9.14: Credentialing Program

Purpose

To ensure that all network practitioners/providers meet the minimum credentials requirements set forth by Care1st and the regulatory agencies including, but not limited to, the NCQA, DHCS, DMHC, and other regulatory agencies for participation in the network. At least every three (3) years, the practitioners/providers are required to undergo recredentialing to ensure that they are in compliance with these standards.

Scope

The credentialing program applies to all direct-contracted and delegated practitioners who are affiliated with Care1st through their relationship with a contracted PPG. Care1st requires the credentialing of the following independent practitioners: physicians (MD, DO), podiatrists (DPM), oral surgeons (DDS, DMD), optometrists (OD), and mid-level practitioners/providers (PA, NP, CNS and NMW) employed in these practitioner’s offices and see Care1st Members. Care1st and its delegates may also credential other allied health professionals, such as psychologists (PhD, PsyD), audiologists (AU), registered dietitians (RD), and other practitioners authorized by law to deliver health care services and contracted by Care1st on an independent basis.

Care1st does not credential hospital-based practitioners (i.e. radiologists, anesthesiologists, pathologists, and emergency medicine physicians) who practice exclusively in an inpatient setting and provide care of Care1st Members because Care1st members are directed to the hospital.

Objectives

- To ensure that all practitioners/providers, including both direct-contracted and delegated, who are added to the network meet the minimum Care1st requirements.
- Care1st practitioners/providers are evaluated for, but not limited to, education, training, experience, claims history sanction activity, and performance monitoring.
- To ensure that network practitioners/providers maintain current and valid credentials.
- To ensure that network practitioners/providers are compliant with their respective state licensing agency and Medi-Cal programs, Care1st has a process to ensure that appropriate action is taken when sanction activity is identified.
- To establish and maintain standards for credentialing and to identify opportunities for improving the quality of practitioners/providers in the network.

Credentialing Policies & Procedures

Policies and procedures are reviewed annually and revised as needed to meet the NCQA, DHCS, DMHC, state and federal regulatory bodies’ requirements. Policies and procedures are reviewed by the Chief Medical Officer and submitted to the Credentials Committee, P&P Committee and Medical Services Committee for review and approval.
Credentials Committee

The Credentials Committee is responsible for overseeing the credentialing and recredentialing of all practitioners/providers contracted with Care1st Health Plan. The CMO serves as chairman of the Credentials Committee, which is comprised of a multispecialty panel of practitioners/providers in the Care1st network, the QI AVP, the Credentialing Manager, and any additional physicians as needed, for their professional expertise. However, only physicians have the right to vote in Credentials Committee Meeting. A minimum of three (3) voting Members is considered a quorum. The Credentials Committee meets once a month but not less than quarterly. If there is a need, committee will conduct an ad-hoc meeting.

The responsibilities of the Credentials Committee include but are not limited to:

- Review, recommend, and approve/deny initial credentialing, recredentialing, ongoing monitoring activities and inactivation of direct-contracted practitioners/providers for the Care1st network;
- Review and approve credentialing policies and procedures and ensure that they are in compliance;
- Review and recommend actions for all network practitioners/providers identified with sanction activities from the state licensing agency and Medi-Cal and OIG;
- Ensure appropriate authorities were reported when there is a quality deficiency. ; and
- Ensure Fair Hearings are offered and carried out in accordance to the established policies and procedures.

9.14.1 Minimum Credentials Criteria

All practitioners will be credentialed and recredentialed in accordance to the approved policies established by Care1st.

1. All applicants will meet the following minimum credentialing requirements:
   a) Hold and maintain a current and unrestricted State medical or professional license.
   b) Hold a current and valid DEA certificate, if applicable.
   c) Maintain current and valid malpractice insurance in at least a minimum coverage of $1 million per occurrence and $3 million annual aggregate (Optometrists and audiologists are required to have minimum malpractice coverage of $1 million per occurrence and $2 million annual aggregate).
   d) Maintain current hospital privileges in the requested specialty at a Care1st contracted hospital. This requirement may be waived only for PCPs if the physician arranges for another Care1st practitioner/provider to provide hospital coverage at a contracted hospital. This arrangement must be documented in writing by the covering physician and submitted to Care1st. Exception to this requirement is granted to specialties that do not typically require admitting privileges (i.e., dermatology, pathology, radiology, psychology, and optometry).
   e) Meet minimum training requirements for the requested specialty. The applicant must have no mental or physical conditions that would, with reasonable accommodation, interfere with his/her ability to practice within the scope of the privileges requested.
   f) Be eligible to participate in the Medi-Cal program with no sanctions.
   g) Have no felony convictions.
h) Be able to provide coverage to Members, either personally or through appropriate physicians 24 hours per day, seven (7) days per week.
i) Agree to abide by Care1st policies and procedures.
j) PCPs are required to have a passing score on the facility site review and medical record review.

2. All applicants will meet the following minimum training requirements:
Physicians (MD, DO) must be either:
- Board certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty boards;
- Board qualified with the ABMS or AOA by having completed the requisite residency or fellowship required by the particular Board;
or
- A practitioner who has satisfactorily completed an Accreditation Council for Graduate Medical Education (ACGME) accredited internship prior to the establishment of the Family Practice Board in 1969, and had been in practice full time since may be "grandfathered" into Family Practice.

a) A specialist provider applying as primary care provider must completed at
least one year stateside training in primary care medicine (Internal Medicine or Family Practice);
b) A primary care provider applying as a specialist must completed at least
one year of specialized training (not in primary care medicine) in United States and provide two letters of recommendation from other primary care physicians.
c) An OB/GYN requesting PCP status must have completed at least one year of stateside primary care medicine. If an OB/GYN has completed at least one year of specialized training (not in primary care medicine) in the United States and he/she may substitute two (2) letters of recommendation from other primary care physicians for one year of primary care training.
d) The physician has completed an International Medical Graduate (IMG) training program and has completed a Canadian or British Isles residency program. (The ABMS formally recognizes Canadian and British medical schools and residencies as equivalent to US training but does not recognize Canadian and British Specialty Boards).
e) Podiatrists (DPM) are required to be either board certified by a Board recognized by the American Podiatric Medical Association (e.g., American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) and American Board of Podiatric Surgery (ABPS) or completed a podiatric residency program or doctorate in podiatric medicine.
f) Optometrists (OD) are required to complete a professional degree in Optometry.
g) Oral Surgeons (DDS, DMD) are required to have completed
a professional degree in dentistry.
h) Physician assistants (PA), nurse practitioners (NP), clinical nurse specialist (CNS) and nurse midwives (NMW) must have successfully completed the academic program required for the requested status. For example, a nurse practitioner must have completed a nurse practitioner academic program.
i) Allied health professionals are required to have successfully completed the professional program required for their requested specialty.
j) The HIV specialist must meet any one of the following four criteria:
   - Credentialed as an “HIV Specialist” by the American Academy of HIV Medicine.
   - Board certified in HIV medicine by a Member board of the American Board of Medical Specialties.
   - Board certified in Infectious Disease and meets the following qualifications:
     - In the immediately preceding 12 months, has provided continuous and direct medical care to a minimum of 24 patients who are infected with HIV.
     - In the immediately preceding 12 months, has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year.
   - Meets the following qualifications:
     - In the immediately preceding 24 months, has provided continuous and direct medical care to a minimum of 20 patients who are infected with HIV.
     - Has completed any of the following:
       i. In the immediately preceding 12 months, has obtained board certification or recertification in infectious disease.
       ii. In the immediately preceding 12 months, has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients.
       iii. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention and diagnosis or treatment of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.
k) The HIV specialist may utilize the services of a nurse practitioner or physician assistant if:
   - The nurse practitioner or physician assistant is under the supervision of an HIV specialist.
   - The nurse practitioner or physician assistant meets the qualifications specified above.
   - The nurse practitioner or physician assistant and the supervising HIV specialist have the capacity to see an additional patient.
The Credentialing Committee may consider other exceptions as it deems necessary and/or appropriate. The Chief Medical Officer may recommend the acceptance of an applicant even if the practitioner/provider does not satisfy minimum criteria if there is a determined need and if there is credible evidence that the practitioner/provider is capable of providing the services requested.

**Recredentialing**

At least every three (3) years, a practitioner/provider must be recredentialied in order to maintain his/her Membership with Care1st. Six months prior to the recredentialing due date, Credentialing Department will mail out a pre-print recredentialing application to the practitioner/provider for review. The practitioner/provider will be instructed to review and update the application with current information, complete an attestation questionnaire, sign, date the appropriate pages, and return it with the supporting documentation as required to the Credentialing Department. A cover letter stating that failure to return the recredentialing application by its deadline may be considered a voluntary resignation by the practitioner/provider. Upon receipt of a completed recredentialing application, the Credentialing Department will follow its procedures in processing the application for recredentialing. If the recredentialing application is not received by Care1st Credentialing Department by the given timeframe, a follow-up for recredentialing will be mailed to the practitioner/provider. A final follow-up will be sent to practitioners/providers who have not returned their applications after 90 days from the initial mailing. The Contracting Department will be notified of the practitioners/providers who are non-responsive to the recredentialing requests and will follow their procedures for appropriate action, including administrative termination for non-compliance.

**Credentialing Time Limit**

The credentialing and recredentialing documents must be within 180 calendar days prior to the Credentialing Committee decision.


PPGs that are delegated for credentialing activities are required to credential and recredential practitioners/providers, mid-level practitioners/providers and non-physician practitioners/providers in accordance with the above Care1st policies and procedures, NCQA guidelines and applicable federal and state laws and regulations. Recredentialing is required at least every three (3) years.

Care1st retains ultimate responsibility and authority for all credentialing activities. Care1st will assess and monitor the PPG’s delegated credentialing activities as follows:

1. The Credentialing Delegation Oversight Auditor will conduct pre-contractual and annual onsite audits in accordance with the Delegated Oversight Policy and Procedure. The audit will include a review of the PPG’s policies and procedures, Credentialing Committee minutes, ongoing monitoring, quarterly reports and the PPG’s credentials files. The standardized audit tool (Appendix C) will be used to conduct the audit. The PPG will be required to submit a credentialing roster, with specialty, credentialing and recredentialing dates, at least one (2) week prior to the scheduled audit date.

2. Care1st will use one of the following techniques for the file review:
Care1st pre-delegation or annual audits will have their credentialing files reviewed based on the NCQA's 8/30 Rule. Prior to the audit, the Care1st auditor will provide a list of 30 initial files and 30 recredentialing files to be reviewed at the audit to the PPG. The Care1st auditor will audit the files in the order indicated on the file pull list. If all eight (8) initial files are compliant with all the required elements, the remaining 22 reserve initial files will not have to be reviewed. If any of the first eight (8) files are scored non-compliant for any required element, then the auditor will need to review all 30 initial files. After completion of the initial file review, the auditor will follow the same procedure for the recredentialing files review.

3. PPG will be required to sign and abide by the credentialing delegation agreement, which is attached to the capitated group agreement.

4. To be delegated and to continue delegation for credentialing, PPGs must meet the minimum standards by scoring at least 95%. If the PPG scored below 95%, a corrective action plan (CAP) is required. PPG must submit all deficiencies to Care1st Credentialing Department within 30 days of notification is received. After reviewing the CAP, the PPG will be sent a letter noting acceptance of the CAP or any outstanding deficiencies.

The Credentialing Department will ensure the CAP meets all regulatory requirements.

1. Delegated credentialing status may be terminated by Care1st at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.

2. Care1st retains the right to approve, suspend and terminate practitioner/providers or sites based on issues with quality of care.

3. Delegated PPGs are required to submit a quarterly report for practitioners/providers credentialing and recredentialing activities.

4. The PPG is required to review all Care1st practitioners/providers sanction activities within the 30 days of the report issued date and report the finding to Care1st as Care1st practitioners/providers are identified.

5. The PPGs is responsible to provide and assist any credentials document needed for investigation and audit which include but not limited to specific information related to a provider's training, action related to any sanctions, etc.

6. The PPG is required to submit copies of originals files for selected practitioners/providers at the time of regulatory agency oversight audits or at any time requested by the health plan for regulatory oversight audit

**Credentials Process for Directly Contracted Physicians**

- The Credentials Committee is responsible for making decisions regarding initial credentialing, recredentialing, and changes to credentials, and inactivation of all direct-contracted practitioners/providers.

- Care1st has adopted the California Participating Physician Application (CPPA), or CAQH applications.

  a. Reasons for inability to perform the essential functions as a provider,
with or without accommodation.

b. Lack of present chemical dependency or substance abuse, including illegal drugs.

c. History of loss of license and felony convictions.

d. History of loss or limitations of privileges or disciplinary activities.

e. Attestation regarding the correctness and completeness of the application.

In addition to completing an initial application, the practitioner must provide:

- A copy of his/her current professional license to practice.
- A copy of a current and valid DEA certificate (if applicable).
- A copy of a current malpractice insurance certificate with the practitioner listed as an insured with the minimum required coverage.
- A current curriculum vitae (CV).
- A copy of the ECFMG certificate (if applicable).
- A written explanation regarding any sanction activity, malpractice judgments in the last five (5) years or pending claims, restriction of privileges, etc.

Upon receipt of a completed application, Care1st will obtain and verify the information in accordance to its policies and procedures. Information, unaccompanied by all the supporting documentation, dated more than three months prior to receipt, etc.) is received, the Credentialing Department will contact the applicant for the missing information. Failure to submit the information within after the third attempt will be considered a voluntary withdrawal of the application.

An initial facility site review/medical record review of all PCP offices are required prior to inclusion into the Care1st network. This will be a structured visit, in accordance with the QI facility site review and medical record procedures. The FSR must be conducted within three (3) years prior to initial credentialing.

Upon completion of the credentialing verification process, a report summarizing each applicant’s credentials is forwarded to the Credentials Committee for review and action. If the Committee recommends denial, limitation, suspension, or termination of Membership based on a medical disciplinary cause or reason, the practitioner shall be entitled to a formal hearing pursuant to the Fair Hearing policy. The Fair Hearing policy does not apply to mid-level practitioners.

A report of the Credentialing activity is forwarded to the Medical Services Committee for approval. The Credentialing Committee’s approval date is considered as the final credentialing approval date.

The Credentialing Department notifies the Contracting Department or the P rovide r Network Operation (PNO) for credentialing activities on monthly basis. The monthly distribution includes a practitioners/providers listing and a practitioner/provider profile. The Contracting Department and PNO will follow their procedures for executing the contract and adding the practitioner/provider to the network.

**Practitioners/Providers’ Rights**
Practitioners/Providers shall have the right to:

- Review all non-protected information obtained from any outside source in support of their credentialing applications, except references or recommendations protected by peer review laws from disclosure.
- Respond to information obtained during the credentialing process that varies substantially from the information provided by the practitioner/provider.
- Correct erroneous information supplied by another source during the credentialing verification process.

Practitioners will be notified of their rights in the initial and recredentialing application packet.

**Confidentiality of Credentials Information**

All information related to credentialing and recredentialing activities is considered confidential. All credentialing documents are kept in locked file cabinets in the Credentialing Department, which is kept locked when not occupied. Only authorized personnel will have access to credentials files. Practitioners/Providers may access their files in accordance with the established policies. All confidential electronic data will be access-controlled through passwords. Access will be assigned based on job responsibility, and also on a need-to-know basis. All Credentials Committee Members, guests, and staff involved in the credentialing process will sign a confidentiality agreement at least annually.

**Sanction Review**

Care1st queries the National Practitioner Data Bank, Office of Inspector General, Medi-Cal S&I, SAM and state licensing agencies at the time of initial and recredentialing to determine if there have been any sanctions placed or lifted against a practitioner/provider. Documentation regarding the identified sanction is requested from the agency ordering the action. If the affected practitioner/provider is contracted directly with Care1st, then the practitioner/provider is notified in writing of the action and requested to provide a written explanation of the cause(s) for the sanction and the outcome. If the practitioner/provider is delegated to a PPG, then the affected PPG is notified of the sanction activity in writing and requested to provide a written plan of action. This information, along with the documentation and the PPG’s response, is forwarded to the Credentials Committee for review and action.

Care1st also monitors the practitioner for license, DEA and malpractice insurance expiration dates. On a monthly basis, the Credentialing Department runs a report for the medical/professional license, DEA, and malpractice insurance due to expire within the following month. License renewals are verified with the licensing board within 30 days of the expiration date. The DEA renewals are verified from the National Technical Information Service (NTIS) or by an updated copy from the provider. Malpractice insurance renewals are verified by an updated copy of the certificate from the provider.

**Summary Suspension of a Practitioner’s Privileges**

Immediate action will be taken to suspend a practitioner’s privileges in the event of a serious adverse event. A serious adverse event is defined as any event that
could substantially impair the health or safety of any Member.
Immediate action will also be taken to suspend a practitioner's privileges in the event
the practitioner fails to meet the following minimum credentialing criteria:

The practitioner's license to practice has been revoked, suspended, or under any
type of restriction or stipulation, including probation, by the state licensing agency.
The practitioner has been suspended from the Medi-Cal program; however, this does not
apply to practitioners who participate in only in the Medicare program.

The practitioner fails to maintain the minimum malpractice liability coverage.
Should a practitioner/provider fail to meet the minimum credentialing criteria as
described above, Care1st will allow the practitioner/provider a chance to correct
the deficiency before inactivating the practitioner/provider. Upon knowing that a
practitioner/provider is noncompliant, the Credentialing Department will notify
the practitioner/provider immediately in writing of the deficiency. The notification will
specify the methods available for correcting the deficiency and the timeframe allowed for
the submission, and that failure to correct the deficiency will result in immediate
inactivation. Any information regarding an adverse event will be forwarded to the QI
Department as a potential quality issue (PQI) and handled in accordance with the
established policies and procedures.

The Chief Medical Officer has the authority to immediately suspend any or all
portions of a practitioner's privileges in the event of a serious adverse event (as
defined above). The written notice will include a notice of the practitioner's right to a
Fair Hearing. (Please refer to Policy 70.1.3.10 Fair Hearing Plan for detail)

A summary suspension of a practitioner's membership or employment is imposed for a
period in excess of fourteen (14) days. The notice of suspension shall be given to legal
department for ratification. In the event of suspension, the practitioner's members shall be
assigned to another practitioner. The wishes of the patient shall be considered, where
feasible, in choosing another practitioner.

Care1st will adhere to the California Business and Professional Codes requirements
for submitting 805 and 805.01 reports to the Medical Board of California and to the
Healthcare Quality Improvement Act of 1986 for reporting to the National Practitioner
Data Bank and to the State Medical Board.

Health Delivery Organizations

Prior to contracting with, and at least every three (3) years thereafter, Care1st will
evaluate health delivery organizations (HDO) such as hospitals, home health
agencies, skilled nursing facilities, and nursing homes to ensure they have
appropriate structures and mechanisms in place to render quality care and services.
The evaluation process includes confirmation of the following:

- In good standing with the state and federal regulatory bodies.
- Current accreditation by a Care1st recognized accrediting bodies.
- If the HDO is not accredited, the Care1st facility site review, CMS or DHHS
- Survey is required.