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SECTION 3: PROVIDER CREDENTIALING

CREDENTIALING

Credentialing is an important function of the Quality Management and Improvement (QMI) Department. Health Plan's credentialing program has been developed in accordance with the standards of the National Committee for Quality Assurance (NCQA), the California Department of Health Care Services (DHCS), California Department of Managed Health Care (DMHC), and all other State and federal requirements. Health Plan initially credentials most health care Providers seeking to participate in the network and recredentials them at least every three (3) years. Credentialing information submitted to Health Plan is reviewed and verified using many resources, including Primary Source Verification as applicable. To verify information, Health Plan uses the same sources and processes for initial credentialing and recredentialing.

In order to assure the highest quality health care delivery system and to maintain compliance with all regulatory agencies, Health Plan credentials or oversees the credentialing of the following types of Providers:

- Physicians (MD)
- Osteopathic Practitioners (DO)
- Podiatrists (DPM)
- Nurse Practitioners (NP)
- Chiropractors (DC)
- Oral Surgeons (DMD)
- Physician Assistants (PA)
- Nurse Midwives (NMW)

In addition, Health Plan also credentials the following allied health professionals and ancillary Providers:

- Psychologists
- Optometrists
- Physical Therapists
- Speech/Hearing Therapists
- Telemedicine Providers
- Mental Health and Substance Use Disorder Provider
- Occupational Therapists
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage Family Therapists (LMFT)
- Other allied or ancillary Providers as deemed necessary.
- Street Medicine Providers

The credentialing process typically takes between sixty (60) and ninety (90) days. For Mental Health and Substance Use Disorder Providers, Health Plan will notify them within seven (7) business days of receipt of a credentialing application to: 1) verify receipt; and 2) inform the Provider whether the application is complete. The information gathered during this process is confidential and disclosure is limited to parties who are legally permitted under State and federal law to have access to this information.

In order to maintain health care quality standards, no Members will be assigned or referred to Providers who have not completed the credentialing process and signed an Agreement with HPSJ to participate in the network.

SECTION 3: PROVIDER CREDENTIALING

OBTAINING A CREDENTIALING APPLICATION

For New Contract Opportunities or for Existing Contracted Providers, contact the Contracting Department by visiting www.hpsj.com/provider-contract-request

A Contracting Coordinator or Network Manager will screen Provider for Medi-Cal Fee for Service Enrollment or submission prior to contacting the Credentialing Department to send out the Electronic Credentialing application.

REQUIREMENTS FOR NETWORK PARTICIPATION

Requirements for Physicians

Health Plan will ensure that at a minimum, physicians considered for network participation and continued participation are in good standing (through Primary Source Verification, as applicable), the sources and processes used at initial credentialing and re-credentialing to verify information are the same and meet the following criteria before being accepted in the network:

- Valid, unrestricted, and current California State license
- Medi-Cal Fee for Service or Ordering, Prescribing, and Referring (ORP) Enrollment
- Clinical privileges at a Hospital or coverage arrangements with another physician for Members who require hospitalization (if applicable)
- Current and valid federal Drug Enforcement Agency (DEA) registration for the State
- Current and valid Controlled Dangerous Substance (CDS) certificate for the State
- Graduation from an approved medical school and completion of an appropriate residency or specialty program
- Board certification (if required)
- Work history of the preceding five (5) years acceptable to Health Plan
- Current professional liability (malpractice) insurance in amounts acceptable to Health Plan
- Professional liability claims history acceptable to Health Plan
- Absence of Office of Inspector General (OIG) exclusions
- Absence of State sanctions against licensure
- National Practitioner Data Bank (NPDB) query results acceptable to Health Plan
- Absence of Medicare and Medi-Cal/Medicaid sanctions
- Absence of Quality of Care and service issues
- Facility Site Review (FSR) findings acceptable to Health Plan, if an office site visit is conducted

For recredentialing, acceptable findings from quality reporting are required. This may include but is not limited to a review of:

- Member and Provider complaints
- Results of access and satisfaction surveys
- Grievance reports
- Potential Quality Incident (PQI) reporting

Requirements for Non-Physician Providers & Non-Physician Medical Practitioners

Health Plan shall ensure, at a minimum, that non-physician Providers and Non-Physician Medical Practitioners considered for network participation and continued participation are in good standing (through Primary Source Verification, as applicable) and meet the following criteria before being accepted in the network:

- Valid, unrestricted, and current State license
- For prescribing practitioners, current, valid federal Drug Enforcement Agency (DEA) registration for the State
- For prescribing practitioners, current, valid Controlled Dangerous Substance (CDS) certificate, for the State
- Work history of the preceding five (5) years acceptable to Health Plan
- Current professional liability (malpractice) insurance in amounts acceptable to Health Plan
- Graduation from an approved professional school
- Board certification, if applicable
- Hospital clinical privileges, if applicable
- Professional liability claims history acceptable to Health Plan
- Absence of Office of Inspector General (OIG) exclusions
- Absence of State sanctions against licensure
- National Practitioner Data Bank (NPDB) query results acceptable to Health Plan
- Absence of Quality of Care and service issues

THE CREDENTIALING PROCESS

During the credentialing process, the information on the Provider's electronic credentialing application is reviewed and verified for correctness, and then reviewed through government

verification sources which will include, but not be limited to:

- National Practitioner Data Bank (NPDB)
- Office of Inspector General (OIG)
- State licensing boards for California and other states if applicable

In addition to providing documentation, a Facility Site Review (FSR) may be required for Primary Care Physicians (PCP). Providers will be contacted by Health Plan's FSR Team to schedule and coordinate the FSR.

Completed electronic credentialing applications will then be presented to the Peer Review & Credentialing Committee (PR&CC) which currently meets every other month. The PR&CC reviews each credentialing application to determine if the Provider meets the initial credentialing or recredentialing criteria, and then makes the decision to either accept or reject a Provider's application.

All credentialing applications approved by the PR&CC are submitted to the San Joaquin County Health Commission for review and final approval. The Commission meets monthly and once the Commission grants approval, the Health Plan can offer or complete an Agreement with the Provider.

INITIAL CREDENTIALING

The Provider data that is examined during the credentialing and recredentialing process includes:

- California State licensure
- Medi-Cal Fee for Service or Ordering, Referring, and Prescribing (ORP) Enrollment
- Current professional liability insurance or self-insurance
- Provider's primary admitting hospital, if appropriate
- Exclusions, suspensions, or ineligibility to participate in any State or federal health care program
- National Provider Identification (NPI) number
- Valid California Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate, if applicable
- Education and training, including board certification (if the Provider states on the application that he or she is board certified)
- American Medical Association (AMA) screening for Education Commission for Foreign Medical Graduates (ECFMG)
- Work history

- History of professional liability claims
- National Practitioner Data Bank
- Licenses of any mid-level Providers employed under the Provider, as well as verification of liability insurance coverage for the mid-level Provider.

RECREDENTIALING

Health Plan re-credentials all Providers at least every three (3) years but may re-credential Providers more often if it is deemed necessary. The same information that is reviewed during the initial credentialing process is usually reviewed during the recredentialing process with the exception of the Provider's educational credentials and work history. In addition, Health Plan will review Provider contact logs to assess any Quality of Care issues.

The recredentialing process requires a timely response from all Providers. Providers will receive an electronic recredentialing link five (5) months in advance of the three (3) year anniversary of the last credentialing date. Providers are required to complete identified areas of the application and verify that the information provided on the application is current. Electronic Recredentialing packets are sent to practitioners at least every thirty-six (36) months or sooner.

The practitioner has 15 business days to send the recredentialing materials to Health Plan. If materials are not received within that timeframe, the Credentialing Specialist sends a second request on the 16th day. If the recredentialing materials are not received 15 business days after the second notice, on the 16th day, a THIRD AND FINAL notice is sent to the practitioner via email by the Contracting Department.

If the recredentialing materials are not received within 15 business days of the final notice, on the 16th day, the Credentialing Specialist notifies the Contracting Department. The Contracting Department attempts to obtain the materials. If unable to do so, the Contracting Department notifies the practitioner that he or she will receive an Administrative Termination via Certified Mail as the recredentialing appointment date has expired.

A practitioner may reapply for participation however the full initial credentialing process will be required.

PROVIDER'S RIGHTS DURING THE CREDENTIALING PROCESS

Review of Credentialing Files

Providers have the right to review the information in their credentialing files that have been obtained in order to evaluate their credentialing application. This includes the application, attestation, and Curriculum Vitae (CV), and information from outside sources. Files that are not available for review would include references, recommendations, or other peer-review protected information which are used by the Chief Medical Officer and/or PR&CC to determine initial

network participation and/or contract continuance.

Requests to review this file must be made in writing to the Chief Medical Officer, and the Chief Medical Officer will be present at the time of review.

Health Plan notifies Providers of this right to review credentialing files through a number of sources, which includes notifications in the credentialing application or reapplication cover letter, Health Plan's website, the Provider contract, this Provider Manual, and other publications distributed to Providers.

Notification of Errors in Credentialing Submissions

In the event that credentialing information obtained by the Health Plan varies substantially from that provided by the Provider on the application materials, Health Plan Credentialing Specialists will notify the Provider by letter, telephone, or fax. If the notification is conducted by telephone, the date, time, and the person initiating the call and obtaining the information along with the response will be documented and the documentation retained in the credentialing file.

The notification to the Provider will include the following:

- A description of the discrepancy
- A request for a written explanation and/or correction of the discrepancy
- The name and telephone number of the Credentialing Specialist to whom the response should be submitted
- Notification that a written response is due no later than sixty (60) calendar days from the date of the letter
- Notification that failure to respond within the sixty (60) calendar days will result in, for initial application, closure of the file for lack of response
- For recredentialing Providers, notification that the file will be presented to the Peer Review and Credentialing Committee without benefit of explanation or correction of the discrepancy

The Credentialing Specialist will review the response, sign and date the response, and then notify the Provider that the response has been received. The Credentialing Specialist will also document the receipt and notification to the Provider of the receipt of the information in the credentialing file. Health Plan staff Members are not required to reveal to a Provider the source of the information if the information is not obtained to meet Health Plan's credentialing verification requirements, or if law prohibits disclosure.

Correction of Erroneous Information

Providers have the right to correct erroneous information they may have provided within 14 business days or which has been submitted by another party in the course of the credentialing process. If information provided on the application is inconsistent with information obtained via Primary Source Verification in the credentialing or recredentialing process, the Credentialing Specialist will send the Provider a written notification of the discrepancy and request formal written clarification.

This letter will include a summary of the information in question and a request to have the Provider's response to the information returned within fourteen (14) business days. This letter will be sent electronically or via certified mail marked as "Confidential" with return receipt requested.

Providers do not have the right to correct an application already submitted and attested to be correct and complete. Providers have the right to correct erroneous information prior to the notification of decision and for applications that have not yet been attested to be correct and complete. However, they may submit an addendum to correct erroneous information they may have provided, or which is submitted by another party. This can be sent to the Credentialing Specialist via electronic or certified mail. If preferred, the Provider may add an explanation for the erroneous information on their application, include a signed and dated statement attesting to the accuracy of the information provided, and then return the information to the Credentialing Specialist who initiated the query.

Application Status and Notification on Decision

Providers have the right to receive information about the status of their application or reapplication and may contact the Credentialing Department at any time to request this information. The Credentialing Department will respond to these requests in writing no later than 60 days after receipt of request.

Health Plan will notify Providers in writing of their approval no later than sixty (60) calendar days from the Peer Review and Credentialing Committee's (PR&CC) approval date. Any Provider who is denied participation, approved with conditions, pended or terminated, will be notified in writing within sixty (60) days of the PR&CC's action and given the reasons for the decision.

CREDENTIALING A NEW GROUP PROVIDER

To ensure that there is no disruption in obtaining services requiring prior authorization and to avoid claims being denied, it is imperative that any new Provider who joins a Group in Health Plan's Provider network is approved by the PR&CC prior to providing Covered Services to Members.

Before a Provider can be added to a Group contract the new Provider must receive notification from the Credentialing Department that all credentialing requirements have been met. In addition, Providers must receive official notice from the Contracting Department as to the effective date upon which they can provide Covered Services to Members. The Provider Services Department should be contacted as soon as possible when new Providers are joining a Group.

ECM Providers

HPSJ will ensure all ECM Providers for whom a state-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant DHCS All Plan Letters (APLs), including APL 19-004 (Provider Credentialing/Recredentialing and Screening/Enrollment) and any subsequent APLs. If APL 19-004 and other subsequent APLs do not apply to an ECM Provider, HPSJ will verify qualifications and experience of ECM Providers, which must extend to individuals employed by or delivering services on behalf of the ECM Provider. HPSJ will ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.

Credentialing Provider Organization Certification

HPSJ may obtain Credentialing Provider organization certification (POC) from the NCQA. HPSJ may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider's facilities.

DELEGATED CREDENTIALING

When appropriate and at our sole discretion, Health Plan may elect to delegate credentialing functions to another entity. However, responsibility for final acceptance of a Provider and the continuation of a Provider rests with the PR&CC and the San Joaquin County Health Commission.

Each delegated credentialing entity must sign the *Delegated Credentialing Agreement* which outlines the responsibilities of both Health Plan and the delegated entity, as well as the evaluation process of the delegated entity's performance. Delegated entities must also meet all other criteria as outlined in Health Plan's delegation policies.

Delegation is renewed annually, contingent upon an ongoing evaluation of the delegate's performance and successful completion of delegation audits. Either party may terminate the *Delegated Credentialing Agreement* without cause with thirty (30) days prior written notice. Delegated entities must provide practitioner rosters at least quarterly to the Compliance Department. These rosters can be submitted to: ComplianceDepartment@hpsj.com

Any Provider additions or terminations that occur in between the quarterly submittals must be submitted to the Compliance Department as soon as possible and as often as they occur. Failure to provide timely updates to the practitioner rosters may result in Provider Authorizations and claims being denied.

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FACILITY SITE REVIEW (FSR)

Health Plan conducts site reviews for all primary care sites contracted to provide care to Medi-Cal Members as required by California statute (Title 22, section 56230). This review is done at the time of initial credentialing and every three (3) years at a minimum as part of the recredentialing

process. Providers must notify Health Plan at least thirty (30) days prior to the relocation of their practice or clinic so that a review may be conducted at the new site. The site review process includes the following:

- **Facility Site Review (FSR):** a formal review of primary care sites that occurs prior to the practice accepting Medi-Cal Managed Care Members, and then every three (3) years thereafter
- **Medical Record Review (MRR):** A review of selected medical records to determine compliance in the documentation of clinical care
- **Physical Accessibility Review Survey (PARS):** A review to determine physical accessibility for seniors and people with disabilities
- **Focused Review:** A focused review is a targeted review of one or more specific areas of the FSR or MRR. The Plan must not substitute a focused review for a site review. The Plan may use focused reviews to monitor Providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions. Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review, or other methods to investigate identified deficiencies or situations. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to the Corrective Action Plan (CAP) timelines.

All new primary care sites must undergo an initial full scope site review and attain a minimum passing score of eighty percent (80%) on both the FSR and on MRR surveys. Initial full scope site reviews will be performed at sites that have not previously had a FSR, PCP sites that have not had a FSR within the past three (3) years, and PCP sites that are returning to Medi-Cal Managed Care and have a passing score but were previously terminated for cause and non-compliance with their CAP.

There are additional scenarios that require the Health Plan to conduct an initial site review. Examples of these scenarios include, but are not limited to, instances when:

- A new PCP site is added to the Plan's network.
- A newly contracted Provider assumes a PCP site with a previous failing FSR and/or MRR score within the last three years.
- A PCP site is returning to the Medi-Cal managed care program and has not had a passing FSR in the last three years.
- There is a change of ownership of an existing Provider site.
- A PCP site relocates.

When a PCP site relocates, the Health Plan must:

- Complete an initial FSR within 60 days of notification or discovery of the completed move.

- Allow assigned Members to continue to see the Provider.
- Not assign new Members to Providers at the site until the PCP site receives passing FSR and MRR scores.
- The reviewer will also complete a PARS during the initial site.

The FSR can be waived by Health Plan for a pre-contracted Provider site if the Provider has documented proof that a current FSR with a passing score was completed by another health plan within the past three (3) years. Health Plan may review sites more frequently if it is determined necessary.

Non-Compliance or Failure on FSR

Pre-contractual Providers

A pre-contractual Provider who scores below 80% on the full scope site review survey shall not be counted as a network Provider. Prior to being contracted with Health Plan, a non-passing Provider must be re- surveyed and pass the Full Scope Site Review Survey at 80% or higher. After achieving a score of 80% or higher, a CAP shall be completed as specified under CAP steps. Health Plan reserves the right not to contract with any Provider who does not pass the pre-contractual Site Review Survey.

Contracted Providers

Contracted Providers must also pass the FSR at a score of eighty (80%) or higher. Non-passing Providers shall be notified of the survey score, all cited deficiencies and CAP requirements at the time of the non-passed survey. Health Plan shall have the right to remove any Provider with a non-passing score from the Provider network. However, if a Provider with a non- passing score is allowed to remain in the Provider network, survey deficiencies must be corrected by the Provider and verified by the plan within the CAP timelines. Enrollment of new Members shall not be assigned to Providers that score below 80% on a subsequent full scope site review survey, until corrections are verified, and the CAP is closed. If the corrections are appropriately made and Health Plan closes the completed CAP the Provider shall remain in the network and new Member assignments shall resume.

Non-Compliant Provider

(1) Providers that do not correct survey deficiencies within the established CAP timelines shall not be assigned new Members, until such time as corrections are verified and the CAP is closed. Any network Provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and Members shall be appropriately re-assigned to other network Providers. Health Plan shall provide affected Members with a 30-day notice that the non-compliant Provider is being removed from the network. In addition, Provider sites that score below 80 percent in either the FSR or MRR for two consecutive reviews must score a minimum of 80 percent in the next site review in both the FSR and MRR (including sites with open CAPs in

place). Sites that do not score a minimum of 80 percent in both the FSR and MRR despite the Health Plan's ongoing monitoring, must be removed from the network and Members must be appropriately reassigned to other network Providers. Health Plan must provide affected Members with a 30-day notice that it will remove the noncompliant Provider from the network.

Site Review and Medical Record Review Requirements for Street Medicine:

Street medicine Providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review.

For street medicine Providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, Health Plan must conduct the full review process of the street medicine Provider and affiliated facility in accordance with APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review.

For street medicine Providers serving as an assigned PCP, and that are not affiliated with a brick-and mortar facility or mobile unit/RV, Health Plan must conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine Provider to ensure Member safety as per the limited/ condensed (as shared by DHCS) to FSR and MRR requirements that would apply only to a street medicine Provider under this scenario.

Scoring

	Exempted Pass	**Conditional Pass**	**Fail**
FSR	• Score of 90% and above with no deficiencies in critical elements, infection control, or pharmacy • CAP not required	• Score of 90% and above with deficiencies in critical elements, infection control, or pharmacy • Score of 80% and above • CAP required	• Score below 80% • CAP required
MRR	• Score of 90% and above, with all section scores at 80% and above • CAP not required	• Score of 90% and above with one or more section scores below 80% • Score of 80% and above • CAP required	• Score below 80% • CAP required
The Health Plan may require a CAP regardless of score for other findings identified during the survey that require correction.			

Corrective Action Plans for Deficiencies

All sites that receive a Conditional Pass, which is defined as eighty to eighty nine percent (80–89%), or ninety percent (90%) and above with deficiencies in critical elements, pharmaceutical services, or infection control, will be required to establish a CAP that addresses each of the noted deficiencies. CAP documentation must identify:

- Specific deficiency
- Corrective action(s) needed
- Re-evaluation timelines/dates
- Responsible person(s)
- Problems in completing corrective actions
- Education and/or technical assistance provided by Health Plan
- Evidence of the correction(s)
- Completion/closure dates
- Name/title of reviewer

Timelines for CAP

Providers will be informed of non-passing survey scores, critical element deficiencies, other deficiencies that require immediate corrective action, and the CAP requirements for these deficiencies.

Below is the timeline for correction and reporting:

CAP Timeline	CAP Action(s)
FSR and/or MRR Completion Day	Health Plan must provide the PCP site a report containing: • The FSR and/or MRR scores; • Any critical element findings, if applicable; and • A formal written request for CAPs for all critical elements, if applicable.
Within 10 calendar days of the FSR and/or MRR	• The PCP site must submit a CAP and evidence of corrections to the MCP for all deficient critical elements, if applicable. Health Plan must provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written request for CAPs for all non- critical element deficiencies. • Health Plan must provide educational support and technical assistance to PCP sites as needed.

Within 30 calendar days from the date of the FSR and/or MRR report	Health Plan must conduct a focused review to verify that CAPs for critical elements are completed. • The PCP site must submit a CAP for all non-critical element deficiencies to the MCP. • Health Plan must provide educational support and technical assistance to PCP sites as needed.
Within 60 calendar days from the date of the FSR and/or MRR report	• Health Plan must review, approve, or request additional information on the submitted CAP(s) for non-critical findings. • Health Plan must continue to provide educational support and technical assistance to PCP sites as needed.

Within 90 calendar days from the date of the FSR and/or MRR report	All CAPs must be closed. • Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
Beyond 120 days from the date of the FSR and/or MRR report	• Health Plan must request approval from DHCS to complete a CAP review for any extenuating circumstances that prevented completion of a CAP within the established timeline. • Health Plan must conduct another FSR and/or MRR, as applicable, within 12 months of the applicable FSR and/or MRR date(s).

FACILITY AND ANCILLARY CREDENTIALING

Facilities and Ancillary Providers seeking to contract with Health Plan must first fill out an application to verify they meet all regulatory and plan criteria for acceptance into the network. Application submission is not a guarantee of acceptance. The criteria for participation and continued participation may vary depending upon the types of Medi-Cal covered services provided and network need/adequacy. The minimum criteria are as follows:

Facility Providers

- Valid California state license
- Current general and professional liability (malpractice) insurance in amounts

acceptable to Health Plan

- Medicare/Medi-Cal Certification
- Accreditation by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or another accreditation body acceptable to Health Plan, if applicable
- Absence of Office of Inspector General (OIG) exclusions

Ancillary Providers

- Valid business license
- Current general and professional liability (malpractice) insurance in amounts acceptable to Health Plan
- Medicare/Medi-Cal certified and/or participating, as appropriate
- Clinical Laboratory Improvement Amendment (CLIA) certificate if applicable
- Accreditation for Radiology/Imaging, if applicable
- Absence of Office of Inspector General (OIG) exclusions

For more information regarding specific requirements for participation, please contact the Provider Contracting Department at (209) 942-6320.