



<b>Policy and Procedure No: PR 12.4</b>		<b>Revision No: 4</b>
<b>Division: Care Management</b>		
<b>Department: Provider Relations</b>		
<b>Title: PHC-CA Delegation Oversight and Contract Management</b>		
<b>Effective Date: 1/1/2022</b>		
<b>Supersedes Policy No: PR 12.1, PR 12.2, PR 12.3</b>		
<b>Reviewed/Revised by: Sandra Holzner</b>		<b>Review/Revision Date: 12/1/2025</b>
<b>Approving Committee: Member Provider Committee</b>		<b>Date: 12/15/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>		

**Purpose:**

To establish PHC California (Health Plan) guidelines pertaining to the oversight and management of delegated activities as well as implement an effective method of contracting and monitoring procedures with delegates and/or subcontractors.

**Policy:**

The Health Plan’s Provider Relations Department will be responsible for the contracting of network contracted delegates and/or subcontractors. The Provider Relations Department coordinates the initial pre-delegation audit activities with internal departments, coordinates annual delegation audit activities and facilitates the monitoring activities via quarterly Joint Operations Committee meetings.

The Provider Relations Department will ensure internal departments understand that although the Health Plan has delegated certain functions/tasks to a contracted delegates and/or subcontractors to perform, the Health Plan is ultimately responsible for all services, terms and conditions of the Health Plan’s agreement with the Department of Health Care Services (DHCS).

**Procedure:**

**Initial Contract**

1. When entering into a contract with a delegated entity, the Health Plan ensures compliance with all applicable regulatory requirements set forth by the California Department of Managed Health Care (DMHC), the Centers for Medicare & Medicaid Services (CMS), and the California Department of Health Care Services (DHCS). See Plan Policy and Procedure PHC-CA Delegation and Subcontractor Network Certification.
  - a. Before entering into a contract with a delegate or subcontractor, the Health Plan conducts a pre-delegation audit to evaluate the following:
    - i. The delegate’s and/or subcontractor’s ability to perform the delegated activities prior to delegation.
    - ii. Whether the delegate and/or subcontractor has appropriate policies and procedures, downstream provider agreements (if applicable), operating systems, qualified staff, and sufficient resources to effectively perform the delegated functions.

- iii. Where the delegates and/or subcontractors meet the above requirements, any contract entered into with a Delegate/subcontractor must include, at a minimum, the following provisions in contractual agreements:
  1. CMS or their designee has the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s), first-tier and downstream entities involving transactions related to the contract with the Health Plan.
  2. CMS, or its designee's, right to inspect, evaluate, and audit any pertinent information for any particular contract period will apply up to ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.
  3. Delegate/subcontractor's agreement to safeguard Plan Members privacy and confidentiality and assure accuracy of beneficiary health records.
  4. Delegate/subcontractor's agreement to hold Plan Members harmless for payment of fees that are the legal obligation of the Health Plan
  5. Delegate/subcontractor will comply with Medicare laws, regulations, and CMS instructions, agree to audits and inspections by CMS and/or its designee, and keep records for a minimum of ten (10) years.
  6. Delegates and/or subcontractors agree to comply with the Health Plan's policies and procedures.
  7. Where the contract is for administrative services, the contract shall clearly state the responsibilities of the administrative service provider and its reporting requirements.
  8. Both the Health Plan and the delegates and/or subcontractors have the right to terminate the contract if the terms of the contract are not satisfactorily performed.
2. A reinsurer contract is executed and maintained for a national multi-organ transplant (MOT) center of excellence (COE) network. The Health Plan delegates MOT COE network contracting functions to the reinsurer. The Health Plan's contract with its reinsurer stipulates ongoing MOT COE network maintenance to ensure access needs are met for enrollees. The Health Plan shall retain responsibility for utilization management and care coordination/care management functions for MOT cases.
3. Contracts for services under the Health Plan's contract with DHCS
  - i. DHCS incorporate and require the inclusion of all clauses required by CMS.
  - ii. Subcontractors will comply with all with Medicaid/Medi-Cal laws, regulations, and DHCS instructions.
  - iii. In order to enter into a contract with a delegated entity, they must be eligible for participation in the State of California's Medi-Cal program.

- iv. If a delegate and/or subcontractor is involuntarily terminated from the Medicaid/Medi-Cal program other than for purposes of inactivity, the delegates and/or subcontractors is no longer an eligible subcontractor.
- v. Contracts shall provide for monitoring of services rendered to beneficiaries delegate and/or subcontractor.
- vi. DHCS require the contract identify the population covered by the contract

**Pre-Delegation Audit and Annual Audit**

1. Delegate and/or subcontractor agreements must outline specific services and/or delegated activities.
  - a. Eligible Delegation Activities
    - i. Credentialing/Re-credentialing
    - ii. Provider Contracting and Provider Relations
    - iii. Quality Management Improvement
    - iv. Claims Payment
    - v. Utilization Management (Referrals and Authorization)
    - vi. Member Services
    - vii. Provider Grievances
    - viii. Information Technology (834, 835 & 837 data exchange)
  - b. All reporting due dates, financial and any other applicable requirements necessary to deliver on contracted activities to Health Plan.
  - c. Delegate and/or subcontractor agreements shall include “Business Associate Agreement” which contain the purpose for which Business Associate may use or disclose PHI.
  - d. Provider Relations department will coordinate with internal department on scheduling pre-delegation assessments.

**Delegation Oversight Corrective Action Plans (CAP)**

1. Corrective Action Plan
  - a. The Health Plan monitors delegate and subcontractor compliance with requirements set forth by the Health Plan, Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). Scoring categories are as follows:
    - i. Full Compliance 90-100%



- ii. Non-compliance
- b. All delegates and/or subcontractors with scores less than 100% may be required to submit a CAP to remedy any deficiencies.
  - i. The delegate and/or subcontractor must submit a complete and comprehensive CAP to the Plan that adequately addresses all deficiencies for each section.
  - ii. A CAP is considered complete only if all deficiencies from each section are present and submitted together
  - iii. The delegate and/or subcontractor are responsible for coordination of its CAP response with each of its internal departments responsible for addressing audit deficiencies.
  - iv. The CAP must be submitted to the Health Plan within thirty (30) calendar days of written notification by the Plan of the audit results
  - v. Upon receipt of the initial CAP, the Health Plan reviews the CAP and either approves or denies the CAP in writing within thirty (30) calendar days of receipt.
- c. Delegates and/or subcontractors wishing to appeal the results of the initial audit report must do so in writing to the Plan within thirty (30) calendar days of receiving their results. Delegates must cite reasons for their appeal, including disputed items or deficiencies.
- d. After receiving a written appeal, the Health Plan will respond to the appealing delegates and/or subcontractors in writing, noting the status of the appeal. Once an appeal is received, all additional documentation submitted by the delegate and/or subcontractor is reviewed and, if appropriate, scores may be adjusted. If necessary, a re-assessment audit is performed for areas with scores being appealed.
- e. Failure to submit a CAP
  - i. Failure to demonstrate CAP implementation and sustained improvement as outlined in the Corrective Action Plan may result in further action including:
    - 1. Sanction;
    - 2. Request for cure under contract compliance;
    - 3. De-delegation of specified functions;
    - 4. Contract non-renewal; or
    - 5. Contract termination.

## Monitoring

- 1. The Provider Relations Department will coordinate Delegate/subcontractor Management/Joint Operation Meetings (JOM) on a biannual or quarterly basis to ensure the Health Plan and delegate

and/or subcontractors will have a formalized forum to focus on the following key attributes of an effective relationship:

- a. Formal review of the contract performance indicators and delegated activities in accordance with the terms of the existing agreement(s).
  - b. Review of any member service issues and ensure that steps are taken to address root causes.
  - c. Establish collaborative communication and issue resolution to continually build and strengthen business associate relationship between the Health Plan and the delegate and/or subcontractor.
2. The Health Plan's reinsurer executes national contracts with MOT COEs. The reinsurer actively coordinates with the Health Plan's Medical Director(s) and Utilization Management (UM) Department Management to review applicable MOT cases to ensure member access needs are met for the appropriate service needs of the members.
3. Membership of Delegate/subcontractor Management/JOC meets:
- a. The Health Plan
    - i. Contracting and Provider Relations
    - ii. Medical Director
    - iii. Utilization Management
    - iv. Quality Improvement
    - v. Claims
    - vi. Credentialing
    - vii. Member Services
  - b. Delegate/subcontractor (***as applicable***)
    - i. Utilization Management
    - ii. Credentialing
    - iii. Quality Improvement
    - iv. Member Services
    - v. Claims
    - vi. Information Technology
    - vii. Finance



- c. Venue and Frequency
    - i. Meetings will occur biannually or quarterly at a mutually agreed upon location or via teleconference.
    - ii. Additional meetings may be conducted on a more frequent basis if business need arise.
4. Delegate/subcontractor quarterly update of the performance against contracted mandated network performance indicators or mutually agreement upon performance metrics.
    - a. Utilization Management
    - b. Network Management
    - c. Credentialing
    - d. Member Services
    - e. Complaints, Grievances and Appeals
    - f. Quality Improvement
  5. Updates on the progress of collaborative efforts to address member serving issues and process inefficiencies.
  6. Roles and Responsibilities:
    - a. Manager/Director of Contracting and Provider Relations:
      - i. Solicit agenda items and supporting document from internal & external business partners;
      - ii. Schedules meetings and develops agenda's.
      - iii. Coordinate meeting rooms, arrange equipment, schedule webinar & audio conferences;
      - iv. Distribute supporting documents and agendas at least three (3) business days prior to scheduled meeting;
      - v. Maintain an issue log and ensure adequate resolution and response time;
      - vi. Serve as the primary point of contact to facilitate open lines of communication;
      - vii. Record meeting minutes and distribute to the meeting participants;
      - viii. Provides updates on the status and quality of the delegates and/or subcontractors Encounter Data submission process.



- b. The delegates and/or subcontractors
  - i. Provides updates and required meeting materials to the Health Plan facilitator based on the timelines as outlined in Provider Agreement.

## 7. Required Reports and Agenda Items

- a. Health Plan to review with Delegate/subcontractor (**examples**)
  - i. Issue Log Status and Trend Analysis
  - ii. Complaints, Grievance and Appeals
  - iii. Member Access
  - iv. Encounter Data Submission Summary (Error Rate)
  - v. Contract Leakage
- b. Delegates and/or subcontractors reports to be provided (**examples**)
  - i. Authorized Services – Monthly/Quarterly submission
    - 1. By line of business (LOB)
  - ii. Complaint & Grievances – Monthly/Quarterly submission
- c. Claim Process – Monthly/Quarterly
  - i. Paid
  - ii. Denied
  - iii. Pended
  - iv. By line of business
- d. Customer Service Statistics (*provide standard*) – Monthly/Quarterly submission
  - i. Average speed of answer
  - ii. Average hold time
  - iii. Call Volume
- e. Credentialing Report – Monthly/Quarterly
- f. Network Access & Availability Analysis (GeoAccess) – Annual submission
- g. Provider Satisfaction Survey – Annual submission

- h. Fraud, Waste & Abuse Training – Annual Submission
- i. Delegate/subcontractor Operating Policies & Procedures (*of delegated services*) – Annual Submission
- j. Claims
  - i. Claim Lag Report
  - ii. Claims Adjudication Codes
- k. Utilization Management
- l. Credentialing
- m. Provider Contracting/Network Management
- n. Member Service(s)
- o. Quality Improvement
- p. Business Continuation Plan – Annual Submission
- q. Financial Information
- s. Provider Agreement – Annual Submission
- t. Provider Manual – Annual Submission

**Definitions:**

1. Corrective Action Plan (CAP): is a written statement identifying the deficiency, root cause and description of the detailed plan of action that is developed to achieve targeted outcomes to correct the deficiency, and the operational results of that action which ensure the deficient practices are not repeated. For deficiencies that required long term corrective action or a period of longer than thirty (30) calendar days to remedy or operationalize, the delegate and/or subcontractor must demonstrate it has taken remedial action and is making progress toward achieving acceptable level of compliance. The CAP must include the date when full compliance is expected to be achieved.
2. Delegate: An individual or entity contracted with the Plan to provide administrative services or health care services for a Plan Member.
3. Subcontractor: an individual or entity that has a Subcontractor Agreement with the Plan that relates directly or indirectly to the performance of the Plan’s obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
4. Downstream Subcontractor: an individual or entity that has a Downstream Subcontractor Agreement with a Subcontractor of the Plan or a Downstream Subcontractor that relates directly or indirectly to the performance of the Subcontractor’s obligations under its Subcontractor Agreement with the Health Plan.



5. Subcontractor Network: a Provider Network of a Subcontractor or Downstream Subcontractor, wherein the Subcontractor or Downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.

**Monitoring:**

This policy is updated as often as necessary and reviewed and approved annually by the Member Provider Committee.

**Reference(s):**

1. Health Plan Policy and Procedure PHC-CA Delegation and Subcontractor Network Certification.
2. Title 28 CCR 1300.67.2.2(a)(3), (d), (h)(6)(A)(iii)

