
Podiatry***				
Rheumatology				
Urology				
Ancillary Providers				
1. Audiology				
2. Diagnostic Radiology				
3. DME				
4. Home Health				
5. Home Infusion Agency				
6. Imaging/Diagnostic/X-Ray				
7. Laboratory				
8. Radiology				

Specialty	Grid Rules
Podiatry	Covers Podiatric Surgery
Orthopedics	Covers Orthopedic Surgery
Neurology	CANNOT cover Neurosurgery

* If Provider does NOT have hospital privileges - to which Hospital do they refer? Must be within 15 miles/30 minutes (exception may be made at the Provider Relations Manager discretion)

** If IPA states they refer to Loma Linda or a neighboring hospital, then they are compliant. Must be within 15 miles/30 minutes (exception may be made at the Provider Relations Manager discretion)

Specialty Network Review

<<IPA Name>> | <<Hospital Name>>

*** Specialties NOT requiring Hospital Privileges