



<b>Policy and Procedure No: CO 12.8</b>	<b>Revision No: 8</b>
<b>Division: Care Management</b>	
<b>Department: Compliance</b>	
<b>Title: PHC-CA Delegation Oversight</b>	
<b>Effective Date: 3/1/2017</b>	
<b>Supersedes Policy No: CO 12.0, CO 12.1, CO 12.2, CO 12.3, CO 12.4, CO 12.5, CO 12.6, CO 12.7</b>	
<b>Reviewed/Revised by: Sandra Holzner</b>	<b>Review/Revision Date: 12/12/2025</b>
<b>Approving Committee: Compliance Committee</b>	<b>Date: 12/15/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>	

**Purpose:**

This policy and procedure details the Health Plan’s process guidelines for effective oversight of its Delegated Entities/First-tier, Downstream and Related Entities (“FDR’s) delegated to perform administrative or health care service functions relating to the Plan’s Medicare and Medicaid contract(s) with the Centers for Medicare & Medicaid Services (CMS) and the Department of Healthcare Services (DHCS) to ensure compliance with statutory, regulatory, and contractual requirements, and the Health Plan’s policies and procedures.

**Policy:**

1. The Health Plan shall provide oversight of the functions and responsibilities, processes, and performance of a Delegated Entity and its Delegated Services.
  - a. The Plan shall provide oversight of delegates’ compliance with standards as set forth in Health and Safety Code section 1367, subs c and d, including oversight of subcontracted plans, provider groups, or other contracting entities who have been delegated services or activities that a Plan is required to perform.
2. The Health Plan ensures that its subcontractors and network provider are informed of and comply with all relevant state and federal laws, contract requirements, CMS and other DHCS/DMHC guidance, including All Plan Letters (APLs) and Policy Letters.
3. The Health Plan’s oversight activities include review of compliance with regulatory requirements, contractual requirements and policies and procedures. The Health Plan’s Compliance Department identifies whether a Delegated Entity’s performance is adequate or inadequate and collaborates with the functional (Provider Relations/Contracting, Utilization Management, Claims, Financial Viability, etc.) business owners to monitor a Delegated Entity’s performance to ensure that improvement occurs where performance is inadequate.
4. The Health Plan shall continually assess a Delegated Entity’s ability to perform delegated functions through initial reviews, ongoing monitoring, performance reviews, analysis of data, and utilization of benchmarks, if available.
5. At a minimum, audits of Delegated Entities will be conducted annually by desktop review, on-site review and/or webinar. The Compliance Officer shall ensure audits are conducted at reasonable times at the Delegated Entity’s place of business or another mutually agreeable location.

6. If or any authorized representative including, but not limited to, the State or Federal government, Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), or the Department of Health and Human Services (DHHS) Inspector General, determines there is a reasonable possibility of Fraud or similar risk, the aforementioned agencies may inspect, evaluate, and audit the Delegated Entity at any time.
7. The Health Plan shall revoke the delegation of activities or obligations or specify other corrective action remedies in instances where DHCS or the Health Plan determine that the Delegated Entity has not performed satisfactorily.
8. The Health Plan shall inform the Delegated Entity of prospective requirements to be met before the effective agreement date. The Delegated Entity shall comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by the Health Plan.
9. The Delegated Entities shall maintain contracts, books, documents, records, encounter data and financial statements for a minimum of ten (10) years from the final date of the contract period or from completion of any audit or investigation, whichever is later and shall be available for inspection, evaluation, monitoring, and auditing to:
  - a. The Health Plan or its Designee.
  - b. Any authorized representative of the state or federal government, including the DHCS, CMS, the U.S. Health and Human Services Office of Inspector General, the Comptroller General, the U.S. Department of Justice, and the Department of Managed Health Care (DMHC); and
  - c. Any quality improvement organization, accrediting organization (e.g., AAAHC, NCQA, their Designees, and other representatives of regulatory or accrediting organizations.
10. Upon request, the Health Plan or its designated representatives shall have the right to inspect, review, and make copies of such records, at the Delegated Entity's expense, to facilitate obligation to conduct oversight activities.

**Procedure:**

- A. Identifying First-Tier Downstream and Related Entities and the Pre-Delegation Process
  1. When an entity is recommended for contracting, the Compliance Department will be notified and will determine whether the entity is an FDR (Delegated Entity).
    - i. Compliance will use the FDR Identification Analysis tool (Attachment A) which uses criteria set forth by DHCS or CMS to determine the entity's FDR status.
  2. Once an entity is identified as an FDR, a document request letter (Attachment B) will be mailed to the entity requesting all relevant documents needed to perform a pre-delegation assessment.
  3. Once documents are collected from the entity, the Compliance Department will perform a pre-delegation assessment of the entity using the pre-delegation assessment tool (Attachment C).



4. After the Compliance Department completes the pre-delegation assessment, it will present its findings to the Compliance Committee.
5. The Compliance Committee will then review the findings for approval.
6. Once an FDR 's pre-delegation assessment is approved, the Contract is executed.

B. Data collection from Delegated Entities. Data collection is not a standardized process and must address the unique processes, systems and reporting methods of each Delegated Entity.

1. Collection Process. Each operational area and the Compliance department develop a process for requesting and/or obtaining required data from FTEs and/or REs in a timely manner.
2. Attestations:
  - i. Operational Director's notify FTE and REs of their responsibility to monitor DEs for compliance with applicable laws, regulatory guidance and Plan policies. As part of its monitoring activities, the Compliance department collects compliance attestations from FTEs and REs annually (Attachment D).
3. Policies and Procedures
  - i. Relevant policies and procedures are provided to Delegated Entities. Delegates and Subcontractors may develop their own policies and procedures for performing specific functions. Those policies and procedures are collected and reviewed by Compliance on an annual basis.
4. Communication and Training
  - i. Communication with delegated entities is customized and communication is directed by results of auditing, monitoring, and other data related to the delegated entities.
5. Reporting Timetables. Operational Director's and the Compliance Department establish reporting timetables to ensure timely data collection
  - i. Operational Director's work with their Delegated Entity's to determine which reports and data sets appropriately capture and measure performance indicators for monitored activities

C. Oversight Areas

1. The areas for oversight focus include, without limitation, the following:
  - i. Credentialing and Recredentialing
  - ii. Care Management, Continuity of Care, and Care Transitions
  - iii. Financial Solvency

1. Policies and Procedures relating to the DE's systems for budgeting and operations forecasting and monitoring financial viability.
2. Annual Audited Financial Reports (if applicable)

- iv. Utilization Management
- v. Claims Processing
- vi. Information Systems Management
- vii. Compliance Program
- viii. Network Management
- ix. Policies and Procedures
- x. Reporting and Monitoring
- xi. Regulatory Initiatives.

D. Monitoring Measures. The Compliance Department performs an annual risk assessment of all functional areas and Delegated Entities. In conjunction with responsible operational areas, The Compliance department develops an annual monitoring work plan. This Work Plan describes monitoring activities conducted by, or on behalf of, the Compliance Department by the applicable Plan operational area.

1. Performance Indicators. Possible performance indicators include process cycle time, timeliness of member notices appropriateness of member contact, correctness of decisions, compliance of contracted entities etc.
  - i. For every monitored FTE and RE, the responsible operational area director develops benchmarks and performance measures to assess compliance with applicable laws, regulations and Plan policies.
    1. Each operational area director, with input from the Compliance Officer, develops an internal monitoring plan documenting its performance indicators, monitoring methods and monitoring frequency.
    2. For processes involving more than one operational area, performance indicators must measure each area's compliance with requirements for its portion of the process.
2. Monitoring Methods. Possible monitoring methods include conducting risk assessments, completion of self-assessments, data review, charts and graphs, spot checks, random sample reviews, staff interviews, etc.
  - i. The director for the applicable operational area develops and implements suitable monitoring methods for each performance indicator and/or benchmark.

3. Monitoring Frequency. The Health Plan bases monitoring frequency on many factors including but not limited to, regulatory thresholds, internal risk factors identified in the annual risk assessments, standard industry benchmarks, audit findings, and internally identified outliers as the result of previous monitoring and auditing activities, etc.
  - i. Plan directors' monitor activities with a frequency appropriate to the process and in keeping with its risk level (e.g., daily/weekly/monthly/quarterly, etc., spot checks or testing)

E. Assessing Compliance. The Compliance Department shall utilize terminology and a procedure consistent with that derived from various audit processes to evaluate internal monitoring or audit results.

1. Any non-compliant measure or audit results is a "condition." Conditions will fall into one of the following categories:
  - i. Immediate Corrective Action Required (ICAR): non-compliance with regulatory requirements with the potential to cause significant beneficiary harm. Significant beneficiary harm exists if:
    1. The non-compliance resulted in the Plan's failure to provide medical services or prescription drugs, causes financial distress, or poses a threat to beneficiary health or safety due to non-existent or inadequate policies and procedures, systems, internal controls, operations or staffing. *Example*: Misclassifying organization determinations or appeals as grievances or failure to effectuate overturns or appeals.
  - ii. Corrective Action Required (CAR): material non-compliance with regulatory requirements that does not have the potential to cause significant beneficiary harm. Non-compliance is usually due to:
    1. Non-existent or inadequate policies and procedures, systems, internal controls, operations or staffing. *Example*: Failure to establish and implement an effective system for monitoring the Plan's Delegated Entity's' compliance with CMS requirements.
  - iii. Observations. Immaterial events of non-compliance with regulatory requirements or other observations that may be useful to management in preventing material non-compliance in the future.
    1. Non-compliance due to isolated human error generally falls into the category of Observations, unless there is potential for significant beneficiary harm. *Example*: Failure to include correct criteria in a coverage determination denial letter due to an isolated human error.

F. Delegated Entity Monitoring. Various Plan operational areas retain responsibility for overseeing ongoing Delegated Entity compliance in the administration and delivery of benefits to the Health Plan members. These areas include, but may not be limited to, Customer Care, Claims, Credentialing, Enrollment, Utilization Management and Fulfillment.

1. Delegated Entity Dashboards. Each operational area documents the monitoring measures in a dashboard.
  - i. Each applicable operational area and the Compliance department enter new and/or additional performance indicators into the dashboard annually and as needed.
  - ii. The data capture in the dashboard includes:
    1. Description of the monitored activity
    2. Name of Plan operation area responsible for oversight
    3. Scope of performance review and threshold amounts
    4. The performance indicator (benchmarks)
    5. Monitoring frequency
    6. Monitoring results for all the reporting periods for the given year.
2. Inputting Collected Data. The Plan directors' input collected data from Delegated Entity's and complete all relevant fields into the dashboards for applicable time period(s).
  - i. If any measures are incomplete or unavailable for a reporting period, the applicable director provides notes in the dashboard explaining the lack of data.
3. Evaluating Performance Indicators. The operational area director reviews all data entered into the dashboard and evaluates each performance measure against the threshold and/or benchmark. [Benchmarks reflect either the CMS or DHCS requirement. Each line of business will have its own dashboard].
  - i. Compliant measures are highlighted green.
  - ii. Non-compliant measures are highlighted red.
  - iii. Dashboards are used to track and trend and develop process improvement measures based on trends.
4. Submitting Data to the Compliance Department. On a monthly/quarterly basis, the Compliance Officer or their designee issues an email to all applicable operational area directors with the deadline for submitting completed dashboards to the Compliance Department.
  - i. Each operational area director ensures that all required data collection and inputting is accurate and complete for all reporting periods.
  - ii. Each operational area director submits a completed dashboard to the Compliance Department by the stated deadline.
5. Development of the Master Dashboard. The Compliance Officer compiles a master dashboard from all submissions from each operational area.

- i. The Compliance Officer creates a final, comprehensive dashboard of based on the monitoring data and shares with the Compliance Committee on a quarterly basis.

G. Delegated Entity Audits. At least annually, the Compliance Department shall schedule an audit with the Delegated Entity. The Compliance Department may determine to conduct more frequent audits and/or targeted audits. The Health Plan utilizes multiple methods to audit Delegated Entities including on-site audits, desk reviews and monitoring self-audit reports.

1. Auditing Procedure

- i. Routine Audits – the Compliance Officer periodically schedules routine Compliance audits to “spot check” Delegated Entity’s as necessary and at the frequency documented in the Audit Plan. The Compliance Officer or their designee conducts or facilitates Delegated Entity audits sufficient to evaluate the level of compliance with applicable laws, regulations and Plan policies.

- 1. For those activities which CMS or DHCS has not included in the audit protocol, the Plan will develop its own audit documents.
- 2. When CMS or DHCS provides an audit protocol and audit documents, the Plan structures all Delegated Entity audits according to established methodology and accepted tools and standards.

- ii. Focused Audits – The Compliance Officer arranges focused audits of specific Delegated Entity, as necessary.

1. Focused audits may be the result of:

- a. Risk assessment data
- b. Departmental monitoring
- c. Regulatory concerns
- d. Employee incident reporting or
- e. Other credible indicators

2. Notice. The Auditor issues a written notice (by fax or email) to the primary contact at the Delegated Entity scheduled for audit. The notice outlines: The audit start and end dates; the operational activities targeted by the audit; the compliance activities targeted by the audit, which include validation of the Delegated Entity’s activities documented in the Delegated Entity compliance attestation submitted annually; the regulatory or sub-regulatory requirements used to assess compliance in the operational area; the audit methodology; the team responsible for conducting the audit; the required documentation necessary for the review; and the timeframe for submitting the requested information [ten (10) business days from receipt of the notice unless otherwise stated in the notice].

3. Entrance Conference. Once the Health Plan issues an audit notice, the Delegated Entity has an opportunity to discuss the elements in the notice with the Plan audit lead.



- i. The Auditor works with the Delegated Entity to resolve any issues that may arise to settle on the best course of action in terms of scheduling the review, documentation to provide, etc.,
  - ii. If the Delegated Entity does not notify the Health Plan audit lead of any issues within the set timeframe listed in the notice, the Auditor proceeds with the review as originally planned.
- 4. Universe Request and Sampling. The Auditor requires Delegated Entity's to provide all requested and required documentation necessary for the review.
  - i. To review case files, the Auditor requests universe listings for a defined review period.
    - 1. The Delegated Entity must provide these listings in the required format.
    - 2. Once received, the Auditor randomly selects cases for review and provides the Delegated Entity with a list of the selected cases.
      - a. Samples are selected using the following methodology:
        - i. Generally, about ten (10) to fifteen (15) cases are selected for each element in the audit.
        - ii. When the universe is less than the number of cases specified for the audit, 100% of cases are audited.
        - iii. Factors such as past performance of an element can influence the number of cases selected.
- 5. Data/Document submission by Delegated Entity. It is the responsibility of each Delegated Entity undergoing an audit to compile case files for each sample case selected by the Auditor, in accordance with the list of required documentation.
  - i. All audit case samples are prepared and ready for review for the Auditor by the scheduled audit date.
    - 1. If the Auditor believes that additional information is necessary, s/he will request it.
  - ii. If the Delegated Entity identifies additional relevant documentation prior to the close of the audit, it may submit it to the Auditor.
- 6. Data/Document Review by the Auditor. The Auditor, and audit team, as applicable, conducts an audit of all provided documentation for each of the audit elements upon receipt of all documentation.
  - i. Audit of sample cases. The Auditor and the audit team, as applicable, audits the sample cases using either the CMS or DHCS audit protocol documents or the audit documents developed by the Plan.

- ii. Staff interviews. The Auditor and team schedule interviews with the relevant staff members of the Delegated Entity to discuss the processes used for the activities under audited.
  - iii. The audit team confers with the Delegated Entity as needed for clarification or to obtain additional information, but no audit documentation may be altered during the audit. Any discrepancies between verbal descriptions of processes and those described in policies and procedures are annotated in the final audit report for that Delegated Entity.
  - iv. System walkthroughs. The Auditor may request a staff person from the Delegated Entity provide a demonstration or “walkthrough” of how activities related to Medi-Cal requirements are input and worked in the Delegated Entity’s information systems.
7. Audit Report Review Period. Upon completion of its review, the Health Plan shall provide the Delegated Entity a written report within thirty (30) calendar days.
- i. In the event there are no conditions resulting from the audit, the audit is closed after the report is sent to the Delegated Entity.
  - ii. If there are conditions and the Delegated Entity disagrees with a condition(s), it has an opportunity to submit additional documentation. The Plan audit team reviews and considers the additional documentation. If the new documentation impacts the condition, the Auditor will adjust the condition in the final audit report. If the Delegated Entity has no comment or does not provide additional documentation within the review period, the Auditor shall issue a corrective action plan (CAP).
  - iii. The Compliance Officer or their designee submits the final audit report to the Managed Care Compliance Committee and the applicable department director.

H. Corrective Action Plans (CAP)

- 1. If noncompliance with any regulatory, contractual, or Plan policies and procedures is detected through the monitoring process, the Delegated Entity shall submit a CAP.
  - i. It is the responsibility of the operational director to work with the Delegated Entity to implement CAPs to address and resolve instances of non-compliance.
  - ii. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, the Compliance Department will review the outstanding CAP items to determine, at their discretion, whether the CAP deadline should be extended.
- 2. Scoring categories are as follows:
  - i. Full Compliance 90-100%
  - ii. Non-compliance

3. Scores less than 100% may be required to submit a CAP and remedy any deficiencies. When non-compliance is discovered through the audit process, the Auditor works with the Delegated Entity to develop appropriate corrective actions to address and resolve each of the Conditions in the report.
  - 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.
4. 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.
5. After receiving a written appeal, the 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.
6. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, the Compliance Department will review the outstanding CAP items to determine, at their discretion, whether the CAP deadline should be extended.
7. Evaluation of effectiveness of CAP. Within a reasonable timeframe following implementation of the CAP, generally not exceeding ninety (90) days from initiation of the CAP, the operational area conducts an evaluation, such as a follow-up audit, to ensure the CAP has been effective in correcting the deficiency(ies). If the deficiency is not corrected, the operational area director discusses next steps with the Compliance Officer and the Compliance Committee
  - I. Failure to Submit a CAP
    1. Failure to demonstrate CAP implementation and sustained improvement as outlined in the Corrective Action Plan may result in further action including:
      - a. Sanction.
      - b. Request for cure under contract compliance.

- c. De-delegation of specified functions.
- d. Contract non-renewal; or
- e. Contract termination.

J. Revocation of Delegation

1. Delegation may be revoked in instances where the Health Plan or a regulatory agency determines that the Delegated Entity has not performed satisfactorily, including failing to successfully implement a CAP or upon determination of Fraud.
2. The Health Plan may also terminate the Delegation Agreement at any time for cause related to findings of significant deficiencies including a full investigation of Fraud. DHCS reserves the right to suspend or terminate the Delegated Entity from participation in the Medi-Cal program, seek recovery of payments made to the Delegated Entity, impose other sanctions provided under the State Plan, and direct Health Plan to terminate their Delegation Agreement with the Delegated Entity due to Fraud.
3. The Managed Care Compliance Committee may recommend a complete or partial de-Delegation of activities to a Delegated Entity.

**Definitions:**

1. Auditing a formal, systemic review of past performance using structured methodology and evaluation tools derived from base measurement standards (e.g., policies and procedures, laws and regulations, DHCS and CMS guidance) used as base measures. Audits are typically performed by individuals outside of the department or function under review.
2. Corrective Action Plan: A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by the Health Plan, the Centers for Medicare & Medicaid Services (CMS), DHCS or designated representatives. FDRs and/or the Health Plan departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by the Health Plan and its regulators.
3. Centers for Medicare and Medicaid Services (CMS): the agency within the Department of Health and Human Services (DHHS) responsible for administering the Medicare program.
4. Delegated Entity: Any party that enters into an acceptable written arrangement below the level of the arrangement between the Health Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services
5. Delegated Services: Services delegated to a Delegated Entity through a Delegation Agreement, which may include, but are not limited to, administration and management services, marketing, utilization management, quality assurance, case management, claims processing, claims payment, credentialing, network management, provider claim appeals, customer service, enrollment, disenrollment, billing, sales and adjudicating organization determinations and appeals.



6. Designee: A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
7. First Tier, Downstream or Related Entity (“FDR’s”)
  - a. First Tier Entity (FTE): any party that enters into a written arrangement to provide administrative services or health care services to a Medi-Cal eligible individual.
  - b. Downstream Entity (DE): any party that enters into a written arrangement below the level of the arrangement between the Plan and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
  - c. Related Entity (RE): means any entity that is related to the Plan by common ownership or control and:
    - i. Performs some of the Plan’s management functions under contract or delegation.
    - ii. Furnishes services to Medi-Cal enrollees under an oral or written agreement; or
    - iii. Leases real property or sells materials to the Plan at a cost of more than \$2,500 during a contract period.
8. Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
9. Monitoring: Regular reviews performed as part of normal operations to confirm all processes are working as intended, ongoing regulatory compliance and to ensure that corrective actions are undertaken and effective. Although auditing techniques may be employed, monitoring is often less structured. Monitoring is typically performed by department staff and communicated to department management. Monitoring efforts are generally more frequent and closer to real time than audit activities.

**Monitoring:**

This policy is updated, as necessary, reviewed and approved every year by the Care Management Compliance Committee.

**Monitoring:**

1. California Health and Safety Code section 1367.03 subsections c and d.
2. Title 42 Code of Federal Regulations section 455.2.
3. Welfare and Institutions Code section 14043.1(i)
4. Title 28, CCR Section 1300.70(b)(2)(H)1



**Regulatory Agency Approval(s):**

<b>Date</b>	<b>Version</b>	<b>Regulatory Agency</b>	<b>Purpose</b>	<b>Response</b>
Not avail.	12.4	Department of Health Care Services (DHCS)	2024 Operational Readiness (OR) R.0243.2	AIR1
8/22/2023	12.5	Department of Health Care Services (DHCS)	2024 OR R.0243.2 AIR1	Approved
Not avail.	12.6	Department of Health Care Services (DHCS)	2024 OR R.0022	Approved
12/7/2023	12.6	Department of Health Care Services (DHCS)	2024 OR R.0073	Approved
7/17/2024	12.7	Department of Managed Health Care (DMHC)	Filing No. 20243154	Filing Closed
10/24/2024	12.7	Department of Health Care Services (DHCS)	APL 24-008 AIR1	Approved
TBD	12.7	Department of Health Care Services (DHCS)	D.0428	
TBD	12.7	Department of Health Care Services (DHCS)	D.0330.2	
TBD	12.7	Department of Health Care Services (DHCS)	D.0343	



Attachment A

**FDR Identification Analysis**

Basic Information		
<b>Entity Name:</b>		
<b>Contact at Entity:</b>		
<b>Health Plan Business Owner:</b>		
<b>Analysis Completed By:</b> <i>(Signature and date)</i>		
<b>Function(s) Being Performed by Entity:</b> <i>(Look at the contract)</i>		
<b>What administrative function does this entity perform to support Medi-Cal?</b>	<input checked="" type="checkbox"/> Credentialing  <input type="checkbox"/> Enrollment/Disenrollment Function  <input type="checkbox"/> Grievance and Appeals  <input type="checkbox"/> Health Care Services  <input type="checkbox"/> Marketing/Sales  <input type="checkbox"/> Member Materials  <input type="checkbox"/> Organization Determinations/Utilization	<input type="checkbox"/> Outbound Enrollment Verification  <input type="checkbox"/> Provider Network Management  <input type="checkbox"/> Quality Improvement  <input type="checkbox"/> Software Only  <input type="checkbox"/> None  <input type="checkbox"/> Other (be specific) <hr/> <hr/> <hr/>
<input type="checkbox"/> Application Processing  <input type="checkbox"/> Bid Preparation  <input type="checkbox"/> Broker Commissions  <input type="checkbox"/> Call Center Functions/Customer Service  <input type="checkbox"/> Care Management  <input type="checkbox"/> Claims Processing  <input type="checkbox"/> COB  <input type="checkbox"/> Configuration		



Criteria	Yes	No	High	Med	Low	Notes
1. Does the entity perform a function that relates to the Medi-Cal?			N/A	N/A	N/A	
2. Is the function something that the Health Plan is <b>required</b> to do or to provide under its contract with Medi-Cal?			N/A	N/A	N/A	
3. Does the entity utilize any persons or entities (downstream) to assist in the fulfillment of functions related to the Medi-Cal contract? Provide name/function ( <b>in the note section</b> ).			N/A	N/A	N/A	
4. Is the entity an offshore or?			N/A	N/A	N/A	
5. Does the function directly impact enrollees? If yes, rank high, medium, or low.						
6. Does the entity interact with enrollees, either orally or in writing? If yes, rank high, medium, or low.						
7. Level of risk that the entity could harm enrollees or otherwise violate Medicare program requirements or commit FWA. If yes, rank high, medium, or low.						
8. Does the entity have access to beneficiary information or personal health information? If yes, rank high, medium, or low.						
9. Does the entity have decision-making authority (e.g., enrollment vendor deciding time frames)? If yes, rank high, medium, or low.						
10. Does the entity strictly take direction from the Health Plan ?			N/A	N/A	N/A	
11. Does the function to be performed put the entity in a position to commit health care fraud, waste, or abuse? If yes, rank high, medium, or low.						



**Compliance Officer and/or the Compliance Committee**

Note: This Section is only used if the FDR Oversight Committee cannot arrive at a decision

Based on consideration of the above criteria and input from the Compliance Committee, the Compliance Officer:

Recommends that the Entity reviewed be classified as an FDR.

Determined that the Entity reviewed does not meet criteria to be classified as an FDR.

Date of Determination:

**Compliance Officer:**

**Date:**

\_\_\_\_\_

\_\_\_\_\_



Attachment B

Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Pre-Delegation Assessment Request for Documentation**

Under the terms of our current agreement, [Name of FDR] has been selected to provide administrative services to the Health Plan related to our members. As a Delegated Entity, [Name of FDR] is required to comply with regulations issued by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS).

As a Medi-Cal Managed Care Plan contracting with DHCS, the Health Plan is required to conduct initial and ongoing oversight activities to ensure that [Name of FDR] complies with all laws, rules, CMS, and DHCS instructions applicable to delegated activities.

A pre-delegation assessment is a process that includes a thorough evaluation including (but not limited to) [Name of FDR] compliance program, necessary certifications, documented process and procedures along with the understanding and ability to perform delegated tasks.

As part of our oversight activities, we need [Name of FDR] to provide documentation shown in the list on the following page. Please provide the information requested on the attached list **via email by [Month Day, year]**.

If you have questions or want to discuss this request, please contact me at [Insert email] or via telephone at [phone number].

Thank you for your assistance in fulfilling our oversight responsibility.



## Pre-Delegation Assessment Request for Documentation

### **Policies and Procedures that address the following:**

- Monitor adherence to performance standards
- Identify actual or suspected fraud, waste, and abuse and notify the Health Plan
- Identify suspected or actual security breach and/or privacy violation and notify the Health Plan
- Monitor all regulatory changes, and update internal documentation and processes related to delegated activities
- Annual and new employee training for Standards of Conduct and Fraud, Waste and Abuse
- Annual and new employee HIPAA/HITECH Training
- OIG Screening for new employees upon hire and all employees monthly
- Disciplinary actions for violations of Privacy or Security Regulations; Fraud, Waste or Abuse; or Standards of Conduct
- Conduct annual review of all policies & procedures related to delegated activities and update as needed (at minimum)

### **Policies and Procedures that outline the processes that have been delegated:**

- Claims Processing
- Monitor Performance of Downstream Entities
- Monitor Performance of Call Center
- Termination of Provider from Network (Voluntary and Involuntary)
- Member Notification of Termed Provider
- Credentialing/Rec credentialing of Providers
- Handling Members Complaints
- Other P&Ps pertaining to delegated activities

### **Downstream Oversight (applies only to first tier entities):**

- List of downstream entities, if applicable
- P&P's that outline the oversight activities performed as well as attestations from downstream entities

Attachment C

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Pre-Delegation Assessment Tool (Internal)**

Name of Entity \_\_\_\_\_

Location \_\_\_\_\_

Type of Entity  First Tier  Downstream  Related

Date of Audit: Click or tap to enter a date.

Type of Audit  Pre-Delegation

Signed Contract  Yes  No

Contract includes all CMS and DHCS requirements  Yes  No (List below)

Signed Business Associate Agreement  Yes  No  N/A

Delegated Activities (List below)

Performance Standards Defined  Yes. (List below)  No

**Policies and Procedures That Address the Following**

- Monitor adherence to performance standards
- Identify actual or suspected fraud, waste, and abuse and notify the Health Plan
- Identify suspected or actual security breach and/or privacy violation and notify the Health Plan
- Monitor all regulatory changes, and update internal documentation and processes related to delegated activities
- Annual and new employee training for Standards of Conduct and Fraud, Waste and Abuse
- Annual and new employee HIPAA/HITECH Training
- OIG Screening for new employees upon hire and all employees monthly
- Disciplinary actions for violations of Privacy or Security Regulations; Fraud, Waste or Abuse; or Standards of Conduct
- Conduct annual review of all policies & procedures related to delegated activities and update as needed (at minimum)

**Policies and Procedures that outline the processes that have been delegated**

- P&Ps pertaining to delegated activities

**Downstream Oversight (Applies only to First Tier Entities)**

- List of downstream entities, if applicable



P&P's that outline the oversight activities performed as well as attestations from downstream entities



**Contact Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

### Summary of Findings

**Finding:**

**Recommendation:**

**Finding:**

**Recommendation:**

**Finding:**

**Recommendation:**



Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Administrative Contracting Requirements Checklist

### CONTRACT REVIEW

Provisions in the administrative services contracts must:

- Specify delegation requirements including specific delegated activities and reporting responsibilities.
- Comply with all applicable Medi-Cal laws, regulations, DHCS and CMS instructions.
- Comply with all State and Federal confidentiality requirements.
- Agree to grant DHHS, the Controller General, or their designees the right to inspect any pertinent information related to the contract for up to ten (10) years from the final date of the contract period
- Clearly state the responsibilities of the agreement, including performance standards, penalties for failure to meet standards, and reporting arrangements.
- Provide revocation provisions for any first tier or downstream entities should either fail to perform agreed upon services.
- Related to delegation of credentialing and/or re-credentialing services, the first tier or downstream entity must meet all credentialing requirements.
- Related to delegation of credentialing and/or re-credentialing services, state that the Plan retains the right to approve, suspend, or terminate any such arrangements.

### PERFORMANCE OVERSIGHT

The following specific requirements apply to all delegated functions:

- Evaluate the entity's ability to perform the delegated activities prior to delegation.
- Document approval of the entity's policies and procedures with respect to the delegated function.
- Verify sufficiency of entity's resources, including appropriately qualified staff to perform delegated function(s).
- Ongoing monitoring of entity's performance with formal review at least annually.
- Annual (unless performance indicates more frequent) comprehensive assessment of the entity's performance, to include identification of any problems or deficiencies and outcome and tracking of corrective action.