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Owner:	*Ricarda Pope-King*
Policy Area:	*Managed Care Operations*
References:	*NCQA RR5, QI13, CR8, CC5, NCQA UM13*

Delegated Functions

POLICY

It is the policy of the Detroit Wayne Integrated Health Network (DWIHN) that processes are in place to ensure that activities which are wholly or partially delegated to providers meet applicable federal, state and local regulations and guidelines.

PURPOSE

The purpose of this policy is to delineate and describe the functions and oversight of the DWIHN, DWIHN's Credentialing Verification Organization (CVO) and the responsibilities of the Managers of Comprehensive Provider Networks (MCPN) and/or their subcontractors, and direct contractors, to implement delegated functions.

APPLICATION

1. Who is required to implement and adhere to this policy: DWIHN Board, All DWIHN Staff, Contractual Staff, MCPN Staff, Network Providers, CVO, Access Center and Crisis Service Vendor.
2. Who does this policy serve: Adults and Children with an Intellectual/Developmental Disability (I/DD), Adults with Serious Mental Illness (SMI), Children and Youth with a Serious Emotional Disturbance (SED), Adults and Children with Substance Use Disorders (SUD)
3. What service line does this policy impact: MI-HEALTH LINK, SUD, Autism, Medicaid

KEY WORDS

1. Delegation
2. Credentialing Verification Organization (CVO)
3. Revoke
4. Managers of Comprehensive Provider Networks
5. Direct Contracted Providers

STANDARDS

1. DWIHN has oversight responsibility for activities that are partially or fully delegated to the Credentialing Verification Organization (CVO), the Managers of Comprehensive Provider Networks (MCPNs), Access

Center and Crisis Service Vendor and their sub-contractors and the direct contract providers.

2. The CVO, MCPNs, providers, Access Center and Crisis Service Vendor are evaluated either through a Request for Proposal/Request for Information process or through the provider impaneling/credentialing process prior to entering into an agreement with DWIHN or the MCPNs.
3. Prior to entering into a written contractual agreement with an outside entity, DWIHN reviews the entity's ability to perform one or all functions to our standards.
4. The delegated functions per the contracted agreements with DWIHN are Provider Network Management which includes clinician Credentialing/Re-Credentialing, Customer Services, Quality Management/ Improvement, Financial Management, Information Systems Management, Comprehensive Service Array and Utilization Management.
5. Contracted agreements ensure that entities that provide all or partial delegated functions meet federal, state and local regulations and standards.
6. Providers responsible for managing Protected Health Information (PHI) must comply with the Health Insurance Portability and Accountability Act of 1996, the Mental Health Code, 42 CFR Part II and any other applicable ethical, statutory and common law privileges
7. The entities responsible for delegated functions submit reports to DWIHN no less than quarterly, additionally they are monitored by the appropriate DWIHN unit. The Delegation Grid contains the report submission schedules and expectations.
8. For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, DWIHN identified and followed up on opportunities for improvement, if applicable.
9. Annual auditing may result in a corrective action plan to ensure that the delegate meets our requirements within a specific time frame. In the event DWIHN identifies an issue that may result in an adverse member event and/or noncompliance with our standards, we reserve the right to monitor any delegated entity on a more frequent basis or to terminate the contract for failure to comply with its quality standards.
10. The organization uses information from its pre-delegation evaluation, ongoing reports or annual evaluation to identify areas of improvement.
11. The CVO, MCPNs, Access Center and Crisis Service Vendor and their sub-contracted providers and the direct contracted providers receive comprehensive site visits to determine compliance with delegated functions, no less than annually or as needed by the Quality Management (QM) unit and the Customer Services unit.
    a. If there are areas of non-compliance during the site visit Quality Management or Customer Service may provide technical assistance, request a plan of correction or if there are issues of consumer health and safety, QM may coordinate consumers receiving medically necessary services at other providers until all issues are addressed.
    b. Failure to correct areas of deficit may result in delegated functions being revoked up to and including termination of their contract.
        1. An ad-hoc committee consisting of staff from different units will be convened by the Chief Operating Officer or their designee including representation from the Compliance Office and Corporation Counsel to review the results of the site visit and any documentation that would support that the provider is non-compliant with the plan of correction and not capable of providing the delegated function.

i. The committee will meet with the provider to inform them of the revocation of the delegated functions.

c. Delegated functions that are revoked are managed by the appropriate DWIHN unit until the MCPN and/or provider have resolved the issue(s). As needed, DWIHN may involve another Provider to support the impacted consumers until the matter is resolved.

d. If issues are resolved, the Contract Manager may request that the Ad-Hoc committee is reconvened to determine if the MCPN or provider can perform the delegated functions.

e. In instances where the issues are not resolved to the satisfaction of DWIHN, that task may be assigned to another entity that is deemed capable of providing that function through an established evaluation process.

QUALITY ASSURANCE/IMPROVEMENT

The Authority shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the Quality Assurance Performance Improvement Program (QAPIP) Goals and Objectives.

The quality improvement programs of MCPNs, their subcontractors and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

Authority staff, MCPNs, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

RELATED POLICIES

1. Incident Reporting Policy
2. Case Records Maintenance and Management Review
3. Network Monitoring and Management

RELATED DEPARTMENTS

1. Clinical Practice Improvement
2. Compliance
3. Customer Service
4. Integrated Health Care
5. Legal
6. Managed Care Operations
7. Quality Improvement
8. Utilization Management

9. Recipient Rights
10. Substance Use Disorders

CLINICAL POLICY

NO

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

DWHMA Delegation Grid_external.pdf
DWHMA Delegation Grid_INTERNAL USE ONLY_2-23-18 (1).xlsx

Approval Signatures

Approver	Date
Dana Lasenby: Deputy Chief Operating Officer	08/2017

Approver	Date

NCQA Element or Factor	Description/Activity	Responsible Dept. (DWMHA)	Who Monitors (DWMHA)	Threshold to meet requirement	Reporting Requirement
Column Description		Please provide department name under which the listed activity falls.	Please provide department name that handles monitoring of listed activity. Includes compliance PIP monitoring, ensuring policy adherence.	Please explain the threshold that determines whether the requirement has been met?	Where & when is/are report(s) submitted. Which department(s), committees, regulatory bodies receive monitoring report(s) for this activity?
Element A	**Written Delegation Agreement**				
Factor 1	**Written Delegation Agreement**				
	DWMHA has ultimate responsibility for oversight and is accountable for any functions and responsibilities it delegates. The executed written agreements with the Managers of Comprehensive Provider Networks (MCPN), Credentialing Verification Organization, and behavioral health providers delineate the roles and responsibilities delegated to them in the areas of Coordination of Behavioral Healthcare, Credentialing, Quality Improvement, rights and Responsibilities and Utilization Management.	Managed Care Operations and Legal	Managed Care Operations, Quality Improvement, Customer Services, Utilization Management, Integrated Care	95% threshold for compliance annual reviews conducted by Quality Improvement	Reports are submitted monthly from MCPN's, and Access Center/Credentialing Verification Organization. Contract Status Reports are completed quarterly for Direct Contra t Providers. Reports are pulled monthly from the Waiver Support Application (WSA) for Autism Providers to monitor progress and identify any compliance issues. As the SUD Unit, continues to meet integration milestones, providers will be trained in the submission of Quarterly Contract Status Reports. A CEO Report is provided monthly to the Board of Directors that highlight significant provider issues, concerns and progress.
Factor 2	**Assigning Responsibilities**	**Please review this section for the tasks/activities that your department delegates to another organization/provider.**			
	Delegated Activities & Responsibilities	**The information below is to be consistent with what is in your respective policies, contracts, monitoring grids, program descriptions, manuals, handbooks, website mentions.**			
	DEPT: Utilization Management delegated activities				
	UM 13				
	1. Each quarter, COPE and the MCPN's must conduct and submit reviews of a sampling of approval cases and 100% of all denial and applicable appeal cases for all staff making UM decisions using the DWMHA's Prior Authorized Service UM Review tool to the UM Department.	Utilization Management	Utilization Management	Goal: 85% or greater	Utilization Management Committee

	2. Each month, the Managed Care Provider Networks and COPE must submit their appeal and denial tracking logs and 100% of files of any denied or applicable appealed cases to be audited by UM Appeal Coordinator. Results of monthly audits collated and presented back to delegated entity and presented to UMC monthly and QISC annually. For any delegated entity that scores under 90%, those results will be reported to QISC at the next regularly scheduled meeting. Expectation is each case will score 90% or greater.	Utilization Management	Utilization Management	Goal: 90% or greater	The findings will be reported to Quality Improvement Steering Committee for further review and determination. Findings reported to Utilization Management Committee, only if threshold not met.
	3. The Managed Care Provider Networks and COPE must submit quarterly timely decision and notification reports to UM Appeal Coordinator. Results are collated and presented to UMC quarterly.	Utilization Management	Utilization Management	Goal: 90% or greater for each type of decision and notification	The findings will be reported to Quality Improvement Steering Committee for further review and determination. Findings reported to Utilization Management Committee, only if threshold not met.
	4. Annually COPE and MCPN UM Program Descriptions submitted for review by DWMHA UM Director or their designee utilizing UM Program Description audit tool. Results will be included in annual UM evaluation and presented to UMC and QISC.	Utilization Management	Utilization Management	Goal: Utilization Management Program Description contains all required items as identified in DWMHA's Utilization Management Program Description 100%.	The findings will be reported to Quality Improvement Steering Committee for further review and determination. Findings reported to Utilization Management Committee, only if threshold not met.
	5. All delegated UM staff performing UM functions applying Medical Necessity Criteria or making decisions based on benefits are expected to take an Inter-rater reliability test annually. Must pass with 90% or greater or will be placed on corrective action plan (CAP).	Utilization Management	Utilization Management	Must pass with 90% or greater or will be placed on corrective action plan (CAP).	The findings will be reported to Quality Improvement Steering Committee for further review and determination. Findings reported to Utilization Management Committee, only if threshold not met.
	6. Results of Inter-rater results will be reported to the UMC and QISC annually.	Utilization Management	Utilization Management	Must pass with 90% or greater or will be placed on corrective action plan (CAP).	Utilization Management Committee; Quality Improvement Steering Committee, if threshold not met, the findings will be reported to Quality Improvement Steering Committee for further review and determination.
	7. The Managed Care Provider Networks, COPE and all delegates submit evidence of UM Affirmative Statement distribution to any employees who perform UM functions annually.	Utilization Management	Utilization Management	100%	The findings will be reported to Quality Improvement Steering Committee for further review and determination. Findings reported to Utilization Management Committee, only if threshold not met.
	DEPT: Credentialing/MCO delegated activities				
	CR 8				

	1) DWMHA contracts with a Credentialing Verification Organization (CVO) to provide common, centralized credentialing of service providers that are subcontractors of the Managed Care Provider Networks or have a direct contract with DWMHA.	Managed Care Operations	Managed Care Operations, Quality Improvement,	95%	Monthly Credentialing Verification Organization Report, Credentialing Committee and Quality Improvement Steering Committee
	i) The Credentialing Verification Organization will conduct the credentialing/re-credentialing process in a timely manner and ensure all files presented to DWMHA Credentialing committee for review and evaluations are complete	Managed Care Operations	Managed Care Operation, Quality Improvement	100%	Monthly Credentialing Verification Organization Report, Credentialing Committee and Quality Improvement Steering Committee
	ii) Maintaining and informing DWMHA in writing of all credentialing changes within 30 calendar days of credentialing decision	Managed Care Operations	Managed Care Operations, Quality Improvement	100%	Monthly Credentialing Verification Organization Report, Credentialing Committee and Quality Improvement Steering Committee
	iii) Verifying the credentials and qualifications of the individual Mental Health Professional throughout the provider networks within 60 calendar days of receipt of the credentialing application which includes the following:	Managed Care Operations	Managed Care Operations, Quality Improvement	100%	Monthly Credentialing Verification Organization Report, Credentialing Committee and Quality Improvement Steering Committee
	a) On an annual basis, conducting a random sample review of credentialing files to certify that files are complete and maintained with DWMHA standards and policy.	Managed Care Operations and Quality Improvement	Quality Improvement	95%	Monthly Credentialing Verification Organization Report, Credentialing Committee, Quality Improvement Steering Committee, and monthly Contract Meeting
	b) Providing reports to DWMHA, Managed Care Provider Networks and direct contractors on the status of credentialing activities and files each month.	Credentialing verification Organization	Managed Care Operations	100%	Monthly Credentialing Verification Organization Report, Credentialing Committee, and Quality Improvement Steering Committee
	c) Notifying the provider and DWMHA in writing within 24 hours of any adverse decisions and the right to appeal.	Credentialing verification Organization	Managed Care Operations, Quality Improvement	100%	Managed Care Operations Credentialing Verification Organization Provider Network Manager, Credentialing Committee and Quality Improvement Steering Committee
	d) DWMHA's applicants will be notified in writing of missing information that prevents the process from proceeding. Applicant files that remain incomplete after 90 days will be closed with notice sent to the applicant.	Credentialing verification Organization	Managed Care Operations, Quality Improvement	100%	Credentialing Committee and Quality Improvement Steering Committee, and Monthly Contract Meeting
	DEPT: Quality Improvement/Quality Management delegated activities				
	QI 13				

	1) Quality Improvement- Behavioral health organizations that provide delegated functions must ensure that they align with the Michigan Department of Health and Human Services (MDHHS) standards and DWMHA's policies and procedures. Reviews are consistent with applicable federal laws, Medicaid statutes, MDHHS/EQR(by HSAG)/NCQA regulations and industry standards.	Quality Improvement	Quality Improvement	95%	Quality Improvement Steering Committee
	i) They are required to submit data that impacts the quality of care.	Quality Improvement	Quality Improvement	95%	Quality Improvement Steering Committee
	ii) They are also required to actively participate in continuous quality improvement activities appropriate to persons served, in alignment with DWMHA's QAPIP. DWMHA QAPIP is developed to align with and support DWMHA's Strategic Plan. Purple wording added per Mary on 11/28)	Quality Improvement	Quality Improvement	95%	Quality Improvement Steering Committee
	2) Performance Monitoring- This is a retained and delegated function. DWMHA has ultimate responsible for performance monitoring. However, there is an expectation that the Managed Care Provider Networks and providers will perform ongoing performance monitoring activity to DWMHA monthly or at least quarterly. The scope of performance monitoring shall include, but not limited to:	Quality Improvement	Quality Improvement	95%	Quality Improvement Steering Committee
	i) Quality Improvement Program. All DWMHA units are responsible for supporting the Quality Improvement program as it relates to their department.	Quality Improvement, Managed Care Operations, Utilization Management, SUD, Clinical, Customer Service, HR, all DWMHA units, get the full list from Toria to add to this grid.	Quality Improvement	95%	Quality Improvement Steering Committee, Program Compliance Committee
	ii) Clinical and support services	Quality Improvement, Managed Care Operations, Clinical	Quality Improvement	95%	Quality Improvement Steering Committee
	iii) Claims verification	Managed Care Operations, Finance	Managed Care Operations, Quality Improvement, Compliance	95%	Quality Improvement Steering Committee
	iv) Residential care	Quality Improvement, Managed Care Operations, Recipient Rights, CPI	Quality Improvement	95%	Quality Improvement Steering Committee
	Performance Measurement-this function is retained by DWMHA. DWMHA sets the standard, collects the data, and analyzes the data. The delegated entity is responsible for ensuring data is entered in the system or submitted to the Authority in a timely manner.	Quality Improvement	Quality Improvement	80% or greater, depending upon activity.	Quality Improvement Steering Committee

	DEPT: Rights and Responsibilities/Customer Service delegated activities				
	Each delegated entity is required to have a Customer Service Unit that aligns with the MDHHS Standards and DWMHA's policies and procedures. They are required to submit data that impacts the quality of care. They are also required to actively participate in continuous quality improvement activities appropriate to persons served.	Customer Service (delegated to: Managed Care Provider Networks, Providers, COPE, Access Center, and ProtoCall)	Customer Service/Quality Improvement/Managed Care Operations	95% Monthly Reporting 95% Annual Reporting	Quality Improvement Steering Committee Program Compliance Committee
	2) The Managed Care Provider Networks and providers will perform ongoing performance monitoring activity and submit documentation to DWMHA monthly or at least quarterly. The scope of performance monitoring shall include, but not limited to:	Customer Service (delegated entities: Managed Care Provider Networks, Providers, Access Center, ProtoCall, COPE)	Customer Service/Quality Improvement/Managed Care Operations	90% or greater	Quality Improvement Steering Committee Program Compliance Committee
	i) Customer Service Activities	Customer Service	Customer Service/Quality Improvement/Managed Care Operations	95% Timely Submission	Quality Improvement Steering Committee Program Compliance Committee
	ii) Grievances	Customer Service	Customer Service/Quality Improvement/Managed Care Operations	95% Timely Submission	Quality Improvement Steering Committee Program Compliance Committee
	iii) Appeals	Customer Service	Customer Service/Quality Improvement/Managed Care Operations	95% Timely Submission	Quality Improvement Steering Committee Program Compliance Committee
	3) Enrollee Rights Performance Measurement are retained by DWMHA. DWMHA sets the standards, collects the data, and analyzes the data. The delegated entity is responsible for ensuring data is entered in the system or submitted to the Authority in a timely manner.	Customer Service	Customer Service/Quality Improvement/Managed Care Operations/ORR	95% Timely Submission	Quality Improvement Steering Committee Program Compliance Committee
	The centralized access and eligibility determination functions are delegated to the Access Center. They conduct telephonic or face-to-face demographic and clinical screenings to determine a consumer's eligibility for services 24 hours a day/7 days a week.	Customer Service	Managed Care Operations/Quality Improvement		Quality Improvement Steering Committee Program Compliance Committee
	DEPT: Care Coordination delegated activities				

	1. For MI Health Link, the completion of Level II assessments. Medicaid and Medicare health plan care coordinators complete an annual health risk assessment for all members. The health risk assessment screens members for the potential presence of a behavioral health, intellectual and or developmental disability or substance use disorder. a. If there is some indication that any of these is present, a referral is made to DWMHA for a subsequent Level II assessment. Level II assessments include a complete biopsychosocial and level of care assessment relevant to the member's need. b. Once a referral is made from the Medicaid or Medicare health plan, the contracted provider has 14 days to complete the Level II assessment. If the provider is unable to complete the Level II assessment, there must be at least 3 documented outreach attempts and then a request can be made to administratively close the referral.	IHC	IHC/Quality Improvement	80% sent back to health plan within 14 days OR at least 3 documented outreach attempts within the 14 day time period	Quality Improvement Steering Committee, Program Compliance Committee (AdHoc Committee as needed - dependent upon size of provider)
	2. MI Health Link outpatient providers are required to submit quarterly reports to DWMHA	Managed Care Operations	Managed Care Operations/IHC		
	3. Monitoring of termination of providers and sending letter within 30 days (last known current address), in respect to Managed Care Provider Networks. Monitoring of evidence that in appropriate cases members given chance to continue with provider for up to 90 days during transition to contracted provider in respect to MCPN's.	Managed Care Operations	Managed Care Operations/Contract Management	100% (last known current address)	Quality Improvement Steering Committee, Program Compliance Committee (AdHoc Committee as needed - dependent upon size of provider)
Factor 3	**Reporting**	**Please review this section for the reporting delegates are required to provide DWMHA as related the tasks/activities delegated to them (what/when/how often).**			
	Credentialing CR 8	**The information below must be consistent with what is in your respective policies, contracts, monitoring grids, program descriptions, manuals, handbooks, website mentions.**			
	The Credentialing Verification Organization submits monthly reports to Managed Care Operations which includes a summary of credentialing activities and the credentialing committee meeting report.	Credentialing Verification Organization	Managed Care Operations	100%	Reports are submitted monthly that include Credentialing Summary Activity for the month, and Credentialing Verification Organization Cred. Committee Meeting Report. A report of activites of the Credentialing Verification Organization is also presented to the DWMHA Credentialing Committee on a monthly basis.
	Quality Management QI 13				

	Delegated entities are required to submit quarterly reports on the performance levels and results as well as submitting an annual report summarizing their quality improvement results	Quality Improvement	Quality Improvement	100%	Quality Improvement Steering Committee, Program Compliance Committee, Quality Operations, Full Board Meeting
	Rights and Responsibilities				
	Delegated entities are required to submit monthly, quarterly and annual reports on the performance levels and results to the Customer Services unit.	Managed Care Provider Networks Access Center	Authority Customer Service	Contracts Performance Measures	Quality Improvement ICO Program Compliance
	Utilization Management UM 13				
	According to the scope of services some Utilization Management reports are on a monthly submission schedule others quarterly. In addition, the Access Center and Managed Care Provider Networks submit an annual UM Program Evaluation report.	Utilization Management	Utilization Management	85% or above, based on activity	The findings will be reported to Quality Improvement Steering Committee for further review and determination. Findings reported to Utilization Management Committee, only if threshold not met.
Factor 4	**Performance Monitoring**	**Please review this section for the monitoring DWMHA conducts to ensure delegates are meeting the requirements of delegated tasks/activities.**			
	Credentialing CR 8	**The information below is to be consistent with what is in your respective policies, contracts, monitoring grids, program descriptions, manuals, handbooks, website mentions.**			
	1) On an annual basis DWMHA's Quality Management Monitoring staff conduct comprehensive standards based reviews of the CVO to determine contract compliance.	Managed Care Operations and Quality Improvement	Quality Improvement	95%	Monthly Credentialing Verification Organization Report, Credentialing Committee and Quality Improvement Steering Committee
	2) The CVO has a contract manager assigned to them that meet no less than quarterly with the CVO to assess how they are providing the delegated services.	Managed Care Operations	Managed Care Operations	100%	Monthly Credentialing Verification Organization Report, Credentialing Committee and Quality Improvement Steering Committee
	Quality Management Q 13				
	Performance standards are required for all delegated entities. The results of the performance are published in the form of a report card.	Quality Improvement	Quality Improvement	95%	Quality Improvement Steering Committee, Program Compliance Committee, Quality Operations
	Rights and Responsibilities				
	DWMHA Customer Services unit conducts random monitoring of the Access Center, Managed Care Provider Networks and providers to ensure compliance with the contract as well as with MDHHS requirements. Annual site reviews are also conducted to evaluate for performance and quality improvements results.	Authority Customer Service	Authority Customer Service	95% Monitoring Tool Performance Measures Contracts	Quality Improvement Steering Committee Managed Care Operations Program Compliance Committee
	Utilization Management				

	Monitoring delegated entity UM performance occurs on an ongoing basis. Reviews are consistent with applicable federal laws, Medicaid statutes, MDHHS/EQR(by HSAG)/NCQA regulations and industry standards.	Utilization Management	Utilization Management	80% or greater, depending upon activity.	Utilization Management Committee
Factor 5	**Remedies Available Including Revocation**				
	Failure to perform at the required standard will result in a plan of correction (POC) or quality improvement plan. Continued failure to meet performance levels could result in suspension or revocation of delegated function up to and including termination of contract.	Quality Improvement, Managed Care Operations, Legal, Utilization Management, Customer Service Integrated Care	Quality Improvement, Managed Care Operations	According to policy the Chief Operating Officer or their designee will convene a multi-unit group to assess providers that could not correct deficits and need to have delegated activity revoked. The process will be monitored by Quality and Managed Care Operations.	Based upon the severity of performance, a plan of correction could be requested. This plan will be monitored ongoing by Managed Care Operations and the Quality Improvement Department with the vendor, until the issue is resolved. If the issue is more severe, the DWMHA Compliance Officer will be notified. If the issue warrants suspension or revocation, the DWMHA Contingency Plan would be followed.
ELEMENT B	**PROVISIONS FOR PHI**				
	The contractual agreements between DWMHA and the delegated entities have language specific to the rules outlined in the Health Insurance Portability and Accountability Act of 1996 to ensure that consumer health information is protected. They each have Business Associates agreements attached to their contracts.	Legal	Legal	100%	Violations reported to Compliance Officer for submission to OIG as required.
ELEMENT C	**PRE-DELEGATION EVALUATION**				
	1) The Managed Care Provider Networks and CVO are selected through a Request for Proposals process that is managed through DWMHA's Procurement Unit	Procurement	Procurement	100%	Board
	2) The Managed Care Operations unit impanels/credentials providers which includes a review of the Office for Inspector General List of Excluded Individuals Entities and System for Award Management websites to determine if they have been excluded from providing Medicaid or Medicare services. The MCPN and DWMHA can only contract with providers that have gone through those processes.	Managed Care Operations	Managed Care Operations	100%	Credentialing Committee, Legal, Compliance