No. COM-002	Delegation Oversight	
Effective Date: 01/01/23	POLICY AND PROCEDURE	
Committee Approval: 01/11/2023 Previous Versions: See revision history on last page		

PURPOSE

This document outlines the policies and processes for overseeing functions that have been delegated to Canopy Health by the upstream health plans and which Canopy Health sub-delegates.

POLICY

Canopy Health is responsible for certain functions that have been delegated by the upstream health plans. These delegated functions ("Delegated Functions") include:

- Utilization Management ("UM")
- Complex Case Management ("CCM")
- Claims Processing ("Claims")
- Provider Dispute Resolution ("PDR")
- Credentialing

As a result of such delegation, Canopy Health is responsible for ensuring that Delegated Functions are performed and executed in compliance with all applicable federal and state laws (including the Knox-Keene Health Care Service Plan Act of 1975, as amended, and its implementing regulations) and contractual requirements.

Canopy Health further delegates certain of the Delegated Functions to certain of its contracting provider groups, the "Sub-Delegates." In connection with such sub delegation, Canopy Health has established an oversight program to ensure that the Sub-Delegates perform these sub-delegated

functions in compliance with all applicable laws, rules, regulations, contractual requirements and Canopy Health policies and procedures.

Delegation Oversight Program Components

Canopy Health's delegation oversight program is comprised of the following components:

1. Pre-Contractual Assessment
2. Annual Oversight Audits and File Reviews
3. Reporting of Key Performance Indicators
4. Monitoring of Key Performance Indicators
5. Evaluating Sub-Delegate Oversight of Credentialing System Controls
6. Committee Oversight

Pre-Contractual Assessment

Prior to entering into an agreement with a Sub-Delegate, Canopy Health conducts a pre-contractual assessment of the organization with respect to those functions that Canopy Health intends to sub-delegate or outsource.

Annual Oversight Audits and File Reviews

Through annual oversight audits, Canopy Health reviews policies, program structure, and files of the Sub-Delegate to ensure continued compliance with all applicable laws, rules, regulations, contractual requirements and Canopy Health policies and procedures.

The first annual audits are conducted within 12 months of initial contracting and every year thereafter.

The oversight audits follow the standard process described below:

1. Canopy Health notifies the Sub-Delegate that an audit will be performed. The notification includes an audit tool and an itemized list of documentation that the auditee must submit in preparation for the audit.

2. The auditee provides required documentation.

a In the case of UM, CCM, Claims and PDR audits, Canopy Health is responsible for Delegation Oversight for members belonging one of two upstream health plans.

i In some cases, the upstream health plan has decided to do a direct audit of Canopy Health enrollees in Canopy Health's sub-delegated medical groups/IPAs. In those cases, Canopy Health uses the results of the upstream health plan audit to assess performance and to issue requests for corrective action. The requirements for corrective action are the same as in a direct audit performed by Canopy Health.

ii If Canopy Health conducts the audit, then the following process takes place.

I. Canopy Health reviews the Sub-Delegates policies and procedures (P&Ps), program documentation and evidence annually.

II. Canopy Health performs a file review at least annually, but more frequently as needed (i.e., quarterly, semi-annually) to coordinate with upstream health plan oversight activities. To ensure that enrollees from both upstream health plans are included in Canopy Health's oversight audits, Canopy Health has adopted a modification of NCQA's "8/30" methodology**.

III. Canopy Health audits in total at least 30 files per file type (i.e., approvals, denials) each year or the maximum number of files available if the entire universe of files has fewer than 30 files of a required type.

IV. To ensure that enrollees from both upstream health plans are included in the file review, Canopy Health audits, at a minimum, 15 files of each type (i.e., approvals, denials) from each upstream health plan's universe of files each year or the maximum number of files available if the universe of files for a particular upstream health plan has fewer than 15 files of a required type. Canopy Health performs a random selection of files from each upstream health plan's universe of files or applies file selection criteria focused on areas where noncompliance was previously identified, areas of importance to regulators and/or the upstream health plans, and new requirements. Canopy Health

may issue a single file request (for an annual file review) or may divide the total number of files requested annually into smaller file requests administered at intervals throughout the 12-month period (i.e., quarterly file reviews).

V. To ensure Canopy Health evaluates a total of 30 files of each file type or the maximum number of files available, if one upstream health plan does not have enough files of a required type in its universe to satisfy the file request:
   a Canopy Health chooses all files from that upstream health plan, and
   b Supplements the difference with files from the other upstream health plan to total the number of requested files for each file type across both health plans.

Conduct a complete audit of every element required by regulation and contractually on all 30 files of each type.
** Details about NCQA's 8/30 methodology are found:
http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupporting.Documents.aspx

b. In the case of Credentialing, Canopy Health conducts annual oversight audits using the HICE audit process and results to ensure compliance with NCQA.
c. The HICE assigned auditor reviews all submitted documentation and files.
d. The auditor provides written audit results to the auditee and to the HICE community upon request to the auditee.

3. When Canopy Health receives the results of an audit, they are reviewed and Canopy Health may issue a request for a Corrective Action Plan ("CAP") should deficiencies be identified. The request for a CAP will include a due date by which the auditee must provide a response.

4. In the event of a request for a CAP, the auditee provides a response that includes steps and timeline for addressing each deficiency, along with the name of the accountable person(s) responsible for ensuring the corrective actions are completed in a timely manner.

5. Upon review of the CAP response, Canopy Health acknowledges receipt or, if necessary, works with the auditee to modify the CAP until acceptable to both parties.

6. Where appropriate, Canopy Health re-reviews documentation and/or files to confirm that all deficiencies have been adequately addressed.

7. Once Canopy Health confirms that all deficiencies have been adequately addressed, Canopy Health notifies the auditee that the audit process is complete.

The following guidelines are applied to determine the necessity for a CAP and/or reaudit:

Audit Score	Resultant Action
For Credentialing: Overall Score ≥ 95%	No further action taken until next annual audit
Overall Score < 95%	• CAP issued • Potential re-audit • Reference policy and procedure on Credentialing delegation oversight for more details (CD-1011)
For UM, CCM, Claims and PDR: Overall Score ≥ 95%	No CAP issued unless a deficiency is found on a must-pass element, in which case a CAP is issued
Overall Score < 95%	• CAP issued • If a deficiency is found on a must pass element, a CAP is issued, with the potential for a re-audit 90 days following initial audit

Reporting of Key Performance Indicators

In addition to conducting audits of its Sub-Delegates, Canopy Health requires that the Sub-Delegates submit reports on key performance indicators for each subdelegated or outsourced function to regularly monitor compliance with all applicable laws, rules, regulations, contractual requirements and Canopy Health policies and procedures. The reporting requirements and frequencies are summarized below:

Function	Reporting Requirements	Minimum Frequency of Reporting
Utilization Management	Utilization Management Program Description	Annually
	Utilization Management Metrics and Work Plan (ICE Format)	Semi-Annually
	Utilization Management Authorization Reports	Monthly
Complex Case Management	Complex Case Management Program Description	Annually
	Case Management Metrics and Work Plan (ICE Format)	Semi-Annually
Credentialing	Credentialing Reports (HICE Format)	Quarterly
	Credentialing System Controls Audit Report (HICE Format)	Quarterly
Claims Processing and Provider Dispute Resolution	Monthly Timeliness Reports	Monthly and Quarterly
	Provider Dispute Report	Quarterly
Documentation to Support Annual Delegation Oversight Audits	Other documentation such as Sub-Delegates' policies and procedures are collected at the time of audit	Annually

Monitoring of Key Performance Indicators

Canopy Health monitors each Sub-Delegate's Utilization Management, Claims Processing, and Provider Dispute Resolutions timeliness monthly or quarterly by analyzing the data included in each Sub-Delegate's key performance indicator reports. The upstream health plan reporting requirements drive the frequency of Canopy Health's monitoring. Canopy Health evaluates Claims and Provider Dispute Resolution timeliness using the calculations embedded in the upstream health plan reports. Canopy Health calculates Utilization Management decision and notification timeliness using the data in the upstream health plan monthly Utilization Management logs. Canopy Health reports each Sub-Delegate's compliance with the timeliness standards.

Sub-Delegates who do not meet the 95% timeliness threshold for any category or categories from the Key Performance Indicator reports for two consecutive months or quarters (depending on the frequency of the report) will be issued a Corrective Action Plan ("CAP"). The request for a CAP will include a due date by which the Sub-Delegate must respond with a root cause, corrective measures with benchmarks, and an expected compliance date. The CAP will remain open until the Sub-Delegate demonstrates compliance with the timeliness standards for at least two consecutive months or quarters. At Canopy Health's discretion, the CAP may stay open longer if the Sub-Delegate has demonstrated a pattern of noncompliance.

Key Performance Indicators monitored for compliance with the timeliness standards (95% threshold) are outlined below:

Function	Line of Business	Reporting Categories Monitored for Timeliness
Utilization Management	Commercial	• Decision Making • Member Notification • Provider Notification
	Medicare	• Decision Making • Member Notification
Claims Processing	Commercial	• Claims paid, contested, denied, processed within 45 working days
	Medicare	• Clean claims paid within 30 calendar days • Unclean claims paid or denied within 60 calendar days
Provider Dispute Resolution	Commercial	• % Resolved within 45 working days
	Medicare	• % Resolved within 30 calendar days

Evaluating Sub-Delegate Oversight of Credentialing System Controls

Canopy Health evaluates each Sub-Delegate's oversight of their Credentialing System Controls ("CSC") by collecting and reviewing CSC Audit Reports quarterly. If a Sub-Delegate attests that no inappropriate modifications were made during the quarter through the CSC Audit Report, no further action is required. If a Sub-Delegate identifies noncompliant modifications during the CSC Audit, a "noncompliant modifications report" is also required upon submission. Canopy Health will review the Sub-Delegates' completed noncompliant modifications report and present it to the appropriate Committee(ies) to determine whether the corrective action plan is sufficient or whether additional measures are necessary to meet compliance.

Committee Oversight

Each sub-delegated and outsourced function is overseen by a Canopy Health executive. In addition, Canopy Health' committee oversight provides an additional level of review and quality assurance of sub-delegated and outsourced functions. A summary of executive and committee oversight for each sub-delegated and outsourced function is provided below.

Function	Executive Oversight	Committee Oversight	Committee Meeting Frequency
Utilization Management	Chief Medical Officer	Canopy Health Delegation Oversight Committee	Quarterly (or more often as needed)
Complex Case Management	Chief Medical Officer		
Claims Processing and Provider Dispute Resolution	Chief Network Development Officer		

Credentialing	Chief Medical Officer	Canopy Health Credentialing and Peer Review (CPRC) Committee	Quarterly (or more often as needed)

The Canopy Health executive tasked with oversight for each delegated function is responsible for raising and discussing relevant Sub-Delegate oversight issues with the applicable committee, which issues include, but are not limited to:

- Trending and analysis of key performance indicators.
- Results of annual audits and file reviews.
- Progress against any CAPs issued.
- Recommendations for de-delegation, should poor performance persist.
- Recommendations for removing individual practitioners from the Canopy Health network should the credentialing process identify persistent concerns.

Revision History:

Version Date	Edited By	Reason for Change
1/23/2018	Y. Wu	Creation date
12/12/17	M. Durbin	Updated to add IPM as an additional entity for delegation oversight
1/16/18	M. Durbin	Updated to reflect ICE credentialing process per WHA's predelegation requirements
3/12/18	Y. Wu	Revised to refine the definition of delegate and new Delegation Committees
7/30/20	R. Scott	Update the methodology to UM/CCM/Claims audits.
1/1/2021	R. Scott	Update the methodology to UM/CCM/Claims audits to account for the upstream health plan direct audit of delegated functions.
4/1/2021	R. Scott	Revised for elimination of COO position.
10/5/2021	L. Sasaki	Policy amended to acknowledge need for selection focus
01/01/2022	L. Sasaki	Updated methodology to reflect more frequent (than annual) file reviews for UM and CCM.
1/1/2023	J. Moesche	Added Canopy Health's processes for Monitoring of Key Performance Indicators and Evaluating Sub-Delegate Oversight of Credentialing System Controls