5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers contracted under IEHP's Direct Network.

POLICY:

A. IEHP is required to adhere to all procedural and reporting requirements under State and Federal laws and regulations regarding the credentialing and recredentialing process, including the confidentiality of Practitioner information obtained during the credentialing process. Department of Health Care Services (DHCS) can modify these requirements at any time and is required to notify the Centers for Medicare & Medicaid Services (CMS) within 90 days prior of any such changes.

B. IEHP has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to its Members.[1]

C. IEHP has a process that describes how primary source information is received, dated and stored; how modified information is tracked and dated from its initial verification; the staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate; the security controls in place to protect the information from unauthorized modification; and how the organization audits the processes and procedures.[2]

D. IEHP has an annual documented process on monitoring its compliance with its CR (Credentialing) system controls.[3]

E. IEHP collects information from quality improvement activities and Member complaints for all Practitioner files undergoing the recredentialing process, to be included in the recredentialing decision making process.[4,5]

F. During the IEHP credentialing, recredentialing, and ongoing monitoring process, Practitioners are reviewed to monitor when network Physicians have opted out of participating in the Medicare Program, by verifying our Practitioners are not included on the Medicare Opt-Out Report.[6,7]

G. IEHP does not contract with Practitioners who are precluded from receiving payment for

[1] Title 42 Code of Federal Regulations (CFR), Part 455, Subpart E
[2] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 1, Element A, Factors 1-11
[3] NCQA, 2023 HP Standards and Guidelines, CR 1, Element D, Factors 1-3
[4] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.0033
[5] Department of Health Care Services (DHCS) All Plan Letter 22-013 Supersedes APL19-004, "Provider Credentialing/Re-Credentialing and Screening/Enrollment
[6] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.2
[7] DHCS APL 22-013

Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries. IEHP does not allow Practitioners identified on the preclusions list to participate in the IEHP network.

H. IEHP documented process for identifying Transgender Competent Practitioners during the credentialing and recredentialing process.

I. IEHP's documented process for pre-screening credentialing applications from Behavioral Health, Mental Health, and/or Substance Use Disorder Providers.

PURPOSE:

A. IEHP promulgates credentialing and recredentialing decision guidelines for Practitioners directly contracted with IEHP and Practitioners credentialed and contracted by IEHP, to perform these activities.

B. IEHP must demonstrate a rigorous process to select and evaluate Practitioners.

C. IEHP must offer to contract with at least one each of the following mandatory Provider types in each of our services counties, where available: Certified Nurse Midwife (CNM) and Licensed Midwife (LM).[8]

DEFINITION:

A. Attestation: A signed statement by a practitioner confirming the validity, correctness and completeness of a credentialing application.[9]

B. Automated Verification: Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

C. Board certified: A Practitioner has satisfied the requirements/standards of a nationally recognized specialty board and received the board's specialist certification.[10]

D. Board-certified consultant: A Practitioner external to a n organization who holds certification from an American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA) or other specialty board and acts in an advisory capacity to the organization.[11]

E. Clean files: Credentialing files that meet the organization's criteria for participation and are not required to be sent to the credentialing committee for review.[12]

F. Clinical Privileges: A Practitioner is authorized by a health care facility to provide defined

[8] DHCS APL 23-001 Supersedes APL 21-006, "Network Certification Requirements"
[9] NCQA, 2023 HP Standards and Guidelines, Glossary
[10] Ibid.
[11] Ibid.
[12] Ibid.

patient care services at the facility, based on the Practitioner's license, education, training, experience, competence and ability.[13]

G. National Practitioner Data Bank (NPBD): A federally mandated agency that is the repository of information about settled malpractice suits and adverse acts, sanctions or restrictions against the practice privileges of a Physician.[14]

H. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g. evaluation of a Physician's credentials and practice by another Physician).[15,16]

I. Primary source: The entity that originally conferred or issued a credential.[17]

J. Primary source verification: Verification of credentialing information directly from the entity (e.g. state licensing board) that conferred or issues the original credential.[18]

K. Qualitative analysis: An examination of deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. Also called a *causal, root cause* or *barrier analysis.* The analysis involves those responsible for the execution of the program.

L. Quantitative analysis: A comparison of numeric results against a standard or benchmark, trended overtime using charts, graphs or tables. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends.

M. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification and include what was verified verbally.

N. Verification Time Limit (VTL): National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification.

O. Written Verification - Requires a letter or documented review of cumulative reports. IEHP must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

PROCEDURES:

A. IEHP has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent Practitioners to provide care to its Members that includes Practitioner Credentialing Guidelines that specify:[19]

[13] NCQA, 2023 HP Standards and Guidelines, Glossary
[14] Ibid.
[15] Ibid.
[16] Business and Professions Code (Bus. & Prof. Code) § 805
[17] NCQA, 2023 HP Standards and Guidelines, Glossary
[18] Ibid.
[19] 42 CFR § 422.204

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

1. The types of Practitioners it credentials and recredentials. Credentialing requirements apply to:[20]
   a. Practitioners who are licensed, certified, or registered by the State of California to practice independently (without direction or supervision).
   b. Practitioners who have an independent relationship with the organization.
      1) An independent relationship exists when the organization directs its Members to see a specific Practitioner or group of Practitioners, including all Practitioners whom Member can select as Primary Care Providers (PCPs).
   c. Practitioners who provide care to Members under the organization's medical benefits.
   d. The criteria listed above apply to Practitioners in the following settings:
      1) Individual or group practices.
      2) Facilities; and
      3) Telemedicine.
   e. IEHP is required to contract with and credential all Practitioners defined as a PCPs, Specialists, Non-Physician Practitioners, and Physician Admitters, including employed Physicians participating on the Provider Panel and published in external directories who provide care to Members. At minimum, they include:
      1) Doctor of Medicine (M.D.)
      2) Doctor of Osteopathic Medicine (D.O.)
      3) Doctor of Podiatric Medicine (D.P.M.)
      4) Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.), who provide medical services only
      5) Occupational Therapists (O.T.)
      6) Physical Therapy (P.T.)
      7) Physician Assistants (P.A.) or Physician Assistants Certified (P.A.-C)
      8) Certified Nurse Midwives (C.N.M.)[21]
      9) Nurse Practitioners (N.P.)
      10) Speech Pathologists (S.P.)

[20] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 1
[21] DHCS APL 18-022 supersedes APL 16-017, "Provision of Certified Midwife and Alternative Birth Center Facility Services"

11) Audiologists (Au.)
12) Registered Dieticians (R.D.) and Nutritionists
13) Psychiatrists (M.D.)
14) Licensed Marriage and Family Therapists (L.M.F.T.)
15) Licensed Clinical Social Workers (L.C.S.W.)
16) Psychologists (Ph.D., Psy.D.)
17) Doctor of Chiropractic (D.C.)
18) Licensed Acupuncturists (L.Ac.)
19) Optometrists (O.D.)
20) Licensed Midwife (L.M.)[22]
21) Other Behavioral healthcare Practitioners
    - Addiction Medicine Specialists
    - Master Level Clinical Nurses
    - Licensed Professional Clinical Counselors (L.P.C.C.)[23]

f. Practitioners who do not need to be Credentialed:

1) Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the Hospital or another inpatient setting.
2) Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility.
3) Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) Functions.
4) Covering Practitioners (e.g., locum tenens).
    - Locum tenens who do not have an independent relationship with the organization are outside NCQA's scope of credentialing.
5) Practitioners who do not provide care for members in a treatment setting (e.g. board-certified consultants).

[22] DHCS APL 18-022
[23] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.3

6) Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

7) IEHP does not require Practitioners that are Hospital-based and that do not see Members on a referral basis to be credentialed.

2. Listed below are the sources used by IEHP to verify credentialing information of each of the following criterion listed below. All verification sources must be included in policy to ensure compliance.[24]

   a. State license to practice all Practitioners must be licensed in the state they practice, by the appropriate state licensing agency. The following license verifications must be obtained by the licensing board or their designated licensing and enforcement systems.

      1) The following licensures may be verified through BreEZe Online services or directly with the licensing board via phone or mail:

         - Medical Board of California (M.D.)
         - Osteopathic Medical Board of California (D.O.)
         - Board of Podiatric Medicine (D.P.M.)
         - Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C., L.P.C.C)
         - Board of Psychology (Ph.D., Psy.D.)
         - Dental Board of California (D.D.S., D.M.D.)
         - California Board of Occupational Therapy (O.T.)
         - California State Board of Optometry (O.D.)
         - Physical Therapy Board of California (P.T.)
         - Physician Assistant Committee (P.A., P.A.-C)
         - California Board of Registered Nursing (C.N.M., N.P.)
         - California Board of Chiropractic Examiners (D.C.)
         - Speech-Language Pathology & Audiology Board (S.P., Au)
         - Acupuncture Board (L.Ac.)

      2) Arizona practitioner licensures may be verified through:
         - Arizona Medical Board (M.D., D.O., P.A.)

   b. Drug Enforcement Administration (DEA) or Controlled Dangerous Substance

[24] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 2

(CDS) certificate, if applicable (VTL: 180 calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate verified through one (1) of the following sources:

1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision.
2) American Medical Association (AMA) Physician Master File
3) IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA number, and NPI number will be documented in the Practitioner's file; or
4) If a Practitioner does not have a DEA or CDS certificate, IEHP must have a documented process to require an explanation why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner's patients who need prescriptions requiring DEA certification.
5) If a Practitioner is practicing in Arizona, IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a Arizona address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA Number, and NPI number will be documented within the Practitioner's file.

c. Education and Training (VTL: Prior to the Credentialing Decision) IEHP may use any of the following to verify education and training:

1) The primary source from the Medical School.
2) The state licensing agency or specialty board or registry, if the state agency and specialty board, respectively, perform primary source verification. IEHP:
   - Obtains written confirmation of primary source verification from the primary source, at least annually; or
   - Provides a printed, dated screenshot of the state licensing agency or specialty board or registry website displaying the statement that it performs primary source verification of Practitioner education and training information; or

- Provides evidence of a state statute requiring the licensing agency, specialty board of registry to obtain verification of education and training directly from the institution, or
- National Student Clearinghouse may be considered an agent of the medical or professional school if the school has a contract with the Clearinghouse to provide verification services.
    - Delegates must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.

3) Sealed transcripts if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program; or
4) Below are acceptable sources for Physicians (M.D., D.O.) to verify graduation from Medical School:
    - American Medical Association (AMA) Physician Master File.
    - American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
    - Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

    Below are acceptable sources for Physicians (M.D., D.O.) to verify completion of residency training:
    - Primary source from the institution where the postgraduate medical training was completed.
    - AMA Physician Master File.
    - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
    - Federation Credentials Verification Service (FCVS) for closed residency programs.
        - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.
5) Below are the acceptable sources for Licensed Professional Clinical Counselors (L.P.C.C.'s) to verify training in Couples and Families:

6) Licensed Clinical Counselors (LPCCs) the additional requirements to Assess or Treat Couples and Families and the requirement for 150 hours of Clinical experience in a Hospital or Community Mental Health settings were eliminated, therefore are no longer required by IEHP.[25] Below is the acceptable source for Nurse Practitioners (NPs) with a Behavioral Health (BH) designation, to verify training in Psych/Mental Health;

- The qualification must be recognized and verified through BreEZe Online services website or directly with the licensing board via phone or mail.

d. Board Certification (VTL: 180 calendar days prior to Credentialing decision date). Below are the acceptable sources to verify board certification:

1) For all Practitioner types

- The primary source (appropriate specialty board).
- The state licensing agency if the primary source verifies board certification.

2) For Physicians (M.D., D.O.)

- American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
    - The ABMS "Is your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
- AMA Physician Master File.
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
- Boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards perform primary source verification of completion of education and training.

3) For other health care professionals

- Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.

4) For Podiatrists (D.P.M.)

[25] Assembly Bill 462

- American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
- The American Board of Podiatric Medicine.
- American Board of Multiple Specialties in Podiatry.

5) For Nurse Practitioners (N.P.)
- American Association of Nurse Practitioners (AANP).
- American Nurses Credentialing Center (ANCC).
- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
- Pediatric Nursing Certification Board (PNCB).
- American Association of Critical-Care Nurses (AACN).

6) For Physician Assistants (P.A.-C).
- National Commission of Certification of P.A.'s (NCCPA).

7) For Certified Nurse Midwives (C.N.M.).
- American Midwifery Certification Board (AMCB).

8) For Psychologists (Ph.D., Psy.D.).
- American Board of Professional Psychology (ABPP).

e. Work history (VTL: 180 calendar days prior to Credentialing decision date) IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.

f. Malpractice Claim History. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the Practitioner. (VTL: 180 calendar days prior to Credentialing decision date). IEHP will obtain confirmation of the past seven (7) years of malpractice settlements through one (1) of the following sources:

1) Malpractice Insurance Carrier.

2) National Practitioner Data Bank Query; or

3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within 180 calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.

g. Current Malpractice Insurance Coverage. IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) or written verification from the insurance

carrier directly, be obtained in conjunction of collecting information on the application. (VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner's participation with IEHP).

1) For Practitioners with federal tort coverage, (e.g. Health Resources & Services Administration (HRSA)), the Practitioner must submit:

   - A copy of the face sheet or a federal tort letter as an addendum to the application. The face sheet or federal tort letter must include the:
     - Insurance effective and expiration dates (future effective dates are acceptable)
   - A roster that lists all practitioners covered under the federal tort coverage.

h. Hospital Admitting Privileges: IEHP must verify that Practitioners have clinical privileges in good standing. Practitioner must indicate their current Hospital affiliation or admitting privileges at a participating Hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be confirmed with the Hospital, in writing, via approved website or verbally.

1) If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in "good standing."

2) If the Practitioner does not have clinical privileges, IEHP must have a written statement delineating the inpatient coverage arrangement documented in the Provider's file. (See Policy 5B, "Hospital Privileges").

3) Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have Hospital privileges and documentation in the file is not required for these types of Practitioners.

4) Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Nurse Midwives (NM)) may not have Hospital privileges. However, if they provide IEHP their Hospital privileges, IEHP will be responsible for verifying if those privileges are active and ensure they are in good standing.

5) Specialists (MDs, DOs and DPMs) may not have Hospital privileges. Documentation must be noted in the file as to the reason for not having privileges (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).

i. State Sanctions and Restrictions on Licensure and Limitation on Scope of Practice. State sanctions, restrictions on licensure or limitations on scope of practice (VTL: 180 calendar days prior to Credentialing decision).

1) Verification sources for sanctions or limitations on licensure include:
   - Chiropractors: State Board of Chiropractic Examiners, Chiropractic Information Network/Board Action Databank (CIN-BAD), NPDB.
   - Oral Surgeons: State Board of Dental Examiners, or State Medical Board, NPDB.
   - Physicians: Appropriate state board agencies, Federation of State Medical Boards (FSMB), NPDB.
   - Podiatrists: State Board of Podiatric Examiners, Federation of Podiatric Medical Boards, NPDB.
   - Non-physician Healthcare Professionals: State licensure or certification board, appropriate state agency, NPDB.
   - For practitioners screened using the Continuous Query (formerly Proactive Disclosure Service (PDS)):
     - Evidence of current enrollment must be provided.
     - Report must be reviewed within 180 calendar days of the initial credentialing decision.
     - Evidence of review must be documented in the file or on checklist.

j. Medicare/Medicaid Sanctions. Verification Sources for Medicare/Medicaid Sanctions:

1) OIG must be the one of the verification sources for Medicare sanctions, to ensure compliance with CMS.[26]
2) The Medi-Cal Suspended and Ineligible list must be one of the verification source for Medicaid sanctions, to ensure compliance with DHCS.[27]
3) NPDB
4) FSMB
5) Federal Employees Health Benefits Program (FEHB) Program Department Record, published by the Office of Personnel Management, OIG.
6) List of Excluded Individuals and Entities (maintained by OIG).
7) Medicare Exclusions Database.
8) State Medicaid Agency or intermediary and the Medicare intermediary.

[26] DHCS APL 22-013
[27] Ibid.

9) For practitioners screened using the Continuous Query (formerly Proactive Disclosure Service (PDS)).

k. National Provider Identifier (NPI) Number: Practitioners must hold and maintain a valid and active individual National Provider Identification Number (NPI) that can be verified through the NPPES website.

1) Primary Practice Address must be registered to an address in California or Arizona, as applicable.

2) Group NPI Numbers may be requested by IEHP, in addition to the mandatory individual NPI number.[28]

3. IEHP verifies that the following are within the prescribed time limits, for all credentialing applications, before Practitioners can provide care to Members. IEHP does not allow provisional credentialing. Policies must define the criteria required to reach a credentialing decision and must be designed to assess the Practitioner's ability to deliver care. Practitioners who do not meet the criterion set forth in this policy are subject for review by the Credentialing Subcommittee and/or Peer Review Subcommittee. This criterion is used to determine which Practitioners may participate in its network, which may include, but are not limited to:[29]

a. Verification of Credentials

1) A current and valid, unencumbered license to practice medicine in the state they practice (i.e. California or Arizona), at the time of Credentialing decision.

2) Current and valid DEA registered in the state they practice (i.e. California and/or Arizona), applies to Practitioner who are required to write prescriptions.

- If the practitioner designates another practitioner to write all prescriptions on their behalf, while their DEA is still pending, the Practitioner must provide the following information for the designation physician to ensure compliance with NCQA:
  - Practitioner Name
  - NPI (IEHP requirement)
    - Used as a unique identifier for the prescribing practitioner
  - DEA Number (IEHP requirement)
    - Used to validate that the DEA is current, active and registered in California

3) Education and Training. Medical Doctors (M.D.) and Doctor of Osteopathic

[28] DHCS APL 22-013
[29] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 3

(D.O.) must meet the education and training requirements set forth by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) and additional criterion set by IEHP and noted below, if applicable. All IEHP specific specialty requirements are subject for review by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

IEHP will consider all relevant information including practice site demographics, Provider training, experience, and practice capacity issues before granting any such change.

- If the Practitioner is not board certified in the subspecialty in which he/she is applying, there must be evidence of verification of residency and training in the subspecialty (e.g. Fellowship in Cardiology, Rheumatology, Pediatric Endocrinology, etc.), as relevant to the credentialed specialty, and meet the training requirements as set forth by ABMS or AOA.
    - Practitioners who do not meet graduate medical training requirements as set forth by ABMS or AOA for the Provider's requested subspecialty, will be subject to review by the IEHP Credentialing Subcommittee for review. Further review may be completed by the IEHP Peer Review Subcommittee.
- IEHP Credentialing guidelines require Providers to meet the internship and residency requirements to be a Pediatric, Internal Medicine, Family Practice, or Public Health and General Preventive Medicine Provider to be credentialed as a Primary Care Provider in IEHP's network.
    - Existing Providers who do not meet this requirement are grandfathered into the network, however if the Provider chooses to terminate, the Provider may not reapply or be reinstated as a Primary Care Provider.
- IEHP designated specialty requirements:
    - **Bariatric Surgery** requirements: Meet the education and training requirements for General Surgery; and one (1) of the following criteria:
        - Completion of an accredited bariatric surgery fellowship.
        - Documentation of didactic training in bariatric surgery (IEHP recommends the American Society for Metabolic and Bariatric Surgery Course). This information will be verified through:
            - Bariatric training certificate and/or supporting letter from supervising bariatric surgeon, which will be verified by Credentialing. Supporting letter will include the minimum criteria:

- ❖ Supervising bariatric surgeon qualifications.
- ❖ Supervising bariatric surgeon relationship with applicant.
- ❖ Duration of relationship of supervising bariatric surgeon with applicant; and
- ❖ Assessment of applicant's competency to perform bariatric surgery by supervising bariatric surgeon.

- Attestation of bariatric surgery case volume signed by applicant (See "Bariatric Surgeon Case Volume Attestation" found on the IEHP website[30]) of case volume from the last three (3) years:
  - Volume of applicant's proctored cases; and
  - Volume of cases where applicant was the primary surgeon.
    - ❖ IEHP requires a minimum of 20 cases where applicant was the primary surgeon.[31]
- Current or past "Regular or Senior Member" of American Society for Metabolic and Bariatric Surgery (ASMBS). Verification of membership will be obtained by the Credentialing Department; or
- IEHP recommends applicant actively participates with the MBSAQIP (Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program) or an equivalent regional or national quality improvement program.
  - Supportive documentation of participation with program is to be submitted with Credentialing application and/or request.

- **Family Practice I: Family Practice Providers with Obstetrics (OB) services**, must meet the education and training requirements for Family Practice, set forth by ABMS or AOA and provide the following:
  - Provide a copy of a signed agreement that states Member transfers will take place within the first 28 weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
    - The OB must be within the same network as the Family

[30] https://www.providerservices.iehp.org/en/resources/provider-resources/forms ~~https://www.iehp.org/en/providers/provider-resources?target=forms~~

[31] American Society for Metabolic and Bariatric Surgery, Joint Task Force Recommendations for Credentialing of Bariatric Surgeons, published June 2013, accessed on 07/15/18 at: https://asmbs.org/resources/joint-task-force-recommendations-for-credentialing-of-bariatric-surgeons.

Practice Provider and hold admitting privileges to the IEHP contracted Hospital linked with that IPA network.

- **Family Practice 2: Family Practice that includes full OB services and delivery)** must:
  - Have and maintain full delivery privileges at an IEHP contracted Hospital.
  - Provide a written agreement for an available OB back up Provider is required.
    - The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and
    - Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).

- Effective August 1, 2023, Internal Medicine Practitioners may not expand their age range to all ages unless they have board eligibility or board certification in Pediatrics.
- Effective August 1, 2023, Pediatric Practitioners may not expand their age range to all ages unless they have board eligibility or board certification in Internal Medicine.
  - **Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Provider only**, will provide outpatient well woman services only with no Hospital or surgical privileges, must provide the following information for consideration:
    - Documentation of Primary Care Provider in the United States.
    - 25 CME units for most recent three (3) year period, of which must be in primary care related areas.
    - Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e. Primary Care Providers with work experience associated with the applicant in the preceding 24 months); and
      - The Physician coworkers must hold an active board certification in a Primary Care Specialty (i.e. board certified in Internal Medicine, Family Practice or Pediatrics).
    - In lieu of having full hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for

identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed and that the OB will provide prenatal care after 28 weeks gestation including delivery (See "Patient Transfer Agreement" found on the IEHP website[32]).

- The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.
- The OB Provider must be credentialed and contracted within the same network.

- These OB/GYNs provide outpatient well woman services only with no Hospital or surgical privileges. This exception must be reviewed and approved by IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

- **Specialties not recognized by either board (ABMS or AOA) are subject to Medical Director or Chief Medical Officer Review.** Further review may be completed by the Credentialing Subcommittee or Peer Review Subcommittee, who will either approve or deny.
- **Urgent Care Providers** must meet the education and training requirements set forth by ABMS or AOA for at least one (1) of the following Specialty boards:
  - American Board of Pediatrics.
  - American Board of Family Practice.
  - American Board of Internal Medicine.
  - American Board of Obstetrics and Gynecology.
  - American Board of Emergency Medicine.
  - Osteopathic Board of Pediatrics.
  - Osteopathic Board of Family Physicians.
  - Osteopathic Board of Internal Medicine.
  - Osteopathic Board of Obstetrics and Gynecology.

[32] https://www.providerservices.iehp.org/en/resources/provider-resources/forms ~~https://www.iehp.org/en/providers?target=forms~~

- Osteopathic Board of Emergency Medicine; or
- If the Practitioner is board certified or eligible in a specialty and/or subspecialty recognized by the American Board of Medical Specialties or American Osteopathic Association not referenced above, then those Providers are subject to Medical Director or Chief Medical Officer Review. Further review may be completed by the Peer Review Subcommittee, who will either approve or deny. For their review and consideration, the following documents must be submitted:
  - Provide evidence of 25 CME units in Pediatric Primary Care completed within the last three (3) years if the Provider is requesting to treat Pediatric patients.
  - Provide evidence of 25 CME units in Adult Primary Care completed within the last three (3) years if the Provider is requesting to treat adult patients; and
  - Applicants must provide two (2) letters of recommendation from a Physician coworker (i.e., Primary Care Providers with work experience associated with the applicant in the preceding 24 months). The Physician coworkers must hold an active board certification in Pediatrics, Family Practice or Internal Medicine.

- **Wound Care Specialists** must be M.D., D.O., D.P.M.'s or N.P.'s who have three (3) or more years of clinical wound care experience or specialize in:
  - Dermatology
  - General Surgery
  - Plastic Surgery
  - Podiatry
  - Vascular Surgery
- If the Practitioner is board certified or eligible in a specialty and/or subspecialty not referenced above, then those Providers are subject to Medical Director, CMO review. Further review may be completed by the Peer Review Subcommittee, who will either approve or deny.

4) Board Certification. IEHP does not require board certification; however, IEHP must verify the certification status of the practitioners who state hey are board certified, to include that board eligibility requirements are met.

5) Work History. IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the practitioner's application or Curriculum Vitae (CV). If the practitioner has fewer than (5) five years of work history, the time frame starts at the initial licensure date. The application or CV includes the beginning and ending month and year for each position if employment experience, unless the practitioner has had continuous employment for five (5) years or more with no gap. In such a case, providing the year meets the intent of this factor.

6) Malpractice History: For Practitioners with a history of malpractice suits or decisions, the following criteria warrants full Credentialing Subcommittee Review of the history and should be applied in making credentialing and recredentialing decisions:

- Number of claims - any claims within the prior seven (7) years.
- Results of cases - any settlements within the prior seven (7) years.
  - Settlements with a minimum payout of $30,000 or more.
  - Settlements resulting in major permanent injury or death.
- Trends in cases - Practitioners with multiple malpractice claims in a similar area (e.g., missed diagnosis, negative surgical outcomes, etc.).

7) Hospital Admitting Privileges. Practitioner must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation(s) or admitting privileges at a participating hospital. Practitioners must have appropriate admitting privileges or arrangements with IEHP's contracted Hospitals, if applicable See Policy 5B, "Hospital Privileges" and "Hospital Admitting Privileges Reference by Specialty" found on the IEHP website[33].

- Providers are not required to maintain Hospital admitting privileges if they are only practicing at an Urgent Care or providing Telehealth Services only.

8) NPI: Must confirm Provider has an active Individual NPI with a Primary address must be registered to an address in the state they practice (i.e. California or Arizona (as applicable)).

- Group NPI may be submitted to IEHP in conjunction to the Individual NPI.
- Telehealth Providers are not required to have an NPI registered with a primary address in California or Arizona (as applicable).

9) Grievance History (if applicable).

[33] https://www.providerservices.iehp.org/en/resources/provider-resources/forms ~~https://www.iehp.org/en/providers?target=forms~~

- Provider Grievance Rate lower than IEHPs grievance rate
- Absence of grievance trend

10) All PCP and Urgent Care Providers must meet the Facility Site Review (FSR)/Medical Record Review (MRR) Guidelines (See Policy 6A, "Facility Site Review and Medical Records Review Survey Requirements and Monitoring").[34]

b. Sanction Information. IEP must verify the following sanction information for Credentialing.

1) State Sanctions, restrictions on licensure and limitations on scope of practice:

- Any actions, restrictions or limitations on licensure or scope of practice, are presented for review and discussion to the Credentialing Subcommittee and/or Peer Review Subcommittee.

2) Medicare and Medicaid Sanctions

- Medi-Cal Suspended & Ineligible List Providers are deemed suspended and ineligible from Medi-Cal will be terminated or not be credentialed and contracted with for Medi-Cal line of business. IEHP does not allow Medi-Cal Suspended & Ineligible List Providers to participate in the IEHP network.
- Providers Excluded/Sanctioned by Medicare or Medicaid (OIG). IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners found on OIG report). Providers identified on the OIG report will not be credentialed or contacted, and terminated from our network if they are existing Providers.[35]
- Medicare Opt-Out Providers who are identified on the Medicare Opt-Out will not be contracted for Medicare line of business. IEHP does not allow Medicare Opt-Out Providers to participate in the IEHP network for Medicare line(s) of business.
- Preclusions List: Providers identified on the preclusions list will be terminated or not be credentialed and contracted.[36]

c. Credentialing Application. Practitioners must submit an application or reapplication that includes the following:

1) Attestation To:

[34] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.3
[35] DHCS APL 22-013
[36] Centers for Medicare & Medicaid Services, "Preclusion List Requirements", 11/02/2018

- Reasons for inability to perform the essential functions of the position.
- Lack of present illegal drug use.
- History of loss of license and felony convictions.
- History of loss or limitation of privileges or disciplinary actions.
- Malpractice Insurance Coverage: Must have current and adequate malpractice insurance coverage that meets the following criteria:
  - Minimum $1 million per claim/$3 million per aggregate.
  - Coverage for the specialty the Provider is being credentialed and contracted for.
  - Coverage for all locations the Provider will be treating IEHP patients.[37]
- Current and signed attestation confirming the correctness and completeness of the application.

2) Release of Information, used for primary source verification

3) Addendum A
   - Practitioner Type
   - Practice Type
   - Name(s) of any employed Advanced Practice Practitioners (e.g. Nurse Practitioners, Nurse Midwives, or Physician Assistants)
   - Age limitations
   - Practitioner Office Hours
   - Practitioner's written plan for continuity of care if they do not have hospital privileges
   - Languages spoken by Physician
   - Languages spoken by staff

4) Addendum B, used for Professional Liability Action explanation(s).

5) Addendum C, used to confirm Practitioner's status as a:
   - Certified Workers Compensation Provider
   - Reservist

[37] NCQA, 2023 HP Standards and Guidelines, CR 3, Element C, Factor 5

6) Addendum D, Notice to Practitioners of Credentialing Rights/Responsibilities

7) Addendum E, applicable to General Practice and Obstetrics/Gynecology providers who are PCP's.

8) Verification of Qualifications for HIV/AIDS Physician Specialist form (See "Verification of Qualifications for HIV/AIDS Physician Specialist" found on the IEHP website[38]) required for Practitioners who would like to be designated as an HIV/AIDS Specialist.

9) Behavioral Health (Area(s) of Expertise Form. To ensure Practitioners are listed with the types of services they offer, this form is required for all Practitioners with a Behavioral Health Affiliation/Designation, to include but are not limited to:

- Psychiatrists
- Psychologists
- Addiction Medicine Specialists
- Master Level Clinical Nurses
- Licensed Clinical Social Workers
- Licensed Marriage Family Therapists
- License Professional Clinical Counselors Nurse Practitioners with a Behavioral Health (BH) designation
- Physician Assistants with a Behavioral Health (BH) designation

10) Transgender Questionnaire (See Attachment, "Transgender Questionnaire, in Section 5) are required for all Practitioners who are or would like to be designated as a Transgender Competent Provider. At minimum, the Practitioner must meet and provide evidence of the following for consideration:

- Demonstrate 10 Continuing Medical Education (CME) hours within the last three (3) years
- Certification through WPATH
- Must provide evidence of the following annual staff training on transgender care, that includes:
  - Agenda

[38] https://www.providerservices.iehp.org/en/resources/provider-resources/forms ~~https://www.iehp.org/en/providers?target=forms~~

- Sign in sheet
- Policies and Procedures

11) Licensed Midwife Attestation: Plan for Consultation, Emergency Transfer, & Transport (See Attachment, "Licensed Midwife Attestation", in Section 5) required for all Licensed Midwife Practitioners.

- IEHP requires the backup Licensed Physician, engaged in active clinical obstetrical practice and with whom the Licensed Midwife consults when there are significant deviations from the normal, in either mother or infant, is an active Obstetrics/Gynecology Practitioner within the IEHP network.

12) Attachment I: Statement of Agreement by Supervising Provider. IEHP requires a completed Attachment I: Statement of Agreement by Supervising Provider, for all Advanced Practitioner and Supervising Physician arrangements, to ensure arrangements are documented appropriately, which will be collected at the time of credentialing, recredentialing and upon relationship change.

- If these arrangements are clearly described on the Delegation of Services Agreement, Practice Agreement, or Standardized Procedures, those documents may be used in lieu of submitting an Attachment I form.

13) Practitioner offices who employ Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) must ensure written arrangements are in place between the Advanced Practice Practitioner and the practice where they treat IEHP members. These documents must be readily available to IEHP upon request. (See Policy 6F, "Facility Site Review – Non-Physician Practitioner Requirements").

- IEHP requires all Advanced Practice Practitioners to practice at the same site as their Supervising Physician.
- Physician Assistants with a Behavioral Health Designation must be supervised by a licensed Physician who specializes in Psychiatry.

The following written arrangements must be provided to IEHP upon request for:

- PAs must provide one (1) of the following:
  - Delegation of Services Agreement and Supervising Physician Form (See "Delegation of Services Agreement and Supervising Physician Form" found on the IEHP website[39]).[40] This agreement must:

[39] https://www.providerservices.iehp.org/en/resources/provider-resources/forms ~~https://www.iehp.org/en/providers?target=forms~~

[40] 16 CCR § 1399.540(b)

- Define specific services identified in practice protocols or specifically authorized by the supervising Physician., and
- Both the Physician and PA must attest to, date and sign the document.
- An original or copy must be readily accessible at all practice sites in which the PA works;

- Practice Agreement, [41] written and developed through collaboration among one or more Physicians and Surgeons and one or more PAs, that defines the medical services the PA is authorized to perform[42] and that grants approval for Physicians and Surgeons on the staff of an organized health care system to supervise one or more PAs in the organized health care system. Any reference to a Delegation of Services Agreement relating to PAs in any other law shall have the same meaning as a practice agreement. The Practice Agreement must include provisions that address the following: [43]
  - The types of medical services a Physician Assistant is authorized to perform.
  - Policies and procedures to ensure adequate supervision of the Physician Assistant, including, but not limited to, appropriate communication, availability, consultations, and referrals between a Physician and Surgeon and the Physician Assistant in the provision of medical services.
  - The methods for the continuing evaluation of the competency and qualifications of the Physician Assistant.
  - The furnishing or ordering of drugs or devices by a Physician Assistant.[44]
  - Any additional provisions agreed to by the Physician Assistant and Physician and Surgeon.
- A practice agreement shall be signed by both of the following:
  - The Physician Assistant.
  - One or more Physicians and surgeons or a Physician and Surgeon who is authorized to approve the practice agreement on behalf of

[41] Senate Bill 697
[42] Bus. & Prof, Code § 3502
[43] Bus. & Prof. Code § 3502.3
[44] Bus. & Prof. Code § 3502.1

the staff of the Physicians and Surgeons on the staff of an organized health care system.

- A delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.
- A practice agreement may designate a PA as an agent of a supervising physician and surgeon.
- Nothing in this section shall be construed to require approval of a practice agreement by the board.
  - Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of California, a practice agreement may authorize a PA to do any of the following:
    - Order durable medical equipment, subject to any limitations set forth in Section 3502 or the practice agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.[45]
    - For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.
    - After performance of a physical examination by the PA under the supervision of a Physician and surgeon consistent with this chapter, certify disability of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.[46]

- Nurse Practitioners and Certified Nurse Midwives are required to have Standardized Procedures. Standardized Procedures must be on-site site specific and:
  - To meet the requirement, reference textbooks and other written sources, which must include:[47]

[45] Bus. & Prof Code § 3502.3 (1)
[46] California Code, Unemployment Insurance Code (UIC) § 2708
[47] 16 CCR § 1474 (3)

(i) Book (specify edition) or article title, page numbers and sections.

- NP and/or CNM must be practicing at a site assigned to their supervising Physician; and
- Standardized Procedures must be signed by both the Practitioner and the supervising Physician, initially and annually; and provided to IEHP, upon request. At minimum, the documents must include:
  - Table of Contents of the Standardized Procedures used, between the NP and/or CNM and supervising Physician, that references the textbook or written sources to meet the requirements of the Board of Registered Nursing.
  - Evidence that the Standards of Care established by the sources were reviewed and authorized by the nurse Practitioner, Physician and administrator in the practice setting (i.e., signature page that includes all parties involved).

- Standardized Procedures written using the Practice Agreement or Physician Assistants Delegation of Services Agreement and Supervising Physician Form format and/or verbiage is not accepted by IEHP.[48,49,50]

d. Adverse History Guidelines: IEHP will review all Practitioners with evidence of adverse history are presented to Credentialing Committee for review and documented in the meeting minutes, that may include, but is not limited to Providers who have:

1) Restrictions on licensure
2) Restrictions on DEA
3) Loss of Clinical privileges or negative privilege actions
4) Absence of Sanctions
5) Other negative actions may include, but are not limited to:
   - Use of illegal drugs.
   - Criminal history.
   - Engaged in any unprofessional conduct or unacceptable business practices.
   - Higher than average grievance rate or trend in grievances.

[48] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 3
[49] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.3
[50] 16CCR § 1474 (3)

e. Provider Network

1) Advanced Practice Practitioners are allowed to increase only one (1) supervising PCPs enrollment capacity per location with a maximum of two (2) unique locations allowed. Advanced Practice Practitioners must be practicing at a site assigned to their supervising Physician.

2) Practice within IEHP's service area.

3) Practice Parameter expansion(s) or reduction(s): Providers are required to submit a request that includes a detailed explanation or complete a Provider Privilege Adjustment Request Form (See "Provider Privilege Adjustment Request Form" found on the IEHP website[51]), when requesting a change in practice parameters such as an expansion or reduction in Member age range or specialty care privileges (i.e. addition of specialty). All Practice Parameter expansions and reductions are subject for review by the IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.

- IEHP will consider all relevant information including practice site demographics, Provider training, experience and practice capacity issues before granting any such change. At a minimum, Provider's written request must include:
    - Documentation of any relevant training (e.g., Continuing Medical Education, postgraduate/residency training, etc.); and
    - Practical experience relating to the request (e.g., years in clinical practice, direct care experience with the relevant membership, etc.).

4) Patient Age ranges

Patient age ranges for Primary Care Providers (PCP) must be specifically delineated as part of the credentialing process. Age range for Medicare IEHP DualChoice line of business is twenty-one (21) and above.

Guidelines for age ranges for Non-Physician Practitioners which include Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse Midwives (CNMs), Licensed Midwives (LMs), Physical Therapists (PT), Occupational Therapists (OT), Speech/Language Therapists (S/LT), Opticians, Optometrists (OD), Chiropractors (DC), Dieticians and Nutritionists are as applicable to the training and certification of the Non-Physician Practitioner.

[51] https://www.providerservices.iehp.org/en/resources/provider-resources/forms ~~https://www.iehp.org/en/providers?target=forms~~

Patient age ranges for specialty Physicians are specific to the specialty involved, training, and education of the Physician.

4. All Practitioners who do not meet the criterion set forth above, must be reviewed by the IEHP Credentialing Subcommittee and/or IEHP Peer Review Subcommittee. IEHP's Credentialing Subcommittee will review, discuss, and document their findings in the respective Subcommittee minutes. At a minimum:[52]
   a. The Credentialing Committee must receive and review the credentials of the Practitioners who do not meet IEHP's established criteria for the Practitioners applying directly to IEHP to provide advice and expertise for credentialing decisions.
   b. If retrospective review by IEHP's Credentialing Department reveals that a Practitioner approved by a Delegate does not meet the above requirements, IEHP can submit the Practitioner to IEHPs Peer Review Subcommittee for review.
5. IEHP utilizes a clean file process. All Practitioners who meet the criterion set forth above, are determined as "clean" and may be submitted to the IEHP Medical Director for sign-off. The sign-off date is the Committee date and evidence of the IEHPs Medical Director signature will be documented in the Practitioners file or on a list of all Practitioners who meet the established criteria.[53]
   a. The IEHP Medical Director, who is responsible for oversight of the credentialing process, has been identified as the individual with the authority to determine that a file is "clean" and to sign off on it as complete, clean, and approved.
6. IEHP's credentialing and recredentialing decisions are not based solely on the applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient in which the Practitioner specializes and describes the steps for monitoring and preventing discriminatory practices during the credentialing/recredentialing process.[54,55]

   IEHP's procedures for monitoring and preventing discriminatory credentialing decisions may include, but are not limited to:
   a. Monitoring: Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination are conducted annually.
   b. Preventing: Maintaining a heterogeneous Credentialing Committee membership and requiring those responsible for credentialing decisions to sign an affirmative statement on, which is included on the sign-in sheet, to make decisions in a non-discriminatory manner.
7. Practitioners are notified in writing, when credentialing information obtained from other

[52] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 4
[53] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 5
[54] 42 CFR § 422.205
[55] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 6

sources varies substantially from that provided.[56]

a. The Credentialing Specialist notifies the Practitioners by fax or email, within 10 business days of any information obtained during the credentialing process that varies substantially from the information provided by the Practitioner that includes but is not limited to:

1) Actions on license.

2) Malpractice history.

3) Board certification, education, and training.

4) Any incomplete or blank sections on the application

IEHP is not required to reveal the source of the information if the law prohibits the disclosure.

1) The notification to the Practitioner includes the following:

- Identification of the discrepancy.
- Identification of the source of the discrepancy.
- Informs the Practitioner that the Practitioner has 10 business days to submit the missing and/or corrected information.
- The format for submitting the correction.
- The person to whom the corrections must be submitted; and
- Where to submit the information.

2) The Practitioner has 10 business days from the receipt of the notification to correct the erroneous information and is responsible for submitting additional or corrected information including any other supporting or pertinent information in writing, to the IEHP Credentialing Specialist. Upon receipt, the Credentialing Specialist stamps the document with the date received, to include the name of the reviewer, and verifies the information is correct. If its correct, the document is included in the Practitioners credentialing file for review and approval.

- For Credentialing files: If the requested information is not received within 10 business days, the Provider is notified that their credentialing process is ceased due to an incomplete credentialing application.
- For Recredentialing files: If the requested information for recredentialing by the recredentialing deadline, the Practitioner is notified that without this information, the practitioner will be administratively terminated due to an

[56] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 7

incomplete recredentialing application.

- For Recredentialing files: If the requested information is not received within 10 business days, the Provider Services Representatives (PSRs) and Contracts Managers (CMs) are notified that the Provider has outstanding items and are approaching their recredentialing due dates. Failure to provide all recredentialing documents timely may result in an administrative termination due to non-compliance to recredentialing.

8. Practitioners are notified of their credentialing and recredentialing decisions within 60 calendar days of the Committee's decision or Medical Director sign off.[57]
9. IEHP's Medical Director's overall responsibility and participation in the credentialing program includes, but is not limited to:[58]
    a. Possession of a current license to practice in his/her state of practice.
    b. His/her role in implementation, development, and coordination in the functions of the Credentialing Program.
    c. Oversight of the Credentialing Program, policies, and procedures.
    d. Membership, attendance and/or chairmanship at all Credentialing Committee meetings; and
    e. Description of the reporting structure and responsibilities for Medical Director/physician designee, Committee and Board of Directors for final recommendation for participation, as applicable.[59]
10. The information obtained in the credentialing process is kept confidential and IEHP mechanisms to ensure confidentiality of the information collected during the credentialing process includes, but is not limited to:[60]
    a. Confidentiality statements are signed by the Committees and Credentialing staff
    b. Practitioners' files (hard copies, as applicable) are maintained in locked file cabinets and are only accessible by authorized personnel, if applicable; and
    c. Security for database systems is maintained through passwords or other means to limit access to Practitioner information to authorized staff only.
11. All information provided by IEHP for Member materials and Practitioner directories is consistent with the information obtained during the credentialing and recredentialing process, regarding Practitioner education, training, certification, and designated specialty.

[57] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 8
[58] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 9
[59] Ibid.
[60] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 10

Information collected and verified during the credentialing and recredentialing process and requests received in between cycles, is entered and maintained by the Credentialing Department to ensure consistency.[61]

B. IEHP notifies Practitioners of their rights to review information submitted to support their credentialing application, correct erroneous information, and receive the status of their credentialing and recredentialing application, upon request, through the Provider Manual, and Provider application.[62]

1. Practitioners may review information submitted to support their credentialing application that are obtained from outside sources (e.g. malpractice insurance carriers, state licensing boards) to support their credentialing application.
    a. IEHP is not required to make available:
        1) References.
        2) Recommendations.
        3) Peer-Review protected information.
2. Practitioners have the right to correct erroneous information (submitted by another source) and must clearly state:
    a. Practitioners have 10 business days of notification of discrepancy from the date the Credentialing Department provides notice to correct any erroneous information. Erroneous information may include substantial variation in information on:
        1) Actions on a license
        2) Adverse history
            - Malpractice Claim History
            - Criminal History
            - Sanction History
            - Clinical Privileges History
        3) Board Certification
        4) Education and Training
            - Insufficient years of training in desired specialty
    b. Practitioners must submit their corrections in writing.
    c. Practitioners must send their written requests via confidential fax, email, or letter to

[61] NCQA, 2023 HP Standards and Guidelines, CR 1, Element A, Factor 11
[62] NCQA, 2023 HP Standards and Guidelines, CR 1, Element B, Factor 1-3

the Credentialing Department:

P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
Fax: (909) 890-5756
E-mail: credentialing@iehp.org.

IEHP is not required to reveal the source of information that was not obtained to meet the verification requirements or if federal or state law prohibits disclosure. IEHP documents receipt of corrected information in the Practitioner's credentialing file.

3. Practitioners have the right to be informed, upon request, of the status of their credentialing or recredentialing application. Following receipt of the Practitioner's request, the Practitioner will be contacted by the Credentialing Department with their status.

C. IEHP process for both paper and electronic processes for Credentialing System Controls include:[63]

1. Credentialing applications, supporting documents, and verifications are:
   a. Received via (mail, email, fax, electronic application, online portal, internet website or web crawler);
   b. Dated electronically or date stamped when they are received;
   c. Reviewed by Credentialing Team Members;
   d. Tracked via internal credentialing checklist and/or electronic database; and
   e. Stored in (locked cabinets and/or password protected database).
2. If a modification needs to be made to:
   a. Credentialing information, the Credentialing Specialist will document:
      1) The date the modification was made;
      2) An explanation of the modification;
      3) Reason for modification; and
      4) Who made the modification within the credentialing system.
   b. Primary Source Verification (PSV), the Credentialing Specialist will document:
      1) The change; and
      2) Who they spoke with; and
      3) Initial and date the PSV; and

[63] NCQA, 2023 HP Standards and Guidelines, CR 1, Element D, Factor 1-3

4) A note will also be placed in the appropriate section of the credentialing database and/or documented in the practitioners file and checklist (as applicable).

3. Only IEHP Team Members with direct involvement in the Credentialing are assigned user roles based on areas of responsibility as defined in their job description. Each user role is assigned specific read/write system access as needed to perform their duties which may include modifying and deleting information.
   a. Verification information may be modified by Credentialing Specialists, Supervisors, Auditors and Managers when verification information changes. If Credentialing information changes, new verifications will be obtained, initialed/dated by Credentialing Team Members, and stored in the practitioner's credentialing electronic file and/or hard file (as applicable).
   b. Appropriate modifications to credentialing information include, but are not limited to:
      1) Updates to expired licensure or other documents;
      2) Changes/updates to education, training or privileges;
      3) To correct data entry errors
      4) Duplicate profiles
      5) Documents appended to incorrect provider profile
   c. Inappropriate modifications to credentialing information, include but are not limited to:
      1) Altering credentialing approval dates;;
      2) Altering dates on verifications;
      3) Whited out dates or signatures on hard copy documents;
      4) Unauthorized deletion of provider files or documentation.
   d. All credentialing database deletions must be submitted to Healthcare Informatics (HCI).[64]
4. IEHP limits physical access to credentialing information, protecting the accuracy of information gathered from primary and approved sources. Under IEHPs Healthcare Informatics Team, additional controls have been added, and database user groups are implemented to further limit access to information that can be inserted and updated through the credentialing database, Network Development Data Base (NDDB). These database groups, or user groups, are specific to the departments that maintain the provider data. The database groups are controlled by HCI.

[64] NCQA, 2023 HP Standards and Guidelines, CR 1, Element C, Factor 3

a. Hard copy data (any printed confidential/sensitive document or file) is stored in locked cabinets. Credentialing Team Members shall secure all practitioner files and information when not in process and during non-work hours in locked cabinets that is only accessible to authorized staff. Workstations are in physically secure areas. Computer screens are positions to prevent viewing by unauthorized individuals.

b. All password-based systems on workstations must mask, suppress, or otherwise obscure the password, so that unauthorized personal are not able to observe them. Authorized users are prohibited from allowing others to access computer systems or restricted areas with their account, password, badge, or unique ID information.

1) Password protecting electronic systems, including user requirements, are in accordance with and enforced through IEHP's Information Technology (IT) Department, that requires:

- Use strong passwords
- Avoid writing down passwords
- Use different passwords for different accounts
- Change passwords periodically
- Password Construction Guidelines for IEHP Team Members and affiliates to create strong passwords for accessing IEHP networks and applications, include:
  - Password length:
    - IEHP Active Directory (AD) accounts must be at least thirteen (13) characters or longer.
    - Other IEHP system and application accounts must be at least eight (8) characters or longer.
    - Passphrases containing several words to create a sentence, or a phrase should be used wherever possible over single word passwords.

- Password complexity: IEHP passwords must contain at least one (1) character from three (3) of the four (4) following categories:
  - English upper-case letters [A, B, C, ... Z]
  - English lower-case letters [a, b, c, ... z]
  - Westernized Arabic numerals [0, 1, 2, ... 0]
  - Non-alphanumeric characters such as punctuation symbols [! @, $,…*]

- IEHP passwords cannot be:
  - A single dictionary word in any language.
  - A person's name.
  - Based on personal information i.e. family member names, pet's names, birth places etc.
  - A single dictionary word or a person's name with simple permutations, i.e. Password1, Christmas17, Jonathan2017, etc.
  - A keyboard pattern, i.e. QWERTY, 123454321, qazwsxedc, etc.
- Password change frequency
  - IEHP Active Directory (AD) passwords must be changed every 180 days.
  - Other IEHP account passwords should be changed every 90 days.
  - When requested or if password(s) are compromised.

2) Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security, such as IEHP IT Department, to:
   - Change passwords when appropriate
   - Disable or remove passwords of employees who leave the organization
     - User account access will be revoked within 24 hours of notification of a Team Member's departure by IEHP senior leadership or authorized Human Resources representatives. Accounts may be suspended or deleted as necessary

3) IEHP does not contract with an external entity to outsource storage of credentialing information.
   - Delegates who are delegated Credentialing responsibilities, IEHP will review the delegate contracts to confirm if it is System Control requirements are addressed.
     - If the contract does not address it, the Delegate may submit policies and procedures for review. This applies to both the Delegate's and each external entity they contract with.
     - This will be reviewed at the Pre-Delegation and any Annual audits thereafter.[65]

[65] NCQA, 2023 HP Standards and Guidelines, CR 1, Element C, Factor 4

c. For preventing unauthorized access, changes to and release of Credentialing information is controlled and granted only to those individuals with direct involvement in the credentialing process. Credentialing information may be released under the following circumstances:

1) Requests from Risk Management, corporate attorney, Credentialing Committee Chair, Peer Review Chair, etc.

- Reasonable efforts will be made to notify the impacted provider(s) prior to disclosure of information to attorney(s).

2) Regulatory or accreditation agencies

- Access will require direct supervising by the Credentialing Manager/Supervisor/Auditor to ensure no data is accessed without authorization.

3) Third parties or organizations (health plans, MCOs, etc) with whom Delegate is contracted.

- Each practitioner must have an appropriate signed authorization and release form on file.

5. IEHP monitors its compliance with its own policies and procedures for Credentialing System Controls at least annually and takes appropriate actions when applicable.

a. At least annually, the Credentialing Subject Matter Experts (SMEs), which includes: the Credentialing Manager, Credentialing Supervisor, Credentialing Auditor, Credentialing Specialists IIs), may perform the audit process and have oversight responsibility for monitoring and reporting, which include, but are not limited to:

1) Annual review of job roles and current user access to ensure system access is still appropriate for the role requirements, which will be done in conjunction with Credentialing Leadership and HCI.

2) Annual review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic systems audit trail function or change tracking reporting capability, will be done in conjunction with Credentialing Leadership and HCI.

3) For paper documents/files, conduct periodic walk-throughs of department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours, i.e. in locked drawers/filing cabinets, not left on fax machines, will be done by the Credentialing Team.

4) Incorporate review of data modification/changes/updates to credentialing data (both electronic and paper as applicable) into file Q&A process, will be done by the Credentialing Auditors, which will assess and document findings for:

- Accuracy;
- Appropriateness; and
- Compliance with policies.

5) Require all credentialing staff and anyone who has access to credentialing information to sign confidentiality forms. Update forms annually.

C. At least annually, IEHP demonstrates that it monitors compliance with its CR controls, by:

1. Identifying all modifications to credentialing and recredentialing information that did not meet the organizations policies and procedures for modifications.
2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications, by conducting qualitative and quantitative analysis of all modification that did not meet its policies and procedures.
3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three (3) consecutive quarters.

E. IEHP collects information from quality improvement activities and Member complaints for all Practitioner files undergoing the recredentialing process, to be included in the recredentialing decision making process.[66,67]

F. During the IEHP credentialing, recredentialing, and ongoing monitoring process, Providers are reviewed to monitor when network Physicians have opted out of participating in the Medicare Program, by verifying our Practitioners are not included on the Medicare Opt-Out Report.[68]

G. IEHP does not contract with Practitioners who are precluded from receiving payment for Medicare Advantage (MA) items and services Part D drugs furnished or prescribed to Medicare beneficiaries. IEHP does not allow Practitioners identified on the preclusions list to participate in the IEHP network.

H. IEHP identifies Transgender Competent Practitioners during the credentialing and recredentialing process.

1. All credentialing and recredentialing applications include a Questionnaire for: Providers for Transgender Members, to review and complete if they would like to be identified as a Transgender Competent Practitioner (See "Transgender Questionnaire" found on the IEHP website[69]).

[66] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.3
[67] DHCS APL22-013
[68] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.2
[69] https://www.providerservices.iehp.org/en/resources/provider-resources/forms
~~https://www.iehp.org/en/providers?target=forms~~

2. All Practitioners who complete the form are reviewed and evaluated by the Medical Director for the following criteria:
    a. Demonstrate 10 Continuing Medical Education (CME) hours within the last three (3) years;
    b. Certification through WPATH; and
    c. Must provide evidence of the following annual staff training on transgender care, that includes:
        1) Agenda
        2) Sign in sheet
        3) Policies and Procedures
3. If the Practitioner meets the requirements, they are identified as a Transgender Competent Practitioner, reflecting their offered services from the Questionnaire.
    a. Practitioners who do not meet the criteria above are subject to Medical Director, Chief Medical Officer Review. Further review may be completed by the Credentialing and/or Peer Review Subcommittee, who will either approve or deny.

I. Effective January 1, 2023, upon receipt of credentialing applications from Behavioral Health, Mental Health, and/or Substance Use Disorder Providers:[70]

1. IEHP will notify the applicant within seven (7) business days of receiving the application to confirm receipt and inform the applicant whether the application is complete.
    a. If the application is incomplete or requested supporting documents were not provided, IEHP will notify the practitioner within seven (7) business days of receiving the Practitioner's application noting the application received date and that the application was deemed incomplete and withdrawn from the credentialing process due to the missing information.
        1) The practitioner must submit the incomplete or requested documentation along with a current application for reconsideration.
        2) Once the additional information is received, the application will be deemed complete.
    b. If the application is deemed complete, the practitioner will be notified that their application will be forwarded to the Initial Application process.
        1) The processing time for an initial application starts on the day the Practitioner is notified of their completed application.
2. Practitioner qualifications will be assessed and verified within 60 business days after

[70] Health & Safety. Code § 1374.197

receiving a completed credentialing application. The 60-day timeframe only applies to credentialing process for Behavioral Health, Mental Health, and/or Substance Use Disorder Providers and does not include contracting completion.

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

1. Credentialing Policies

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	September 1, 1996	
Revision Effective Date:	January 1, 2024	

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
2. Credentialing Committee

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHPs Credentialing Subcommittee reviews the credentials for Providers who do not meet established thresholds and give thoughtful consideration of the credentialing information. IEHPs Credentialing Subcommittee obtains meaningful advice and expertise from participating Practitioners when it makes credentialing decisions in accordance with National Committee for Quality Assurance (NCQA) guidelines.

1. **Assessment of Timeliness.** IEHP uses the Credentialing Subcommittee or Medical Director decision date to assess timeliness in the file review elements if a review board or governing body reviews decisions made by the Credentialing Subcommittee or Medical Director.

2. **Providing care to Members.** IEHP does not permit Practitioners to provide care to its Members before they are credentialed.

B. IEHPs Credentialing Subcommittee ensures files that meet established criteria are reviewed and approved by a medical director or designated Physician.

PURPOSE:

A. IEHP designates the Credentialing Subcommittee who uses a peer-review process to make recommendations regarding credentialing decision. Activities of the Subcommittee are reported to Quality Management (QM) Committee on a quarterly basis or more frequently for issues of a more serious nature.

DEFINITIONS:

A. Clean files: Credentialing files that meet the organization's criteria for participation and are not required to be sent to the credentialing committee for review.[1]

B. Credentials Committee Minutes: A document from a peer review committee which includes thorough discussion of credentialing files, decisions/recommendations, and follow-up of issues.

C. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g. evaluation of a physician's credentials and practice by

[1] National Committee for Quality Assurance (NCQA), 2022~~2~~3 Health Plan Standards and Guidelines, Glossary

another physician).[2]

D. Timeliness: A term used when auditing file elements to confirm they are within ~~one hundred eighty (~~180~~)~~ calendar days of the credentials committee decision.

PROCEDURES:

A. The Credentialing Subcommittee is structured to provide review of Practitioners applying for participation with IEHP and to ensure compliance with IEHP requirements.[3]

1. IEHP uses participating Practitioners to provide advice and expertise for credentialing decisions. IEHPs voting rights are restricted to the appointed Subcommittee Members, who are Physicians only. Participating Practitioners are external to the organization and are part of the organization's network, as defined by NCQA.

    a. IEHP Medical Director or designee as Chairperson;

        1) IEHP's Medical Director is directly responsible for the credentialing process, Credentialing policies and procedures, and has overall responsibility and participation in the credentialing process.

    b. Chief Medical Officer (CMO);

    c. At least four (4) multidisciplinary participating Primary Care Providers (PCPs) or specialty Physician representative of network Practitioners;

        1) Any other specialty not represented by Subcommittee membership including vision and behavioral health serves on an ad hoc basis for related issues.

            - Prospective appointed Physician Members of the Subcommittee are subject to verification of licensure, Drug Enforcement Agency (DEA) and malpractice history prior to participating on the Subcommittee.
            - Prospective Physician Members not providing requested information to perform verification in a timely manner, or who do not meet IEHP's requirements upon verification may not participate on the Subcommittee.
            - The full term for practicing primary care and specialists Subcommittee voting Members is two (2) years, with replacements selected from network Practitioners.
                - The determination of whether any Practitioner Member may serve additional terms is at the sole discretion of the Chief Medical Officer and Medical Director, with approval of the Subcommittee.
                - The initial term(s) of Subcommittee Members are staggered to ensure

[2] NCQA, 2023~~2~~ HP Standards and Guidelines, Glossary
[3] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 2, Element A, Factor 1

consistent Subcommittee operations.

d. IEHP's non-physician staff on the Subcommittee do not have voting rights and consists of the following:

1) Director of Provider Relations;

2) Director of Quality Management;

3) Director of Provider Network;

4) Credentialing Manager;

- Credentialing ensures the timeframe for notifying applicants of their credentialing decisions for both credentialing and recredentialing, does not exceed ~~sixty (~~60~~)~~ calendar days from the committee's decision.

5) Quality Manager;

6) Other IEHP staff, as necessary; and

- IEHP staff attend as permanent Members of the Credentialing Subcommittee.

7) Provider Services Administrative Assistant.

- Acts as secretary to the Credentialing Subcommittee.

B. IEHPs Credentialing Subcommittee reviews the credentials for Providers who do not meet established thresholds and give thoughtful consideration of the credentialing information. IEHPs Credentialing Subcommittee obtains meaningful advice and expertise from participating Practitioners when it makes credentialing decisions.[4]

1. The committee's discussion must be documented within its meeting minutes. The Credentialing decision date is used to determine the timeliness requirements for credentialing.

a. Credentialing Subcommittee meetings and decision making may take place in form of real-time virtual meetings (e.g. through video conferencing or web conferencing with audio). Meetings may not be conducted only through email.

b. Voting cannot occur unless there is a quorum of voting Members present. For decision purposes a quorum can be composed of one of the following:

1) The Chairperson, (who is the IEHP Medical Director or designee), CMO, and three (3) appointed Subcommittee Members; or

2) The Chairperson (who is the IEHP Medical Director or designee), or CMO and two (2) appointed Subcommittee Members.

[4] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 2, Element A, Factor 2

c. Credentialing Subcommittee decisions cannot be based on applicant's race, ethnic/national identity, gender, age, sexual orientation, type of procedure, or patient type (i.e. Medicaid) in which the Practitioner specializes. Policies and procedures must describe specific steps that the organization prevent and monitor discriminatory practices. This does not preclude the organization from including in its network Practitioners who meet certain demographic or specialty needs (i.e. meeting cultural needs of the Members).

d. In-depth minutes are recorded at each meeting by a Provider Services Administrative Assistant, with review by the Credentialing Manager and IEHP Medical Director.

1) Minutes include all activities addressed in Subcommittee meetings, including credentialing and recredentialing decisions, and other business related to credentialing and recredentialing of Practitioners including thoughtful discussion and consideration of all Practitioners being credentialed and recredentialed before a credentialing decision is determined.

2) Minutes are dated, signed, and reflect the responsible person for follow-up actions.

3) Credentialing minutes are stored in a confidential and secure location with access only to authorized staff.

e. Updates of activities including minutes and appropriate reports are submitted to Quality Management (QM) Committee on a quarterly basis, or more frequently as needed.

f. The Credentialing Subcommittee meets monthly with additional meetings as needed.

C. Ensures that files that meet established criteria are reviewed and approved by a medical director or designated Physician. IEHP implemented a process to designate a Medical Director or other designated Physician review and approval of clean files submits all Practitioner files, and then provides a list to the Credentialing Subcommittee for review as a repository.[5]

1. IEHP's Medical Director is directly responsible for the credentialing process. Credentialing policies and procedures and has overall responsibility and participation in the credentialing process.

2. Evidence of the medical director's or equally qualified Physician's review will be present on a list or file of the Practitioners who meet the established criteria.

3. IEHP's Medical Director reviews, analyzes, and recommends any changes to the IEHP Credentialing and Recredentialing Program policies and procedures on an annual basis, or as deemed necessary.[6]

[5] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 2, Element A, Factor 3
[6] Ibid.

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
2. Credentialing Committee

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2020	
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5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
2. Credentialing Committee

~~INLAND EMPIRE HEALTH PLAN~~		
~~**Chief Approval:** *Signature on File*~~	~~**Original Effective Date:**~~	~~January 1, 2020~~
~~**Chief Title:** Chief Operating Officer~~	~~**Revision Date:**~~	~~January 1, 2024~~3

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

3. Credentialing Verification

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHP verifies that the following are within the prescribed time limits: License to Practice, Drug Enforcement Administration (DEA), education and training, board certification, work history and malpractice history.

B. IEHP verifies State sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions.

C. IEHP ensures applications for credentialing and recredentialing include reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitation of privileges or disciplinary actions, current malpractice insurance coverage, and a current and signed attestation confirm the correctness and completeness of the application.

D. IEHP verifies that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital.

E. IEHP verifies that Practitioners meet all screening and enrollment requirements to include, but not limited to: enrollment in the Medi-Cal Program; Federal and State Database Checks for Social Security Administration's Death Master File (SSADMF), National Plan and Provided Enumeration System (NPPES), List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS' Medicare Exclusion Database (MED), DHCS' Suspended and Ineligible List, Restricted Provider Database (RPD).

F. IEHP monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out.

G. IEHP includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process.

H. IEHP ensures all Primary Care Provider's (PCP) and Urgent Care's (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring").

I. IEHP monitors its Provider network and ensures their Providers are not included in the Centers Medicare & Medicaid Services (CMS) Preclusions List.

J. IEHP must ensure all Practitioners are within the appropriate age range guidelines, as appropriate to ensure compliance with IEHP guidelines. (See Policy 5A1, "Credentialing Standards - Credentialing Policies".)

K. IEHP must obtain appropriate documentation to expand or limit their practice parameters for IEHP review and approval.

L. IEHP must ensure and obtain the appropriate documentation for all Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) between the Mid-Level and Supervising Physician, provide them to IEHP, and ensure these documents are readily available upon request. (See Policy 6F, "Facility Site Review – Non-Physician Practitioner Requirements").

PURPOSE:

A. IEHP conducts timely verification of information to ensure that Practitioners have the legal authority and relevant training and experience to provide quality care.

B. Pencils are not an acceptable writing instrument for credentialing documentation.

C. Each file contains evidence of verification from a listed source and review by organization staff, defined by NCQA as "Appropriate documentation." IEHP documents verification in the credentialing files using any of the following methods or a combination:

1. Credentialing documents signed (or initialed) and dated by the verifier.
2. A checklist that includes for each verification:
    a. The source used.
    b. The date of verification.
    c. The signature or initials of the person who verified the information.
    d. The report date, if applicable.
3. A checklist with a single signature and a date for all the verifications that has a statement confirming that the signatory verified all the credentials on that date and that includes for each verification.
    a. The source used.
    b. The report date, if applicable.
    c. If the checklist does not include checklist requirements listed above appropriate credentialing information must be included.

D. Using the Internet for Primary Source Verification (PSV): PSV on documents that are printed/processed from an internet site (e.g. BreEZe, National Practitioner Data Bank (NPDB) etc.), the data source date (as of date, release date) must be queried within the timeframe. The date of the query must be verified prior to the Credentialing Decision. If there is no data source date, the verifier must document the review date on the verification or the checklist. Verification must be from an NCQA approved and appropriate state-licensing agency.

E. PSV Documentation Methodology. The organization may use an electronic signature or unique electronic identifier of staff to document verifications (to replace the dating and initialing of each verification) if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The system must identify the individual verifying the information and the date of verification.

DEFINITION:

A. Attestation: A signed statement by a practitioner confirming the validity, correctness and completeness of a credentialing application.[1]

B. Automated Verification - Requires there be a mechanism to identify the name of the entity verifying the information, the date of the verification, the source, and the report date, if applicable.

C. Board certified: A practitioner has satisfied the requirements/standards of a nationally recognized specialty board and received the board's specialist certification. [2]

D. CMS Preclusions List – List of prescribers and individuals or entities who fall within any of the following categories: (1) Are currently revoked from Medicare, are under an active re-enrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.

E. Death Master File (DMF) contains information about persons who had Social Security numbers and whose deaths were reported to the Social Security Administration from 1962 to the present; or persons who died before 1962, but whose Social Security accounts were still active in 1962.

F. National Practitioner Data Bank (NPBD): A federally mandated agency that is the repository of information about settled malpractice suits and adverse acts, sanctions or restrictions against the practice privileges of a physician. [3]

G. NPPES – CMS National Plan and Provider Enumeration System.

H. Primary source: The entity that originally conferred or issued a credential. [4]

I. Primary source verification: Verification of credentialing information directly from the entity (e.g. state licensing board) that conferred or issues the original credential. [5]

J. Types of Signatures:

1. Wet signature - created when a person physically marks a document.

[1] National Committee for Quality Assurance (NCQA), 20232 Health Plan Standards and Guidelines, Glossary
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.

2. Faxed signature – the "copy" or "duplication" of your signature (no matter the method, system or medium you choose) is referred to as a facsimile signature.
3. Digital signature - type of electronic signature that encrypts documents with digital codes that particularly difficult to duplicate. It includes a certificate of authority, such as a Windows certificate, to ensure the validity of the signatory (the signature's author and owner).
4. Electronic signature - symbols or other data in digital form attached to an electronically transmitted document as verification of the sender's intent to sign the document.
5. Scanned signature - a written signature that's been scanned into an electronic format, like a PDF.
6. Photocopied signature - a signature reproduced provided that the copy must be of an original document containing an original handwritten signature.
7. Signature stamp - is an implement personalized with an individual's name for a quick and easy authorization of documents. These stamps can come customized with just a signature or can include both a signature and printed name.

K. Verification Time Limit (VTL): National Committee for Quality Assurance (NCQA) counts back from the decision date to the verification date to assess timeliness of verification.

1. For web queries, the data source data – e.g. release date or as of date is used to assess timeliness of verification.

L. Verbal Verification - Requires a dated, signed document naming the person at the primary source who verified the information, his/her title, the date and time of verification and include what was verified verbally.

M. Written Verification - Requires a letter or documented review of cumulative reports. IEHP must use the latest cumulative report, as well as periodic updates released by the primary source. The date on which the report was queried, and the volume used must be noted.

PROCEDURES:

A. IEHP verifies that the following are within the prescribed time limits:

1. A current and valid license to practice in California (Verification Time Limit (VTL): ~~one hundred eighty (~~180~~)~~ calendar days prior to Credentialing decision date).
   a. Must be valid, current, and unencumbered at the time of committee and remain valid and current throughout the Practitioner's participation with IEHP.
      1) Failure to maintain a valid and current license at all times, will result in an

administrative termination of the Practitioner.[6]

2. A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable (VTL: ~~one hundred eighty (~~180~~)~~ calendar days prior to Credentialing decision date). All Practitioners who are qualified to write prescriptions, except non-prescribing Practitioners, must have a valid and current DEA certificate. IEHP must verify that the practitioner's DEA or CDS certificate is valid and current in each where the practitioner provides care to members. The DEA or CDS certificate:

   a. Verification may be in the form of:

      1) Confirmation from the American Medical Associates (AMA) Physician Masterfile

      2) American Osteopathic Association Official Osteopathic Physician Profile report or Physician Master File

      3) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision;

   ~~a.~~b. Must be valid and current at the time of committee and remain valid and current throughout the Practitioner's participation with IEHP) and registered with an address in State of California.

   ~~b.a. Verification may be in the form of:~~

      ~~1) A photocopy of the current DEA certificate, with date stamped and initialed by the reviewer to show receipt and review prior to the credentialing decision;~~

   c. Any Practitioner with a DEA with an "EXEMPT" Fee or status, the DEA is only valid at the exempting institution and any affiliate Hospital or Clinic rotations within the scope of training.

      1) IEHP must confirm the Practitioner's practice and exempting institutions relationship and document their findings in the Provider file, if the address on the DEA does not match the Providers practice location.

         - If a Practitioner is practicing outside of the exempting institution and/or its affiliates, the Practitioner must obtain a "Paid" status DEA.

   d. IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a California address, IEHP must obtain written documentation from the Provider of their arrangements with another Practitioner who will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA number and NPI number will be documented in the Practitioner's file. (See

[6] National committee for Quality Assurance (NCQA), 2023~~2~~ Health Plan Standards and Guidelines, CR 3, Element A, Factor 1

~~Attachment,~~ "Prescribing Arrangements for DEA and CDS Eligible Practitioners" found on the IEHP website~~in Section 5~~[7])

1) If a Practitioner does not have a DEA or CDS certificate, IEHP must obtain an explanation to why the Practitioner does not prescribe medications and to provide arrangements for the Practitioner's patients who need prescriptions requiring DEA certification.

   - For credentialing files where verification of DEA or CDS is before June 1, 2020, and a practitioner who is DEA- or CDS- eligible does not have a DEA or CDS certificate, NCQA accepts either the verification process required in the 2020 standards or the applicable prior year's standards, which state "If a qualified practitioner does not have a valid DEA or CDS certificate, the organization notes this in the credentialing file and arranges for another practitioner to fill prescriptions."
     - Practitioner's statement. I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management, example provided by NCQA.

e. If a practitioner is practicing in Arizona, IEHP may credential a Practitioner whose DEA certificate is pending or pending a DEA with a Arizona address, by obtaining written documentation that the Practitioner with a valid DEA certificate will write all prescriptions requiring a DEA number for the prescribing Practitioner until the Practitioner has a valid DEA certificate. The prescribing Practitioner's name, DEA Number, and NPI number will be documented within the Practitioner's file.

f. The Credentialing Specialist reviews the Practitioner's Attestation Question regarding the Practitioner's DEA registration in any jurisdiction, for correctness, completeness and to ensure any applicable written explanation(s) are present in the file, date stamped ~~one hundred eighty (~~180~~)~~ calendar days prior to Credentialing decision.

   If the practitioner chooses not to provide a written explanation or correct his/her attestation, it will be documented the practitioners file and included for Credentialing Subcommittee review, as needed.

   1) If the practitioner is new to the IEHP Network, Credentialing will prepare the file as a Level II, files that do not meet IEHP's established thresholds, for review and discussion at the next scheduled Credentialing Subcommittee meeting.

[7] https://www.iehp.org/en/providers?target=forms

2) If the practitioner is an existing Practitioner, the Credentialing Specialist will confirm if the practitioner was reviewed by the IEHP Credentialing Subcommittee previously, for area not met.

- If so, the Credentialing Specialist will document in the Practitioner's file when the Practitioner's adverse action was reviewed and discussed by the IEHP Credentialing Subcommittee.
- If not, the Credentialing Specialist will prepare the Practitioner's file as a Level II, for the next scheduled IEHP Credentialing Subcommittee meeting, for review and decision.

g. Failure to maintain an active DEA, may result in an administrative termination of the Practitioner.[8]

3. Education and training (VTL: Prior to the Credentialing Decision) All Practitioners must have completed appropriate education and training for practice in the U.S. or a residency program recognized by NCQA, in the designated specialty or subspecialty they request to be credentialed and contracted. IEHP verifies the highest of the following three levels of education and training obtained by the Practitioner, as appropriate. i.e., Board Certification, Residency or Graduation from medical or professional school. An expired board certification may be used for verification of education/training.

   If the Practitioner is not board certified in the specialty or sub-specialty in which he/she is applying, there must be evidence of verification of residency and training in the sub-specialty (e.g., Fellowships in Cardiology, Rheumatology, Pediatric Endocrinology etc.), as relevant to the credentialed specialty.

   a. IEHP may use any of the following to verify education and training:

      1) The primary source from the Medical School.

      2) The state licensing agency or specialty board or registry if the state agency and specialty board, respectively, perform primary source verification.

         - IEHP obtains, at least annually, written confirmation of primary source verification from the primary source or at least annually; or
         - Provides a printed, dated screenshot of the state licensing agencies or specialty boards or registry website displaying the statement that it performs primary source verification of Practitioner education and training information; or

[8] NCQA, 2022~~2~~3 HP Standards and Guidelines, CR 3, Element A, Factor 2

- Provides evidence of a state statute requiring licensing agency, specialty board or registry to obtain verification of education and training directly from the institution.
- National Student Clearinghouse may be considered an agent of the medical or professional school if the school has a contract with the Clearinghouse to provide verification services.
    - Delegates must provide documentation that the specific school has a contract with the Clearinghouse, to ensure compliance with NCQA.

3) Sealed transcripts if the organization provides evidence that it inspected the contents of the envelope and confirmed that Practitioner completed (graduated from) the appropriate training program.

4) Below are acceptable sources for physicians (M.D., D.O.) to verify graduation from Medical School:
    - AMA Physician Master File.
    - American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
    - Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

5) Below are acceptable sources for physicians (M.D., D.O.) to verify completion of residency training:
    - Primary source from the institution where the postgraduate medical training was completed.
    - AMA Physician Master File.
    - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
    - FCVS for closed residency programs.
        - NCQA only recognizes residency programs accredited by the Accredited Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.[9]

6) Below is the acceptable sources for Nurse Practitioners with a Behavioral Health (BH) designation, to verify training in Psych/Mental Health.

[9] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element A, Factor 3

- Nurse Practitioner License with a qualification in Psych/Mental Health and verified through the BreEZe Online services website or directly with the licensing board via phone or email.

7) Below is the acceptable source for Registered Dietician (R.D.s):

- Commission on Dietetic Registration

b. If the practitioner does not meet education and training requirements, set forth in this policy, the Credentialing Specialist will notify the practitioner that they do not meet the training requirements therefore is subject to Credentialing Subcommittee review, with the possibility of denial due to not meeting education requirements. The Credentialing Specialist will:

1) Confirm the verified training and the required education and training requirements with the practitioner

2) Request for any additional training or justification the practitioner would like to include for consideration, for the Credentialing Subcommittee for discussion.

c. The Credentialing Specialist reviews the Practitioners Attestation Question regarding internship, residency, fellowship, preceptorship, or any other clinical education program, for correctness, completeness and to ensure any applicable written explanation(s) are present in the file, date stamped ~~one hundred-eighty (~~180~~)~~ calendar days prior to Credentialing decision.

If the practitioner chooses not to provide a written explanation or correct his/her attestation, it will be documented in the practitioners file and included for Credentialing Subcommittee review, as needed.

1) If the practitioner is new to the IEHP Network, Credentialing will prepare the file as a Level II, files that do not meet IEHP's established thresholds, for review and discussion at the next scheduled Credentialing Subcommittee meeting.

2) If the practitioner is an existing Practitioner, the Credentialing Specialist will confirm if the practitioner's education and training was reviewed by the IEHP Credentialing Subcommittee previously.

- If so, the Credentialing Specialist will document in the Practitioner's file when the Practitioner's education and training was reviewed and discussed by the IEHP Credentialing Subcommittee.

- If not, the Credentialing Specialist will prepare the Practitioner's file as a Level II, for the next scheduled IEHP Credentialing Subcommittee meeting, for review and decision.

4. Board certification status, if applicable (VTL: ~~one hundred-eighty (~~180~~)~~ calendar days prior to Credentialing decision date).

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

3. Credentialing Verification

a. IEHP verifies current certification status of Practitioners who state that they are board certified.

1) IEHP must document the expiration date of the board certification within the credential file.

- If a Practitioner has a "lifetime" certification status and there is no expiration date for certification, the organization verifies that the board certification is current and documents the date of verification.

2) If board certification has expired, it may be used as verification of education and training.

3) Verification must be performed through a letter directly from the board or an online query of the appropriate board as long as the board states that they verify education and training with primary sources, is an acceptable source by NCQA, and indicate that this information is correct. Below are the acceptable sources to verify board certification:

- For all Practitioner types
  - The primary source (appropriate specialty board).
  - The state licensing agency if the primary source verifies board certification.
- For Physicians (M.D., D.O.)
  - ABMS or its Member boards, or an official ABMS Display Agency, where a dated certificate of primary-source authenticity has been provided.
    - The ABMS "Is your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
  - AMA Physician Master File.
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - Boards in the United States that are not Members of the ABMS or AOA if the organization documents within its policies and procedures which specialties it accepts and obtains annual written confirmation from the boards that the boards performs primary source verification of completion of education and training.
- For other health care professionals

- Registry that performs primary source verification of board that the registry performs primary source verification of board certification status.

- For Podiatrists (D.P.M.)
  - American Board of Foot and Ankle Surgery (formerly The American Board of Podiatric Surgery).
  - The American Board of Podiatric Medicine.
  - American Board of Multiple Specialties in Podiatry.
- For Nurse Practitioners (N.P.)
  - American Association of Nurse Practitioners (AANP).
  - American Nurses Credentialing Center (ANCC).
  - National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties (NCC).
  - Pediatric Nursing Certification Board (PNCB).
  - American Association of Critical-Care Nurses (AACN).
- For Physician Assistants (P.A.-C).
  - National Commission of Certification of P.A.'s (NCCPA).
- For Certified Nurse Midwives (C.N.M.).
  - American Midwifery Certification Board (AMCB).
- For Psychologists (Ph.D., Psy.D.).
  - American Board of Professional Psychology (ABPP).

4) Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification to members.

5) If IEHP is unable to verify the board certification, the Practitioner is notified and given the right to review and correct erroneous information. In addition, further review of the Providers attestation may be required for correction.[10]

b. The Credentialing Specialist reviews the Practitioner's Attestation Question regarding any changes in their board certification (other than changing from eligible to certified, for correctness, completeness and to ensure any applicable written

[10] NCQA, 20232 HP Standards and Guidelines, CR 3, Element A, Factor 4

explanation(s) are present in the practitioner's file, date stamped ~~one hundred eighty (~~180~~)~~ calendar days prior to Credentialing decision.

If the practitioner chooses not to provide a response or correct his/her attestation, it will be documented in the practitioner's file and presented to the Credentialing Subcommittee for review, as needed.

5. Work history (VTL: ~~one hundred eighty (~~180~~)~~ calendar days prior to Credentialing decision date) IEHP must obtain a minimum of the most recent five (5) years of work history as a health professional through the application, Curriculum Vitae (CV) or work history summary/attachment, providing it has adequate information.
   a. IEHP must document review of work history on the application, CV, or checklist that includes the signature or initials of staff who reviewed work history and the date of review. Documentation of work history must meet the following:
      1) Must include the beginning and ending month and year for each work experience.
      2) The month and year do not need to be provided if the Practitioner has had continuous employment at the same site for five (5) years or more. The year to year documentation at that site meets the intent.
      3) If the Practitioner completed education and went to straight into practice, this will be counted as continuous work history.
      4) If the Practitioner has practiced fewer than five (5) years from the date of credentialing. The work history starts at the time of initial licensure.
      5) IEHP must review for any gaps in work history. If a work history gap of six (6) months to one (1) year is identified, IEHP must obtain an explanation from the Practitioner. Verification may be obtained verbally or in writing for gaps of six (6) months to one (1) year.
      6) Any gap in work history that exceeds one (1) year must be clarified in writing from the Practitioner. The explanation of the gap needs to be sufficient to ascertain that the gap did not occur as a result of adverse and/or reportable situations, occurrences or activities.[11] (See ~~Attachment, "~~Work History Form Past Five (5) years' request" ~~in Section 5~~found on the IEHP website~~.~~[12])
6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the Practitioner. (VTL: ~~one hundred eighty (~~180~~)~~ calendar days prior to Credentialing decision date)

[11] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element A, Factor 5
[12] https://www.iehp.org/en/providers?target=forms

a. IEHP will obtain confirmation of the past seven (7) years of malpractice settlements through one of the following sources:

1) Malpractice Insurance Carrier.

2) National Practitioner Data Bank Query.

3) Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within ~~one hundred eighty (~~180~~)~~ calendar days of the initial credentialing decision. Evidence must be documented in the file or on checklist.

b. The Credentialing Specialist will review the practitioner's malpractice claim history by querying National Practitioner Data Bank or confirmation from their malpractice carrier. A minimum the seven (7) years claim history must be reviewed for initial credentialing and all claim history activities after the previous credentialing decision date, will be reviewed for recredentialing. The seven (7) year period may include residency and fellowship years. IEHP is not required to obtain confirmation from the carrier for Practitioners who had a hospital insurance policy during a residency and fellowship.[13]

For Practitioners with a history of malpractice suits or decision, the following criteria warrants Credentialing Subcommittee Review of the history:

1) Number of claims – any claims within the prior seven (7) years

2) Results of cases – any settlements within the prior seven (7) years.

- Settlements with a minimum payout of $30,000.00 or more
- Settlements resulting in major permanent injury or death

3) Trends in cases – Practitioners with multiple malpractice claims in a similar area (e.g. missed diagnosis, negative surgical outcomes, etc.,)

c. The Credentialing Specialist reviews the practitioners Attestation Question regarding Malpractice history for correctness, completeness and to ensure any applicable written explanation(s) are present in the file, date stamped ~~one hundred eighty (~~180 ~~)~~calenda days prior to Credentialing decision.

If the practitioner chooses not to provide a written explanation or correct his/her attestation, it will be documented in the practitioners file and included for Credentialing Subcommittee review, as needed.

1) If the practitioner is new to the IEHP Network, Credentialing will prepare the file as a Level II, files that do not meet IEHP's established thresholds, for review

[13] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element A, Factor 6

and discussion at the next scheduled Credentialing Subcommittee meeting.

2) If the practitioner is an existing Practitioner, the Credentialing Specialist will confirm if the adverse history was reviewed by the IEHP Credentialing Subcommittee previously.

- If so, the Credentialing Specialist will document in the Practitioner's file when the Practitioner's adverse action was reviewed and discussed by the IEHP Credentialing Subcommittee.
- If not, the Credentialing Specialist will prepare the Practitioner's file as a Level II, for the next scheduled IEHP Credentialing Subcommittee meeting, for review and decision.

B. Medicare and Medicaid sanctions. (VTL: ~~one hundred eighty (~~180~~)~~ calendar days prior to Credentialing decision). IEHP uses the NPDB, for Medicare and Medicaid sanctions.

1. If a Practitioner is not identified on any reports, the OIG Compliance Now findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the ~~one hundred eighty (~~180~~)~~ calendar-day timeframe.

- If a Practitioner is identified on the report for the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List, the Credentialing Specialist obtains and reviews the information.

1) State Medicaid Agency or intermediary

2) Medicare intermediary

3) List of Excluded Individuals and Entities (maintained by OIG and available over the internet).

4) Medicare Exclusions Database.

5) FEHB Program Department Record, published by the Office of Personnel Management, Office of the Inspector General

6) AMA Physician Master File

7) Federation of State Medical Boards (FSMB).

8) NPDB

- Continuous Query (formerly Proactive Disclosure Service (PDS)). Evidence of Continuous Query (formerly Proactive Disclosure Services (PDS). Continuous Query must be reviewed within ~~one hundred eighty (~~180~~)~~ calendar days of the credentialing decision and show evidence the practitioner was enrolled in the alert services at the time of the cited report. Evidence must be documented in the file or on checklist.

2. The Credentialing Specialist reviews the Practitioner's Attestation Question regarding the restriction on licensure or limitations on scope of practice, for correctness, completeness and to ensure any applicable written explanation(s) are present in the file, date stamped ~~one hundred eighty (~~180~~)~~ calendar days prior to Credentialing decision.

   If the practitioner chooses not to provide a response or correct his/her attestation, it will be documented in the practitioner's file and included for Credentialing Subcommittee review, as needed.

   a. If the practitioner is new to the IEHP Network, Credentialing will prepare the file as a Level II, files that do not meet IEHP's established thresholds, for review and discussion at the next scheduled Credentialing Subcommittee meeting.

   b. If the practitioner is an existing Practitioner, the Credentialing Specialist will confirm if the adverse history was reviewed by the IEHP Credentialing Subcommittee previously.

      1) If the Practitioner is new to the IEHP network, Credentialing will notify the Practitioner that their credentialing is closed due to IEHP not allowing Practitioners identified on the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List to participate in the IEHP network.

      2) If the Practitioner is an existing Provider, the Credentialing Specialist will send the Provider a notification to terminate due to IEHP not allowing Practitioners identified on the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List to participate in the IEHP network.

         - The Credentialing Specialist will prepare these documents for the Peer Review Subcommittee review and discussion for Providers identified through IEHPs ongoing monitoring of sanctions process for the HHS-OIG Exclusions List and/or Medi-Cal Suspended & Ineligible List review.[14,15]

C. IEHP applications for credentialing and recredentialing must include the following:

   1. Reasons for inability to perform the essential functions of the position.[16]

   2. Lack of present illegal drug use.

      a. IEHPs application may use alternative language or general language that may not be exclusive to present use or only illegal substances.[17]

   3. History of loss of license and felony convictions.

[14] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element B, Factor 2
[15] Department of Health Care Services (DHCS) All Plan Letter (APL) ~~19~~22-~~004~~ 013 Supersedes APL ~~17~~19-~~019~~004, "Provider Credentialing / Recredentialing and Screening / Enrollment"
[16] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element C, Factor 1
[17] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element C, Factor 2

a. At initial credentialing, the Practitioner must attest to any loss of license or felony convictions since their initial licensure.

b. At recredentialing, the Practitioners may attest to any loss of licensure or felony convictions since their last credentialing cycle.[18]

4. History of loss or limitation of privileges or disciplinary actions.

a. At initial credentialing, the Practitioner must attest to any loss or limitation of privileges since their initial licensure.

b. At recredentialing, the Practitioners may attest to any loss or limitation of privileges since their last credentialing cycle.[19]

5. Current malpractice insurance coverage. IEHP requires that a copy of the insurance face sheet or Certificate of Insurance (COI) or written verification from the insurance carrier directly be obtained in conjunction of collecting information on the application.

(VTL: Must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee date and remain valid and current throughout the Practitioner's participation with IEHP).

a. All Practitioners must have current and adequate malpractice insurance coverage that is current and:

1) Meets IEHP's standard of $1 million/$3 million, as well as IEHPs standards. Professional Liability Insurance coverage and amounts of coverage must be verified with the insurance carrier or through the Practitioner via a copy of the policy and the signed attestation completed by the Practitioner.

- The copy of the Practitioner's certificate must be initialed, and date stamped to show receipt prior to the credentialing decision and to show it was effective at the time of the credentialing decision.

2) Must include coverage for the specialty the Practitioner is being credentialed for and for all locations the Practitioner will be treating IEHP patients.

- If the specialty coverage and/or the locations are not identified on the malpractice insurance certificate, the coverage must be verified with the insurance carrier and documented in the Practitioner's file.

3) For Practitioners with federal tort coverage, (e.g. Health Resources & Services Administration (HRSA)), the Practitioner must submit:

- A copy of the face sheet or federal tort letter as an addendum to the application. The face sheet or federal tort letter must include the:

[18] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element C, Factor 3
[19] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element C, Factor 4

- Insurance effective and expiration dates (future effective dates are acceptable)

- A roster that lists all practitioners covered under the federal tort coverage.

4) There must be evidence that the Practitioner has current and adequate malpractice coverage prior to the Credentialing Committee approval date.

- Failure to maintain current malpractice coverage for the specialty the Provider is being credentialed for and for all locations the Practitioner will be treating IEHP patients, will result in an administrative termination of the Practitioner.[20]

6. Current and signed attestation confirm the correctness and completeness of the application. Attestation must be:

a. Signed and dated within the timeframe and must include all elements to be compliant.

1) The ~~one hundred eighty (~~180~~)~~ calendar day timeframe is based on the date the Practitioner signed the application.

- If the signature or attestation exceeds ~~one hundred eighty (~~180~~)~~ calendar days the Practitioner must only attest that the information on the application remains correct and complete, be re-signing and re-dating the attestation. Practitioner does not need to complete another application.

b. Signed with a full signature, if the attestation needs to be re-signed by the Practitioner; dating and initialing is not acceptable.

1) Faxed, digital, electronic, scanned or photocopies signatures are accepted. Signature stamps are not acceptable. (See Definitions, "Types of Signatures")

- If the full signature is not acceptable, the Credentialing Specialist will reach out to the practitioner to re-sign and date the attestation.

c. If the attestation is not signed and/or dated, within the appropriate time frame, all application elements are non-compliant (except current malpractice coverage since IEHP requires a face sheet is obtained).

1) If a question is answered and does not correlate with the practitioner's file, IEHP is responsible for notifying the Practitioner of the discrepancy and to have them re-review the question.

- If the Practitioner chooses to change their response, the Provider may initial and date next to the change.

- If the Practitioner chooses not to change their response, then IEHP will

[20] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element C, Factor 5

document their attempt to have the Practitioner review their response and that the provider chose not to change their response.

d. When reviewing the CAQH application, IEHP accepts the last attestation date generated by the CAQH system as the date when the practitioner signed and dated the application to attest to its completeness and correctness.[21]

D. IEHP must verify that Practitioners must have clinical privileges in good standing. Practitioner must indicate their current hospital affiliation or admitting privileges at a participating hospital. Verification that all clinical privileges are in good standing to perform functions for which the Practitioner is contracted, to include verification of admitting privileges, must be:

1. Confirmed with the Hospital, in writing, via approved website or verbally, and must include:
   a. The date of appointment;
   b. Scope of privileges, restrictions (if any i.e. restricted, unrestricted) and recommendations.
   c. Confirmation Provider has admitting privileges in the specialty the Provider is credentialed and contracted for.
   d. If a published Hospital directory is used, the list must include the necessary information and be accompanied by a dated letter from the Hospital attesting that the Practitioner is in "good standing."
   e. Practitioner must meet the requirements for Hospital Privileges as required by IEHP. (See Policy 5B, "Hospital Privileges"), i.e. if an admitter or hospitalist arrangement is used, a written agreement that meets IEHP admitter requirements, confirming coverage for all inpatient work covering the entire age range of the Practitioner must be included in the Practitioner's credentialing file.
      1) These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider application, admitter report or attachment.
      2) If the Provider utilizes an admitter or hospitalist arrangement, IEHP will document these arrangements in the Provider file, to include when the Provider was notified. Documentation must include:
         - The date the Practitioner was notified
         - Name(s) of the admitter and/or hospitalist, admitting on behalf of the Provider
         - Name(s) of the Hospital, affiliated with the inpatient coverage arrangements

[21] NCQA, 20232 HP Standards and Guidelines, CR 3, Element C, Factor 6

2. If the Practitioner does not have clinical privileges, then IEHP must have a written statement delineating the inpatient coverage arrangement documented in the Providers file. (See Policy 5B, "Hospital Privileges"). For Specialties that are required to have clinical privileges or admitting privileges at a Participating hospital, See ~~Attachment,~~ "Hospital Admitting Privileges Reference by Specialty" found on the IEHP website[22].
3. Allied Health Professionals (Non-physicians i.e. Chiropractors, Optometrists) will not have hospital privileges and documentation in the file is not required for these types of Practitioners. (See ~~Attachment,~~ "Hospital Admitting Privileges Reference by Specialty" found on the IEHP website[23])
4. Advanced Practice Practitioners (Physician Assistants (PA), Nurse Practitioners (NP), Certified Nurse Midwives (CNM)) may not have hospital privileges. However, if the Advanced Practice Practitioners provides IEHP their hospital privileges, IEHP will be responsible for verifying if those privileges are active and ensure they are in good standing.
5. Specialists (MDs, DOs and DPMs) may not have hospital privileges, documentation must be noted in the file as to the reason for not having privileges. (e.g. A note stating that they do not admit as they only see patients in an outpatient setting is sufficient).
    a. These arrangements must be provided to IEHP for all Practitioners participating in the IEHP network, via Provider application, admitter report or attachment.
        1) These arrangements are subject to IEHP review and approval.
        2) IEHP may request for inpatient coverage arrangements for the Practitioner, if IEHP identified that specialty as a specialty that requires hospital admitting arrangements.
6. Certified Nurse Midwives (CNMs) may provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services only after they are fully credentialed and approved by the same Provider network. CNM Providers must meet the following criteria:
    a. In lieu of having full hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed.
        1) The Agreement must include back-up physician's full delivery privileges at IEHP network hospital, in the same network as the CNM Provider.

[22] https://www.iehp.org/en/providers?target=forms
[23] Ibid.

2) The OB Provider must be credentialed and contracted within the same practice and network.

7. Family Practice including outpatient Obstetrics (OB) services (FP-1) Must provide a copy of a signed agreement that states:
   a. Member transfers will take place within the first ~~twenty-eight (~~28~~)~~ weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB.
      1) The OB must be contracted and credentialed by the same network as the Family Practice Provider and must hold admitting privileges to the IEHP hospital linked to IEHPs Direct Network.
8. Family Practice including full Obstetrics services and delivery (FP-2). Providers that fulfill these requirements may be referred to and see Ob/Gyn Members within IEHPs Direct Network, and must have:
   a. Full delivery privileges at an IEHP network hospital; and
      1) Provide a written agreement for an available OB back up Provider is required. The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP hospital linked with the Family Practice Provider; and
      2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc.).
9. Obstetrics/Gynecology (OB/GYN) Providers who would like to participate as a Primary Care Provider only, will provide outpatient well woman services only with no hospital or surgical privileges, must provide the following information for consideration:
   a. In lieu of obtaining or maintaining full hospital delivery privileges, the Practitioners must provide a written agreement with OB that includes:
      1) A protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.).
      2) Must be available for consultations, as needed and that the OB will provide prenatal care after ~~twenty-eight (~~28~~)~~ weeks gestation including delivery.
      3) The agreement must include back-up physician's full delivery privileges at IEHP network hospital, in the same network as the non-admitting OB Provider.
         - The OB Provider must be credentialed and contracted within the same network.
10. Licensed Midwife (LM) practitioners are required to have a backup Licensed Physician, engaged in active clinical obstetrical practice and with whom the Licensed Midwife consults when there are significant deviations from the normal, in either mother or infant.

Therefore, LMs must complete a Licensed Midwife Attestation: Plan for Consultation, Emergency Transfer, & Transport (See ~~Attachment,~~ "Licensed Midwife Attestation" found on the IEHP website~~, in Section 5~~) required for all Licensed Midwife Practitioners.

a. IEHP requires the backup Licensed Physician is an active Obstetrics/Gynecology Practitioner within the IEHP network.

11. Urgent Care Providers are not required to maintain hospital privileges if they are exclusively practicing at an Urgent Care.[24,25,26]

E. IEHP verifies that Practitioners meet all screening and enrollment requirements to include, but not limited to: enrollment in the Medi-Cal Program, Federal and State Database Checks for Social Security Administration's Death Master File (SSADMF), National Plan and Provider Enumerated System (NPPES), List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS' Medicare Exclusion Database (MED), DHCS' Suspended and Ineligible List (S&I), Restricted Provider Database (RPD). (VTL: ~~one hundred eighty (~~180 ~~)~~ calendar days prior to Credentialing decision).[27]

1. Dual Choice Practitioners are not required to be enrolled in the Medi-Cal Program.

2. To verify Federal State Database checks, the during the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening.

   a. If a practitioner is not identified on any reports, the OIG Compliance Now Screening Report will be included in the practitioner's file, date stamped by the reviewer, to ensure compliance of the ~~one hundred eighty (~~180~~)~~ calendar day timeframe.

3. If a practitioner is identified on a report, the Credentialing Specialist obtain and review the action(s) identified from the verification sources listed below:

   a. Social Security Administration's Death Master File (SSADMF) IEHP must obtain and provide IEHP with Social Security Numbers for all new and existing Practitioners participating Providers, to ensure all Practitioners are included in IEHP's screening of the Social Security Administration's Death Master File (SSADMF).

      1) All Provider applications for participation in the IEHP network, must include the Providers full Social Security Number (SSN).

         - Submissions without SSN will be ceased and not processed by IEHP.

      2) Existing Providers without SSNs will be notified. Providers are required to

[24] Medicare Managed Care Manual, "Relationships with Providers", Section 60.3
[25] DHCS APL ~~19~~22-013~~-004~~
[26] California Code of Regulations (CCR) § 1300.51(d)(H)(iii)
[27] DHCS APL 22-013~~19-004~~

provide all missing SSNs to IEHP.

- Providers who do not provide the requested information will be placed on a Corrective Action Plan (CAP), until all missing SSNs are submitted.

3) If a Practitioner confirms that his/her SSN is correctly stated on the SSADMF, but is clearly not deceased, IEHP must request for:

- A copy of the Social Security Card;
- A photo ID;
- A signed attestation from the Practitioner confirming they are who they say they are; and
- The Provider to contact the Social Security Administration's Death Master File (SSADMF) to correct the issue.

4) If a Practitioners' SSN is correctly stated but the name and Date of Birth (DOB) does not, the IEHP must request for:

- A copy of the Social Security Card;
- A photo ID;
- A signed attestation from the Practitioner confirming they are who they say they are; and
- The Provider to contact the Social Security Administration's Death Master File (SSADMF) to correct the issue.[28]

5) This list will be reviewed monthly through the Ongoing Monitoring of Sanctions review, outside of the credentialing and recredentialing cycle.

b. National Plan and Provider Enumerated System (NPPES). IEHP must ensure all Practitioners hold and maintain a valid and active National Provider Identifier (NPI) Practitioners individual NPI number, and the information provided must be:

1) Verified through the NPPES website;

2) Active while in the IEHP network;

3) Current at all times (i.e. Primary Practice Address must be registered to an address within California);

- Telehealth Providers are not required to have an NPI registered to an address within California.

[28] DHCS APL 22-013~~19-004~~

4) Practitioners that have a group NPI number may submit that information to IEHP, in addition to the mandatory individual NPI number.[29]

c. List of Excluded Individuals/Entities (LEIE) maintained by the Office of Inspector General must be the verification source for Medicare sanctions, to ensure compliance with CMS.

1) If the practitioner is new to the IEHP Network, the Credentialing Specialist will notify the practitioner they were identified on the LEIE list, therefore not eligible to participate in the IEHP Network.

2) If an existing practitioner is identified, the Practitioner must be administratively terminated for all lines of business without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation. [30]

- Members will be reassigned to new Practitioners.
- The Provider is presented to Peer Review Subcommittee for further review and discussion as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings of any additional prior quality of care issues and Member complaints regarding the Provider.[31]

d. System for Award Management (SAM). The OIG LEIE includes all healthcare providers and suppliers that are excluded from participation in federal health care programs, including those health care providers and suppliers that might also be on the SAM (previously Excluded Parties List System (EPLS)). In addition to health care providers (that are also included on the OIG LEIE) the EPLS includes non-health care contracts[32] which are out of scope for the practitioners undergoing the Credentialing process.

e. CMS' Medicare Exclusion Database (MED) is the source that is used to populate the LEIE list. IEHP will use the LEIE to verify if practitioners are identified on the MED.

f. DHCS' Suspended and Ineligible List (S&I) the verification source for Medicaid sanctions, to ensure compliance with DHCS.

1) If the practitioner is new to the IEHP Network, the Credentialing Specialist will notify the practitioner they were identified on the Medi-Cal Suspended and

[29] Ibid.
[30] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.2
[31] NCQA, 2023~~2~~ Health Plan Standards and Guidelines, CR 05, Element A, Factor 5
[32] Medicare Managed Care Manual, Chapter 21 "Compliance Program Guidelines and Prescription Drugs Benefit Manual", Section 50.6.8

Ineligible List, therefore not eligible to participate in the IEHP Network.

2) If an existing practitioner is identified, the Practitioner must be administratively terminated for all lines of business without appeal rights.

- Members will be reassigned to new Practitioners.
- The Suspended Practitioner is presented for further review and discussion at the Peer Review Subcommittee as an administrative termination. Peer Review Subcommittee discussion includes Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality of care issues and Member complaints regarding the Provider.[33]

g. Restricted Provider Database (RPD). The Credentialing designee will obtain the Restricted Provider Database report on a monthly basis, outside of the credentialing and recredentialing process.

1) Providers identified on the RPD are presented to Peer Review Subcommittee for review and discussion. The following actions are required to ensure compliance with DHCS guidelines:

- Payment Suspension: Providers are placed under a payment suspension while under investigation based upon a credible allegation of fraud.
  - IEHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services are withheld; or
    - If IEHP chooses to continue the contractual relationship with providers who are placed on payment suspensions, IEHP must allow out-of-network access to members currently assigned to the provider by approving the request.
  - IEHP may choose to terminate the contract by submitting appropriate documentation as outlined in APL 21-003.[34]

2) Temporary Suspension: Providers placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.

- IEHP must terminate the contract and submit appropriate documentation as outlined on APL 21-003.[35]

4. The Credentialing Specialist will review the report finding along with the Practitioners Application and Attestation for correctness, completeness and ensure any applicable written explanations are present in the practitioners file and for Credentialing

[33] Medicare Managed Care Manual, Chapter 21 "Compliance Program Guidelines and Prescription Drugs Benefit Manual", Section 50.6.8~~Ibid.~~

[34] DHCS APL 21-003 Supersedes APL 16-001 "Medi-Cal Network Provider and Subcontractor Terminations"

[35] Ibid.

Subcommittee review, as needed.

F. IEHP monitors its credentialing files to ensure that it only contracts with Practitioners who have not opted out. IEHP uses OIG Compliance Now, a sanction screening service to monitor its Provider network to ensure have not opted out of Medicare.

1. During the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening. The results are reviewed by the Credentialing Specialists and included in the Provider file.

   a. The document will identify when the Provider was screened, and if the Provider was identified on any of the ongoing monitoring of sanctions review required by IEHP, to include but is not limited to the Medicare Opt-Out Report.

      1) If a Practitioner is not identified on any reports, the OIG Compliance Now findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the ~~one hundred eighty (~~180~~)~~ calendar-day timeframe.

      2) If a Practitioner is identified on the report for Medicare Opt-out, the Credentialing Specialist reviews and obtains the information via hard copies, electronic from https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollemtn/opt-out-affidavits. The OIG compliance Now findings are included in the Provider file and date stamped by the review, to ensure the findings were reviewed within ~~one hundred eighty (~~180~~)~~ calendar-days of the IEHP Subcommittee decision.

         - The Credentialing Specialist will include these findings in the Provider's file and prepare these documents for Credentialing Subcommittee review and discussion.
         - Certain healthcare Provider categories cannot opt-out of Medicare. These include Chiropractors, physical therapists and occupational therapists in independent practice.
         - Behavioral Health (BH) Practitioners identified on the Medicare Opt Out Report are not allowed to participate in the IEHP network for any lines of business due to contract limitations and system design, therefore, are administratively terminated for all lines of business.
            - All Members will be reassigned to new Practitioners.
         - The Credentialing designee includes these findings in the Provider's file and prepares these documents for further review and discussion in the Peer Review Subcommittee as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality

of care issues and Member complaints regarding the Provider.

- Practitioners outside of BH identified on the Medicare Opt Out Report are not allowed to participate in the IEHP network for Medicare lines of business. [36]
- All Medicare Members are reassigned to new Practitioners.[37]

G. IEHP includes information from the quality improvement activities and Member complaints in the recredentialing decision-making process. (Verification Time Limit: Last recredentialing cycle to present).

1. Quality activities include, but are not limited to:
   a. Adverse events
   b. Medical record review
   c. Data from Quality Improvement Activities
   d. Performance Information, may include but is not limited to:
      1) Utilization Management Data
      2) Enrollee satisfaction surveys
      3) Other activities of the organization
   e. Not all quality activities need to be present
2. Grievance/complaints[38,39]

H. All Primary Care Provider's (PCP) and Urgent Care's (UC) are informed that they must pass an on-site site review conducted by IEHP. (See Policy 6A, "Site Review and Medical Record Review Survey Requirements and Monitoring"). All PCPs and UCs must pass an IEHP facility on-site review at the time of initials credentialing and every three (3) years thereafter, for Medi-Cal Programs.[40]

I. IEHP uses OIG Compliance Now, a sanction screening service to monitor its Provider network and ensures their Providers are not included in the Centers of Medicare & Medicaid Services (CMS) Preclusions List.

1. During the credentialing or recredentialing process, the Credentialing Specialist or designee will submit the Provider to OIG Compliance Now for screening. The results are

[36] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Section 60.3
[37] Medicare Managed Care Manual, "Relationships with Providers", Section 60.2
[38] Medicare Managed Care Manual, "Relationships with Providers", Section 60.3
[39] DHCS APL 22-013~~19-004~~
[40] Medicare Managed Care Manual, "Relationships with Providers", Section 60.3

reviewed by the Credentialing Specialists and included in the Provider file.

a. The document will identify when the Provider was screened, and if the Provider was identified on any of the ongoing monitoring of sanctions review required by IEHP, to include but is not limited to the Centers of Medicare and Medicaid Services (CMS) Preclusions List.

1) If a Practitioner is not identified on any reports, the OIG Compliance Now findings are included in the Provider file and date stamped by the reviewer, to ensure that findings were reviewed within the 180 calendar-day timeframe.

2) If a Practitioner is identified on the report for the (CMS) Preclusions List, the Credentialing Specialist reviews the information the (CMS) Preclusions List provided by IEHPs Compliance Department. The OIG compliance Now findings are included in the Provider file and date stamped by the review, to ensure the findings were reviewed within ~~one hundred eighty (~~180~~)~~ calendar-days of the IEHP Subcommittee decision.

- If the Practitioner is new to the IEHP network, Credentialing will notify the Practitioner that their credentialing is closed due to IEHP not allowing Practitioners identified on the Centers of Medicaid and Medicaid Services (CMS) Preclusions List to participate in the IEHP network.
- If the Practitioner is an existing Provider, the Credentialing Specialist will send the Provider a notification to terminate due to IEHP not allowing Practitioners identified on the CMS Preclusions List to participate in the IEHP network.
- The Credentialing Specialist will include these findings in the Provider's file and prepare these documents for the Peer Review Subcommittee review and discussion for Providers identified through IEHPs ongoing monitoring of sanctions process for the CMS Preclusions List.[41]

J. IEHP must obtain appropriate documentation to expand or limit their practice parameters for IEHP review and approval. Practitioners may practice outside of scope with approval from IEHP, by undergoing the Provide Privilege Adjustment process in this policy.

1. Provider Privilege Adjustment. Practitioners who request a change in practice parameters (i.e. reduction of Member age range, additional specialty) must:

a. Submit a detailed explanation or complete a Provider Privilege Adjustment Request Form (See Attached, "Provider Privilege Adjustment Request Form") that includes the following, for review and consideration:

1) Practice site demographics;

[41] 2019 Medicare Program Final Rule, "Preclusions List Requirements"

2) Practical experience relating to the request (years in clinical practice, direct care experience with the relevant membership, etc.);

3) Practice capacity; and

4) Relevant training in the specialty, if applicable (e.g. Continuing Medical Education (CME), Post-graduate training, etc.)

2. Primary Care Providers age range expansions, the Credentialing Specialist will confirm if the practitioner submitted and meets the following requirements.

a. For PCP's who have Pediatric age ranges assigned and would like to expand their age range to reflect all ages, will be processed with a secondary specialty of General Practice, must provide the following information for review and consideration:

1) Provide documentation of primary care practice in the United States for the past five (5) years which includes a mix of pediatric and adult patients. (See ~~Attachment,~~ "IEHP Addendum E" ~~in Section 5~~found on the IEHP website[42]);

2) Provide evidence of ~~twenty-five (~~25~~)~~ CME units in Adult Primary Care completed within the last three (3) years;

3) PCPs that have Members assigned ages (14 and above) must enroll in the Vaccines for Children (VFC) Program;

4) Malpractice coverage for the age range Provider is requesting for that all locations the Provider will be treating IEHP Members; and

5) Pass a Medical Record Chart Audit for Adult Members

b. After Practitioner submits his/her written request, the Credentialing Specialist will confirm the practitioner is compliant with the criteria set forth in Section 5, "Credentialing Standards – Credentialing Policies" and then forward it to the IEHP Medical Director for review and approval.

K. Practitioner offices who employ Advanced Practice Practitioners (i.e. Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) must ensure written arrangements are in place between the Advanced Practice Practitioner and the practice where they treat IEHP members. These documents must be readily available to IEHP upon request. (See Policy 6F, "Facility Site Review – Non-Physician Practitioner Requirements").

1. IEHP requires all Advanced Practice Practitioners to practice at the same site as their Supervising Physician. The following written arrangements must be provided to IEHP upon request for:

[42] https://www.iehp.org/en/providers?target=forms

a. Physician Assistants must provide one (1) on the following:

1) Delegation of Services Agreement and Supervising Physician Form (See ~~Attachment,~~ "Delegation of Services Agreement and Supervising Physician Form" ~~in Section 5~~found on the IEHP website[43]).[44] This agreement must:

- Define specific services identified in practice protocols or specifically authorized by the supervising Physician., and
- Both the Physician and PA must attest to, date and sign the document.
- An original or copy must be readily accessible at all practice sites in which the PA works;

2) Practice Agreement, effective January 1, 2020, [45] the writing, developed through collaboration among one or more physicians and surgeons and one or more physicians' assistants, that defines the medical services the physician assistant is authorized to perform pursuant to Section 3502 [46] and that grants approval for physicians and surgeons on the staff of an organized health care system to supervise one or more physician assistants in the organized health care system. Any reference to a Delegation of Services Agreement relating to physician assistants in any other law shall have the same meaning as a practice agreement. The Practice Agreement must include provisions that address the following:

- A practice agreement shall include provisions that address the following:[47]
    - The types of medical services a physician assistant is authorized to perform.
    - Policies and procedures to ensure adequate supervision of the physician assistant, including, but not limited to, appropriate communication, availability, consultations, and referrals between a physician and surgeon and the physician assistant in the provision of medical services.
    - The methods for the continuing evaluation of the competency and qualifications of the physician assistant.

[43] Ibid.
[44] California Code of Regulations (CCR) § 1399.540(b)
[45] Senate Bill 697
[46] Business & Professions Code (BPC) § 3502
[47] Business & Professions Code (BPC) § 3502.3

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

3. Credentialing Verification

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Regulatory/ Accreditation Agencies:	☒ DHCS	☐ CMS
	☐ DMHC	☒ NCQA
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~~**Chief Title:** Chief Operating Officer~~	~~**Revision Date:**~~	~~January 1, 2023~~

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
4. Recredentialing Cycle Length

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers contracted under IEHPs Direct network.

POLICY:

A. IEHP is responsible for formally recredentialing its contracted Practitioners (i.e. Primary Care Providers (PCPs), Non-Physician Practitioners, Specialists, and Admitting Physicians) at least every ~~thirty-six (~~36~~)~~ months from their last credentialing decision date.[1],[2]

PURPOSE:

A. To describe the guidelines for IEHP recredentialing and ensures recredentialing is conducted in a timely manner.[3]

PROCEDURES:[4]

A. The length of the recredentialing cycle is within the required ~~thirty-six (~~36~~)~~ month time frame. The ~~thirty-six (~~36~~)~~ month recredentialing cycle begins on the date of the previous credentialing decision. The ~~thirty-six (~~36~~)~~ month cycle is counted to the month, not to the day.[5]

All written and verbal communications regarding recredentialing applications are documented within the Credentialing database, by the person who made the attempt (i.e. Credentialing Specialist, Provider Services Representative (PSR) etc.), to ensure all attempts are documented and readily available for those Practitioners terminated due to non-compliance to recredentialing.

1. Six (6) months prior to the recredentialing due date, the Credentialing Department generates and sends out the recredentialing applications to the respective Practitioners via email or fax to the Practitioners credentialing contact or Practitioner directly, for review and signature.
    a. The Practitioners is provided a due date within ~~fourteen (~~14~~)~~ calendar days to return the completed recredentialing application to the Credentialing Department.
        1) If the Practitioners does not submit the application within the designated timeframe, the Credentialing Specialist will make at least three (3) separate attempts to follow-up with the Practitioner's office. During this time, the

[1] National Committee for Quality Assurance (NCQA), ~~2022~~ 2023 Health Plan Standards and Guidelines, CR 4, Element A
[2] Title 42 Code of Federal Regulations (CFR) § 422.204(b)(2)(ii)
[3] Medicare Managed Care Manual, "Relationships with Providers", Section 60.3
[4] NCQA, ~~2022~~ 2023 HP Standards and Guidelines, CR 4, Element A
[5] 42 CFR § 422.204(b)(2)(ii)

Credentialing Specialist must obtain the following information:

- Confirm the best contact for the recredentialing application
- Best communication method (i.e. e-mail, fax, phone call etc.)
- Confirmation of receipt of recredentialing application
- Next follow-up date
- Anticipated date of completion and submission to IEHP

2. Three (3) months prior to the recredentialing due date, the Credentialing Department will notify the Provider Services and Contracts Department of the Practitioners who have not submitted their recredentialing applications.
   a. The PSRs are responsible for at least three (3) separate attempts, via phone, email, and office visit, to follow up on the recredentialing application with the practitioner. During this time, the PSRs are responsible for:
      1) Reminding the Practitioner:
         - Their recredentialing application is past due;
         - If their application is not submitted to credentialing@iehp.org, by the 15th of the month prior their recredentialing application is due, their file will be recommended for termination due to non-compliance to recredentialing; and provide the following disclaimer:
            - After termination and the Practitioners wants to continue participation in the IEHP Direct Network, the Practitioners must undergo the initial credentialing process, regardless if the termination date was less than ~~thirty (~~30~~)~~ calendar days.
      2) Obtain the next follow-up date and/or anticipated date of completion and submission to IEHP.
      3) Collecting and forwarding the recredentialing application to credentialing@iehp.org.
3. Two (2) months prior to the recredentialing due date, the Credentialing Department will notify the Provider Services and Contacts Department of the Practitioners who have not submitted their recredentialing applications. During this time, the PSRs are responsible for:
   a. Notifying the Contracts Managers (CMs) and Credentialing Specialists of their attempts to obtain the Practitioner's recredentialing application.
   b. If the recredentialing application is not received by the 15st of the month prior to the Practitioner's recredentialing due date, the PSRs will coordinate with the CMs, to

send a request to terminate the Practitioner due to non-compliance to recredentialing, with an effective date of the 1st of the following month, their recredentialing application is due.

1) The CMs are responsible for sending a request to terminate the respective Practitioner(s) due to non-compliance to recredentialing, with an effective date of the 1st of the month, following their recredentialing due date, to allow members at least ~~thirty (~~30~~)~~ days advance notice of their Practitioners termination and ensure the Practitioners does not see Members beyond their approved credentialing cycle.

2) The Credentialing Specialist will send the termination letter due to non-compliance to recredentialing, via FEDEX and include the respective CMs and PSRs.

4. If the recredentialing application is received after the termination letter is sent to the Practitioner, the Practitioner is notified by recipient that the Practitioners was terminated due to non-compliance to recredentialing and if the Practitioner would like to continue their participation with the IEHP network, the Practitioner must undergo the initial credentialing process and submit their application to contracts@iehp.org to initiate the process.

B. IEHP may extend a Practitioner's recredentialing cycle time frame (beyond the ~~thirty-six (~~36~~)~~ months) if the Practitioner is on active military assignment, on maternity/medical leave or a sabbatical. If the Credentialing Department is made aware of any of the reasons above, Credentialing must:

1. Obtain written documentation from the Practitioner's office that includes the reason and anticipated date of return.
2. Recredential the Practitioner within ~~sixty (~~60~~)~~ calendar days of the Practitioner's return to practice.
    a. Failure to meet the allocated time frame above, will result in the administrative termination of the Practitioner due to non-compliance to recredentialing.

C. Practitioners who have exceeded the ~~thirty-six (~~36~~)~~ month timeframe. If IEHP does not have the necessary information for recredentialing, IEHP will:

1. Inform the Practitioner that this information is needed at least ~~thirty (~~30~~)~~ calendar days before the recredentialing deadline and that without this information, the Practitioner will be administratively terminated.
    a. This notification will be included in the Practitioner's credentialing file.
    b. If the practitioner is subsequently terminated for lack of information, the termination notice will be included in the Practitioner's file.
2. Terminate the Practitioner for administrative reasons (e.g. the Practitioner failed to

provide complete credentialing information). IEHP does not allow automatic reinstatement within ~~thirty (~~30~~)~~ calendar days of termination to Practitioners terminated due to non-compliance to recredentialing. IEHP will review and consider requests to reinstate Practitioners terminated due to non-compliance to recredentialing, on a case-by-case basis.

a. IEHP will perform initial credentialing if the reinstatement is more than ~~thirty (~~30~~)~~ calendar days after termination.

D. IEHP allows reinstatements to Practitioners terminated for administrative reasons and not quality reasons if the reinstatement is within ~~thirty (~~30~~)~~ calendar days of the termination.

1. If IEHP terminates a Practitioner for administrative reasons and not for quality reasons, IEHP may reinstate the Practitioner within ~~thirty (~~30~~)~~ calendar days of termination and is not required to perform initial credentialing. The practitioner will resume their previous credentialing cycle.

a. IEHP must perform initial credentialing if the reinstatement is more than ~~thirty (~~30~~)~~ calendar days after termination.

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5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

5. Ongoing Monitoring and Interventions

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHP conducts ongoing monitoring of Practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against Practitioners when it identifies occurrences of poor quality on a monthly basis.[1]

B. IEHP maintains a documented process for monitoring whether network Providers have opted out of participating in the Medicare Program.[2,3]

C. IEHP verifies that contracted Providers have not been terminated as Medi-Cal Providers or have not been placed on the Suspended and Ineligible Provider List.[4]

D. IEHP maintains a documented process for monitoring whether its Practitioners are included in the Centers for Medicare & Medicaid Services (CMS) Preclusions List, to ensure compliance with the Medicare Program Final Rule.[5]

E. IEHP maintains a documented process for monitoring practitioners identified on the Restricted Provider Database.[6]

F. IEHP maintains a documented process that includes the System for Award Management (SAM) in their list of database checks.[7]

G. IEHP maintains a documented process for potential adverse concerns through media.

~~G.~~H. IEHP notifies the respective delegates of any identified findings through the ongoing monitoring of sanctions process. Delegates are required to present these findings to their Credentialing/Peer Review Committee for review and discussion, followed by a written response to IEHP of the written plan of action for each Practitioner within fourteen (14) calendar days of IEHP's notification.

~~H.~~I. IEHP notifies the respective Delegates of any findings and actions of the Peer Review Subcommittee regarding the Practitioners identified through the ongoing monitoring of

[1] National Committee for Quality Assurance (NCQA), 202~~2~~3 Health Plan Standards and Guidelines, CR 5, Element A, Factors 1-5
[2] Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks," § 60.2
[3] Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013~~19-004~~ Supersedes APL ~~17-019~~19-004 "Provider Credentialing/Recredentialing and Screening/Enrollment"
[4] Ibid.
[5] Centers for Medicare & Medicaid Services (CMS), Policy CMS-4182 Final Rule
[6] DHCS APL ~~19-004~~22-013
[7] Ibid.

sanctions, complaints, and quality issues between recredentialing cycles.

~~I.~~J. IEHP verifies and ensures Practitioners maintain an active licensure status, Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) and remedies if the license or certification expires or status changes during the Practitioner's participation with IEHP regardless of occurrence outside of the recredentialing cycle.

~~J.~~K. IEHP must collect Social Security Numbers for all new and existing Practitioners to IEHP to ensure all Practitioners are included in IEHP's screening of the Social Security Administration's Death Master File (SSADMF).[8]

PURPOSE:

A. IEHP identifies and when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.[9]

DEFINITION:

A. Adverse event – An injury that occurs in the course of a Member receiving health care services from a Practitioner.[10]

B. Peer review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g., evaluation of a physician's credentials and practice by another physician).[11]

C. Quality of care: The degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[12]

PROCEDURES:

A. IEHP utilizes OIG Compliance Now as a contracted vendor to conduct the Ongoing Monitoring of Sanctions screenings for IEHPs credentialed and contracted Practitioners. All reports are reviewed within ~~thirty (~~30~~)~~ calendar days of its release. New findings are presented to the next scheduled Peer Review Subcommittee, for review and discussion.[13,14]

1. The Credentialing designee submits a file by the fifth (5th) of each month, prepared by Health Care Informatics (HCI). The file contains a list of credentialed Providers to submit to OIG Compliance Now for screening. The sanction screening service provides screening across various Federal and State agencies including those required by IEHP as

[8] DHCS APL ~~19-004~~22-013
[9] NCQA, 202~~2~~3 Health Plan Standards and Guidelines, CR 5, Element A, Factor 1-5
[10] NCQA, 202~~2~~3 HP Standards and Guidelines, Glossary
[11] Ibid.
[12] Ibid.
[13] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 5, Element A, Factor 5
[14] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 5, Element A, Factor 1-2

noted in this policy.

2. All reviews for Ongoing Monitoring of Sanctions are tracked in a Sanctions Log maintained by the Credentialing Department. This log includes the following information:
   a. Name of Institution, Licensing Board, Organization or Agency issuing the Sanction
   b. Practitioner types
   c. Report frequency
   d. Date Publication was released
   e. Date report was reviewed
   f. Providers identified and active credentialed affiliations
   g. Description of the Sanction or finding
   h. Name of person reviewing the report
3. All findings are referred to the following Departments and people and is included in the next scheduled Peer Review Subcommittee meeting:
   a. IEHP Peer Review Chairperson/Medical Director
      1) Reviews the sanction in preparation for the upcoming Peer Review Subcommittee discussion.
      2) Notifies the following departments if additional is needed for presentation at the Peer Review Subcommittee meeting:
         - Information may include but are not limited to:
            - Licensure status
            - Education and Training
            - Hospital Affiliations or arrangements
            - Practice Locations
            - Advanced Practice Practitioners under his/her supervision (if applicable)
            - Membership counts
            - National Practitioner Data Bank history
            - Malpractice Claim History
            - Delegated IPA affiliations
            - Facility Site Review/Medical Record Audit Status (if applicable)

- Quality Improvement activities
- Grievance History
- Narcotics Audits (if needed, will work with Pharmacy to coordinate)

b. Chief Medical Officer (CMO)

c. Chief Operating Officer (COO)

d. Director of Provider Operations

e. Director of Quality Management

f. Director of Grievance and Appeals

g. Credentialing Manager

h. Credentialing Designee

1) Responsible for the Peer Review Subcommittee packet compilation and coordination with the Provider Services Administrative Assistant for distribution to the Peer Review Subcommittee.

i. Quality Assurance Nurse

1) Responsible for collecting Quality Improvement activities, grievance history and summarizing licensure and/or action findings for the Peer Review Subcommittee packet.

j. Additional Information from other Departments, upon request

4. IEHP will provide evidence of ongoing monitoring and appropriate interventions by:

a. IEHP ensures OIG Compliance Now collects and reviews information from the following sources for Medicare and Medicaid sanctions

1) List of Excluded Individuals and Entities (LEIE) (maintained by Office of Inspector General) as the verification source for Medicare Sanctions, and review the report on a monthly basis, within ~~thirty (~~30~~)~~ days of its release.[15]

- CMS' Medicare Exclusion Database (MED) is the source that is used to populate the LEIE list. IEHP will use the LEIE to verify if Practitioners are identified on the MED.[16]

2) If a Practitioner is identified, the Credentialing designee will review the OIG Exclusions Report and confirm the findings.[17]

- A Practitioner identified on the HHS-Office of Inspector General (OIG)

[15] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 5, Element A, Factor 5
[16] DHCS APL ~~19-004~~22-013
[17] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 5, Element A, Factor 5

Exclusions Report is administratively terminated for all lines of business without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.[18,19]

- Members will be reassigned to new Practitioners.
- The Practitioner is presented to Peer Review Subcommittee for further review and discussion as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance Department findings of any additional prior quality of care issues and Member complaints regarding the Practitioner.

3) IEHP ensures OIG Compliance Now collects and reviews information from BreEZe Online Services or directly from the licensing Board via phone, email, or mail, for reviewing sanctions or limitations on licensure. If a Practitioner is identified, the Credentialing designee will review and confirm the findings, The verifications are verified through:[20]

- Physicians
  - Medical Board of California (M.D., L.M.)
    - Subscription for email notifications of accusations, licensure suspensions, restrictions, or surrenders distributed by the Medical Board of California. (http://www.mbc.ca.gov/Subscribers/)
    - A distributed list of Disciplinary Actions/License Alerts can be obtained at (https://www.mbc.ca.gov/Resources/Publications/Alerts.aspx)
  - Osteopathic Medical Board of California (D.O.)
    - Distribution list from ~~J. Corey Sparks~~Erika Calderon, ~~Lead Enforcement Analyst~~Executive Director, ~~Corey.Sparks@dca.ca.gov~~Erika.Calderon@dca.ca.gov Phone: (916) 928-839~~3~~0 ext 8 Fax: (916) 928-8392; or
    - Enforcement Action Reports posted by the licensing board (https://www.ombc.ca.gov/consumers/enforce_action.shtml) ~~.~~
- Chiropractors

[18] Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider
[19] DHCS APL ~~19-004~~22-013
[20] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 5, Element A, Factor 2

- California Board of Chiropractic Examiners (D.C.)
  - Disciplinary Action Reports are posted monthly by the licensing board. (http://www.chiro.ca.gov/enforcement/actions.shtml)
  - Subscription email list (https://www.chiro.ca.gov/webapplications/subscribe/index.shtml)

- Oral Surgeons
  - Dental Board of California (D.D.S., D.M.D.)
    - Disciplinary Action Reports are posted monthly by the licensing board. (http://www.dbc.ca.gov/consumers/hotsheets.shtml)
    - Subscription for list of Board actions (https://www.dbc.ca.gov/webapplications/apps/subscribe/index.shtml)

- Podiatrists
  - Board of Podiatric Medicine (D.P.M.)
    - Recent Disciplinary Actions are updated every three to four (3 to 4) months by the licensing board. (https://www.pmbc.ca.gov/consumers/dispsumm.shtml). An email to the board may be sent if medical board site does not get updated within the three to four (3 to 4) month timeframe to inquire on status. (PMBC@dca.ca.gov).

Non-physician healthcare Practitioners.

- Board of Behavioral Sciences (L.M.F.T., L.C.S.W., M.F.C.C., L.P.C.C.)
  - Subscription for list of enforcement actions. (https://www.dca.ca.gov/webapps/bbs/subscribe.php)
  - Enforcement Actions are updated monthly by the licensing board. (Enforcement Actions - Board of Behavioral Sciences (ca.gov))

- Board of Psychology (Ph.D., Psy.D.)
  - Subscription for list of enforcement actions. (https://www.dca.ca.gov/webapps/psychboard/subscribe.php)
  - Quarterly Journals are issued by the licensing board with all the Disciplinary Actions for that quarter reported. (https://www.psychology.ca.gov/forms_pubs/updates.shtml)

- California Board of Occupational Therapy (O.T.)

- Disciplinary Actions are updated as needed by the licensing board, contingent when there is an Occupational Therapist placed on probation or revoked. (http://www.bot.ca.gov/consumers/disciplinary_action.shtml)

- Subscription for list of enforcement actions. (https://www.bot.ca.gov/webapplications/apps/subscribe/index.shtml)California State Board of Optometry (O.D.)
  - Disciplinary Actions are updated as actions are adopted. (http://www.optometry.ca.gov/consumers/disciplinary.shtml)
- Physical Therapy Board of California (P.T.)
  - Subscription for email notifications of accusations, licensure suspensions, restrictions, or surrenders distributed by the Physical Therapy Board of California send an email requesting to be added to the monthly disciplinary distribution list (CPS@dca.ca.gov) Consumer Protection Services Phone: (916) 561-8200 Fax: (916) 263-2560.
  - Quarterly Progress Notes are available by the licensing board indicating the quarterly Administrative Actions for Discipline and Citations (https://www.ptbc.ca.gov/publications/index.shtml)
- Physician Assistant Committee (P.A., P.A.-C)
  - Disciplinary Actions are posted monthly by the licensing board. (https://pab.ca.gov/forms_pubs/disciplinaryactions.shtml)
  - Subscription for disciplinary actions from the licensing board (https://www.pab.ca.gov/webapplications/apps/subscribe/index.shtml)
- California Board of Registered Nursing (C.N.M., N.P.)
  - This Licensing Board does not release sanction information reports; therefore, organizations are required to conduct individual queries every ~~twelve (~~12~~)~~ to ~~eighteen (~~18~~)~~ months on credentialed practitioner)
- Speech-Language Pathology & Audiology Board (S.P., AuD.)
  - Disciplinary Actions are updated quarterly by the licensing board. (http://www.speechandhearing.ca.gov/consumers/enforcement.shtml)
  - Subscription for disciplinary actions from the licensing board (https://www.speechandhearing.ca.gov/webapplications/apps/subscribe/index.shtml)
- Acupuncture Board (L.Ac.)

- Disciplinary Action Reports reported monthly by the Licensing board. (www.acupuncture.ca.gov/consumers/board_actions.shtml); or
- Subscription for disciplinary actions from the licensing board (https://acupuncture.ca.gov/webapplications/subscribe/index.shtml) [21]

3. IEHPs Grievance and Appeals Department is responsible for collecting and reviewing complaints and:[22]
   a. Investigates Practitioner-specific Member complaints upon their receipt and evaluates the Practitioner's history of complaints, if applicable.
   b. Evaluates the history of complaints for all Practitioners history of complaints at least every six (6) months.
   c. Quality or collecting and reviewing complaints received by Delegates must be forwarded to IEHP, since they are not delegated for these activities.
   d. Policy and evidence may be found in the Grievance and Appeals Department.[23]
4. IEHPs Quality Management Department is responsible for collecting and reviewing information from identified adverse events and:[24]
   a. Monitors for adverse events every six (6) months.
   b. Quality/collecting and reviewing adverse events received by Delegates must be forwarded to IEHP, since they are not delegated for these activities.
   c. Policy and evidence may be found in the Quality Department.
5. IEHP implements appropriate interventions when it identifies instances of poor quality related to Practitioners with Medicare/Medicaid Sanctions, Sanctions and/or limitations on licensure, member complaints, or adverse events may be found in the Quality Management, Grievance and Appeals, and/or Credentialing Department and documented in the Peer Review Subcommittee minutes. This process determines if there is evidence of poor quality that could affect the health and safety of its Members and implements the appropriate policy based on action/intervention.

   The Peer Review Subcommittee meets the 4th Wednesday of every ~~other~~ month and reviews all Practitioners identified through the Ongoing Monitoring of Sanctions Process, Practitioners escalated from the Medical Director(s) for Potential Quality Incidents (PQIs), Practitioners escalated from the Grievance and Appeals Department, and any new Practitioner (s) with adverse history requesting participation through one (1) or more of our Delegated IPA networks. The Peer Review Subcommittee will review each of the

[21] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 5, Element A, Factor 2
[22] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 5, Element A, Factor 3
[23] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 5, Element A, Factor 3
[24] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 5, Element A, Factor 4

Practitioners and gives thoughtful consideration to the information collected[25] and presented for review. The Peer Review Subcommittee obtains advice from participating Practitioners during the decision process. All discussions and actions will be documented in the Peer Review Subcommittee meeting minutes and will be reviewed and approved at the following Peer Review Subcommittee.

a. At minimum, Practitioners identified through ongoing monitoring for licensure actions, sanctions, adverse history, grievances and/or complaints, must be fully discussed and reviewed by the Peer Review Subcommittee. The reason for review must be considered and documented in the meeting minutes.[26]

1) Interventions can be identified in one of the following:

- Committee minutes
- Practitioner files
- Delegate file binders

D. IEHP monitors when network physicians have opted out of participating in the Medicare Program through the Ongoing Monitoring process with OIG Compliance Now and ensures the vendor is conducting screenings for Medicare Opt-Out using https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits.

1. IEHP must review the Opt-Out Report most current list available within ~~thirty (~~30~~)~~ calendar days of its release.

a. Certain healthcare Practitioner's categories cannot opt-out of Medicare. These include Chiropractors, Physical Therapists and Occupational Therapists in independent practice.

b. If a Practitioner is identified on the Medicare Opt-out Report, the Credentialing designee reviews the information via hard copies, electronic or one (1) of the CMS.gov Opt-Out sites to confirm the finding.[27]

1) Practitioners identified on the Medicare Opt-Out Report are administratively terminated for Medicare lines of business. IEHP does not allow Providers who have opted out of Medicare to participate in the IEHP network for Medicare lines of business.

- Medicare Members are reassigned to new Practitioners.

2) The Credentialing designee includes these findings in the Provider's file and

[25] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 2, Element A, Factor 2
[26] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 5, Element A, Factor 5
[27] Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks," § 60.2

prepares these documents for further review and discussion in the Peer Review Subcommittee as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality of care issues and Member complaints regarding the Provider.

E. IEHP ensures OIG Compliance Now collects and reviews the Medi-Cal Suspended and Ineligible List published monthly by the Department of Health Care Services (DHCS) (http://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx) as the verification source for Medicaid Sanctions. Delegates must review the Suspended & Ineligible List on a monthly basis, within thirty (30) days of its release.

1. If a Practitioner is identified, the Credentialing designee reviews the Medi-Cal Suspended and Ineligible List and confirms the findings.
    a. Providers identified on the Medi-Cal Suspended and Ineligible List are automatically terminated for all lines of business without appeal rights.
        1) All Members assigned to the suspended Practitioner are reassigned to new Practitioners.
        2) The Suspended Practitioner is presented to the Peer Review Subcommittee for further review and discussion as an administrative termination. Peer Review Subcommittee discussion includes Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality of care issues and Member complaints regarding the Provider.[28]

D. IEHP ensures OIG Compliance Now screens the CMS Preclusions List to ensure compliance with the Medicare Program Final Rule. In order for Providers (including entities) to receive payment from Medicare Plan (Part C and D), they must not be included in the CMS Preclusions List.[29]

1. If a Practitioner is identified, the Credentialing designee reviews the CMS Preclusions List and confirms the findings.
    a. Providers identified on the CMS Preclusions List are automatically terminated for all lines of business, without appeal rights.
        1) All Members assigned to suspended Practitioners are reassigned to new Practitioners.
        2) The Practitioner is presented to the Peer Review Subcommittee for further review and discussion as an administrative termination. Peer Review Subcommittee discussion will include Quality Management (QM) and Grievance and Appeals Department findings of any additional prior quality of

[28] DHCS APL ~~19~~22-~~00~~40013.
[29] Centers for Medicare & Medicaid Services (CMS), Policy CMS-4182 Final

care issues and Member complaints regarding the Practitioner.

E. IEHP maintains a documented process for monitoring Practitioners identified on the Restricted Provider Database (RPD). The California-specific lists identifies providers who are placed under: a payment suspension while under investigation based on a credible allegation of fraud, or a temporary suspension while under investigation for fraud or abuse, or enrollment violations.[30] The Credentialing designee will obtain the Restricted Provider Database report on a monthly basis, within ~~thirty (~~30~~)~~ days of its release~~by the 5th of each month~~.

1. Practitioners identified on the RPD are presented to Peer Review Subcommittee for review and discussion. The following actions are required to ensure compliance with DHCS guidelines:

   a. Payment Suspension: Practitioners are placed under a payment suspension while under investigation based upon a credible allegation of fraud.

      1) IEHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services are withheld; or

         - If IEHP chooses to continue the contractual relationship with Practitioners who are placed on payment suspensions, IEHP must allow out-of-network access to Members currently assigned to the Practitioner by approving the request.

      2) IEHP may choose to terminate the contract by submitting appropriate documentation.[31]

   b. Temporary Suspension: Practitioners placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.

      1) IEHP must terminate the contract and submit appropriate documentation.[32]

F. IEHP maintains a documented process that includes the System for Award Management (SAM) in their list of database checks. IEHP uses OIG Compliance Now as the vendor to collect data and alert services, including but not limited to the System for Award Management (SAM) in the scope of review.

1. The OIG LEIE includes all healthcare Practitioners and suppliers that are excluded from participation in federal health care programs, including those health care Practitioners and suppliers that might also be on the SAM (previously Excluded Parties List System (EPLS)). In addition to health care Practitioners (that are also included on the OIG LEIE) the EPLS includes non-health care contracts[33] which are out of scope for the Practitioners

[30] DHCS APL ~~19~~22-~~004~~013
[31] DHCS APL 21-003 Supersedes APL 16-001 "Medi-Cal Network Provider and Subcontractor Terminations".
[32] Ibid.
[33] Medicare Managed Care Manual, Chapter 9 & 21 "OIG/GSA Exclusion,"

undergoing the Credentialing process.

G. IEHP maintains a documented process for potential adverse concerns through media is treated in the same manner as any other identified sanction, complaint and/or adverse issue.

1. All pertinent information and documentation will be gathered and presented to our Peer Review Subcommittee for review and discussion to ensure appropriate action is taken.

a. In instances where there may be an imminent danger to the health of any individual, the IEHP Medical Director and/or the IEHP Peer Review Subcommittee may summarily restrict or suspend the participating Practitioner's privilege to provide patient care services, effective immediately upon written notice to the Practitioner. The outcome will be presented at the next scheduled Peer Review Subcommittee for further review and decision.

~~G.~~H. During the ongoing monitoring of sanctions, the Credentialing designee notifies the respective delegates of any identified findings.

1. IEHP sends an email to the Delegate, notifying them of the findings and the affiliation of the Practitioner to IEHP. Delegates must provide a written plan of action for the Practitioner identified within ~~fourteen (~~14~~)~~ calendar days that includes:

a. The date the practitioner was presented to the Credentialing Committee for review and discussion.

1) If the Credentialing Committee has not discussed the practitioner, the Delegate must provide the date the practitioner is scheduled for review.

2) A summary of the Credentialing Committee's discussion and plan of action.

b. Committee's Decision. Delegates are responsible for notifying IEHP of any findings and the actions decided by the Credentialing Committee within thirty (30) days of the decision, to include, but not limited to:

1) Date(s) of the Credentialing Committee the Practitioner was reviewed.

2) Date of the Credentialing Committee decision.

3) Delegate's Plan of action for the Practitioner.

4) Frequency of monitoring (if applicable); and

5) Any follow-ups scheduled.

6) Any of the following occurs with one of their contracted Practitioners:

- The surrendering, revocation or suspension of a license.
- The surrendering, revocation or suspension of DEA registration.
- A change in hospital staff status or hospital clinical privileges, including any restrictions or limitations.

- A change in Hospital admitting arrangements for Practitioners without IEHP affiliated Hospital privileges.
- Loss of malpractice insurance; and
- The notification must include the IPA's proposed action and/or resolution.

7) Committee decision resulting in Suspension or termination. The Delegate must confirm if the termination was due to administrative reasons or Quality of Care. Delegates are required to notify IEHP in writing within thirty (30) days of the filing, if any of the following occurs with one of their contracted Practitioners:

- Any filing pursuant to Business and Professions Code Sections § 805, 805.01 or 809.
- Any filing with the NPDB; and
- The notification must include the Delegate's proposed action and/or resolution.
- Suspension or terminations for administrative reasons, the Delegate needs to provide the termination date and reason for termination.
    - This termination notification does not replace the standard termination notification sent to our Provider Relations Team. Delegates must submit terminations to providerupdates@iehp.org to ensure practitioners are terminated timely.
- Terminations for Quality of Care the Delegate must submit a copy of the 805 filing to IEHP for review, within ~~thirty (~~30~~)~~ days of file submission to ~~DG~~CredentialingSME~~'s~~@iehp.org.

2. IEHP presents the Practitioner to the Peer Review Subcommittee for review and discussion and includes the plan of actions from their respective networks.
3. IEHP is responsible for notifying the Practitioner's respective Delegated networks of any findings and the actions decided by the Peer Review Subcommittee within ~~thirty (~~30~~)~~ days of the decision, including, but not limited to:
    a. Date(s) of the Credentialing Committee Practitioner review;
    b. Date of the Credentialing Committee decision;
    c. IEHPs Plan of action for the Practitioner;
    d. Frequency of monitoring (if applicable);
    e. Any follow-ups scheduled; and
    f. All Practitioners identified through the ongoing monitoring and Delegated Review

Process are presented to IEHP's Peer Review Subcommittee for review and decision.

1) IEHP reserves the right to approve, deny, terminate or otherwise limit Practitioner participation in the IEHP network for any reason including quality issues.

- If a Provider is denied participation due to quality of care, an 805 is filed with the appropriate licensing agency and the National Practitioner Data Bank (NPDB) is notified than the Provider is not eligible to reapply.
    - A Provider may reapply for participation in the IEHP network, after one (1) year if denied participation due to administrative terminations or denials.

2) Practitioners can appeal adverse decisions by the IEHP Peer Review Subcommittee as delineated in IEHP's Peer Review Process and Level I Review and Level II Appeal (See ~~Attachments, "~~IEHP Peer Review Level I and Cre~~a~~dentialing Appeal" and "IEHP Peer Review Process and Level II Appeal" ~~in Section 5~~found on the IEHP website[34]).

I. IEHP runs a monthly report of all licensures and DEA certifications that have or will expire within ~~thirty (~~30~~)~~ days.

1. For all licensures, IEHP will verify the Practitioner's licensure with the appropriate licensing agency and ensure that the practitioners' licensure is valid and current.
    a. IEHP will send a notification of administration termination for all lines of business to Providers whose licensure is not valid and current.
        1) The letter notification:
            - Is copied to the Practitioners' affiliated networks.
            - Includes the effective termination date, which is the day after the licensure is no longer valid.
            - Includes a current copy of the licensure verification as an enclosure.
        2) All Members assigned to the Practitioner are reassigned to other Practitioners.
2. For all Practitioners with expired DEA certificates, IEHP will verify the DEA certificate through the DEA Number website, to ensure the Practitioners DEA certificate is valid and current.
    a. For all DEA certificates that are no longer valid, the Credentialing Specialist will contact the individual Practitioner's office to obtain the Practitioner's:

[34] https://www.iehp.org/en/providers?target=forms

1) New DEA Number.
2) The Practitioner's prescribing arrangements until the Practitioner obtains a new DEA certification.
3) Written explanation for the Practitioner not having a DEA certification, which is presented to the Peer Review Subcommittee for review and discussion.
   - If the Practitioner does not have an appropriate DEA arrangement on file, the Practitioner's respective network will be notified and IEHP will request a plan of action to include the option of an administrative termination due to not having appropriate DEA arrangements, as required by NCQA.[35]

3. Practitioners are responsible for notifying IEHP of any licensure and DEA changes within thirty (30) days of the change. The notification must include:
   a. Date the Practitioner was aware
   b. Type of change
   c. Effective date of the change

J. IEHP must collect Social Security Numbers (SSN) for all new and existing Practitioners in the network, to ensure all Practitioners are included in IEHP's screening of the SSADMF.

1. All Delegates and/or Practitioners must provide the Social Security Numbers for the respective Practitioners under the following:
   a. Credentialing/Recredentialing Application(s)
   b. Provider Profile Submission
   c. Credentialing Activities Report
   d. Upon request by IEHP. Applicable to all existing Practitioners with missing SSN.
      1) Delegates and/or Practitioners who do not provide the requested information will be placed on a Corrective Action Plan (CAP) until all missing SSNs are submitted.
2. If a Practitioner is identified on the SSADMF, and the Practitioner:
   a. Is not deceased but confirms that his/her SSN is correctly stated on the SSADMF, IEHP will request for the following information from the practitioner:
      1) A copy of the Social Security Card;
      2) A Photo ID;
      3) A signed attestation (See ~~attachment,~~ "Death Master File Identity Attestation"

[35] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 3, Element A, Factor 2

~~in Section 5~~found on IEHP website[36]) from the Practitioner; and

4) Request for the Practitioner to contact the SSADMF to correct the issue.

b. Is not deceased, confirms their SSN is correctly stated but the name and/or Date of Birth (DOB) is not correct, IEHP will request for the following:

1) A copy of the Social Security Card;

2) A Photo ID;

3) A signed attestation (See ~~attachment,~~ "Death Master File Identity Attestation" found on the IEHP website~~in Section 5~~[37]) from the Practitioner; and

4) Request for the practitioner to contact the Social Security Administration's Death Master File (SSADMF) to correct the issue.

3. Upon receipt of the required documents, the Credentialing designee will provide the attestation and supporting documentation to our Compliance Department for review and repository.[38]

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☒ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2020	
Revision Effective Date:	January 1, ~~2023~~2024	

[36] https://www.iehp.org/en/providers?target=forms
[37] Ibid.
[38] DHCS APL ~~19~~22-~~004~~ 013

~~INLAND EMPIRE HEALTH PLAN~~		
~~**Chief Approval:** *Signature on File*~~	~~**Original Effective Date:**~~	~~January 1, 2020~~
~~**Chief Title:** Chief Operating Officer~~	~~**Revision Date:**~~	~~January 1, 2023~~

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers.

POLICY:

~~A.~~ IEHP must review participation of Practitioners whose conduct could adversely affect members' health or welfare, specify the range of actions that may be taken to improve practitioner performance before termination, report the Practitioner's actions to the appropriate authorities including state licensing agencies, the National Practitioner Data Bank (NPDB), and Inland Empire Health Plan (IEHP)[1] and inform Practitioners of the appeal process.[2]

~~A.~~

B. A Practitioner's status or participation in the IEHP network may be denied, reduced, suspended, or terminated for any lawful reason, including but not limited to a lapse in basic qualifications such as licensure, insurance, or required medical staff privileges or admission coverage at an IEHP contracted Hospital or a determination by IEHP based on information obtained during the credentialing process that the Practitioner cannot be relied upon to deliver the quality or efficiency of Member care required by IEHP.

PURPOSE:

A. IEHP must use objective evidence and patient-care considerations when deciding on a course of action for dealing with a Practitioner who does not meet its quality standards.[3]

~~B.~~

~~C.~~B. Notification applies to licensed Practitioners for suspensions and terminations for quality reasons.[4]

~~D.~~C. IEHP must provide evidence that it followed its appeal process if it altered the conditions of a Practitioner's participation based on quality of care or service reasons.[5]

~~E.~~D. Practitioners must appeal directly to their contracted IPA for adverse credentialing decisions rendered by the Delegated IPA.

~~F.~~E. Reporting to appropriate authorities is not applicable in the following circumstances:

[1] National Committee for Quality Assurance (NCQA), 202~~2~~3 Health Plan Standards and Guidelines, CR 6, Element A, Factor 1
[2] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 6, Element A, Factor 2
[3] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 6, Element A, Factor 1-2
[4] Title 42 Code of Federal Regulations (CFR) § 422.202
[5] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 6, Element A, Factor 2

1. There are no instances of suspension, termination, restriction or revocation to report for quality reasons.
2. Automatic administrative terminations based on the Practitioners not meeting specific contractual obligations for participation in the network.

~~G.~~F. All credentialing records and proceeds are confidential and protected to the fullest extent allowed by Section 1157 of the California Evidence Code, and any other applicable law.[6]

DEFINITION:[7]

A. "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates.

B. "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

C. "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, or physician's assistant. Licentiate also includes a person authorized to practice medicine pursuant to California Code, Business and Professions Code Section 2113 or 2168.[8]

D. "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to the patient's safety or to the delivery of patient care.

E. "Peer" is an appropriately trained and licensed Physician in a practice similar to that of the affected physician.

F. "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

[6] California Evidence Code § 1157
[7] Business and Professions Code § 805
[8] Business and Professions Code § 2113 and 2168

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

6. Notification to Authorities and Practitioner Appeal Rights

PROCEDURES:

A. IEHP's Credentialing Subcommittee is appointed by its Quality Management Committee and is responsible for reviewing, approving and denying Practitioners who are directly contracting with IEHP's Direct network.

IEHP's Peer Review Subcommittee is responsible for reviewing Member complaints, Practitioner or Provider grievances appeals and sanctions regarding Practitioners and Practitioner-related quality of care and service issues including Facility Site and Medical Record Reviews. Other Peer Review matters such as Retrospective Practitioner Quality Reviews referred by the Grievance and Appeals Department are reviewed and discussed as directed by the IEHP Medical Director(s) and IEHP Chief Medical Officer (CMO). The Peer Review Subcommittee also performs oversight of the credentialing activities of Delegates.[9]

1. The range of actions IEHP may take to improve Practitioner performance before termination[10] includes, but is not limited to:
   a. Profiling
   b. Corrective actions(s)
   c. Monitoring
   d. Medical Record Audit
   e. Pharmacy Audit
   f. Focused Quality Management Audit
2. Practitioners have the right to appeal any adverse credentialing decision that impacts their participation status with IEHP in accordance with the appeals procedures provided herein. IEHP will:
   a. Provide written notification when a professional review action has been brought against a Practitioner, including reasons for the action. (See ~~Attachments,~~ "Credentialing Subcommittee Termination Letter" and "Peer Review Termination Letter" ~~in Section 5~~found on the IEHP website[11])
   b. Allow Practitioners ~~thirty (~~30~~)~~ calendar days to request a hearing/appeal.
   c. IEHP cannot have an attorney if the practitioner does not have attorney representation

[9] Bus. & Prof. Code § 805
[10] NCQA, 2023~~2~~ HP Standards and Guidelines, CR 6, Element A, Factor 1
[11] https://www.iehp.org/en/providers?target=forms

to ensure compliance with California Business & Professions Code 809.3(c).[12,13]

3. Practitioner Appeal Process. IEHP informs the affected Practitioner of its appeal process and includes the following information in the process and notification.[14]

   a. IEHP provides written notification by FedEx delivery, return receipt requested, within ~~thirty (~~30~~)~~ calendar days of the decision reached by the IEHP Subcommittee (Peer Review or Credentialing) to any Practitioner denied participation. The written notice will indicate the following:

      1) A professional review action has been brought against the Practitioner

      2) Reason(s) for the action. This may include a brief description of the factual basis for the proposed action that includes but is not limited to:

         - A lapse in basic qualifications such as licensure, insurance, or required medical staff privileges;
         - A determination that the Practitioner cannot be relied upon to deliver the quality or efficiency of patient care desired by IEHP;
         - A determination that the Practitioner cannot be relied upon to follow IEHP's clinical or business guidelines or directives;
         - Falsification of information provided to IEHP;
         - Adverse malpractice history;
         - Adverse events that have potential for or have caused injury or negative impact to Members; and/or
         - Felony convictions.

      3) A summary of the appeal rights and process is provided in the provider manual and is included as an enclosure with the decision letter. (See ~~Attachment,~~ "IEHP Peer Review Level I and Credentialing Appeal" found on the IEHP website~~in Section 5~~[15]).

      4) A statement that the Practitioner may request an IEHP Peer Review Level I Appeal or Credentialing Appeal conducted by the IEHP Subcommittee (Credentialing or Peer Review) who denied participation is included in the decision letter in

[12] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 6, Element A, Factor 2
[13] Bus. and Prof. Code §809.3(c)
[14] NCQA, 202~~2~~3 HP Standards and Guidelines, CR 6, Element A, Factor 2
[15] https://www.iehp.org/en/providers?target=forms

accordance with this policy.

5) The Practitioner is notified that a request for an IEHP Peer Review Level I Appeal or Credentialing Appeal must be requested by the Practitioner in writing, addressed to the IEHP Committee Chairperson or Medical Director designee.

6) The Practitioner is notified that are quest for an IEHP Peer Review Level I Appeal or Credentialing Appeal must be received within ~~thirty (~~30~~)~~ days of the date of receipt of the notice. The Practitioner's written request must include:

- A clearly written explanation of the reason for the request; and
- A request to exercise the right to present the appeal orally

7) A summary of the Practitioner's Rights at the appeal includes the right to:

- Present additional written material for review by the IEHP Subcommittee (Peer Review or Credentialing);
- Present any information orally to the IEHP Subcommittee (Peer Review or Credentialing);
- Notification that the IEHP Peer Review Level I or Credentialing Appeal meeting takes place before the IEHP Peer Review or Credentialing Subcommittee.
    - The IEHP Peer Review Level I and Credentialing Appeal meetings are not hearings and procedural rights associated with the formal peer review hearings do not apply for adverse credentialing decisions.
        - Practitioners may not be represented by a licensed attorney at the IEHP Peer Review Level I or Credentialing Appeal meeting. However, they have a right to be represented by a non-attorney representative of their choice.

b. Practitioners not requesting an appeal within the required timeframe and as specified above waive the right to further appeals and the decision of the IEHP Subcommittee is final.

1) The decision will be adopted as the final action and

2) IEHP reports the final decision to the IEHP Governing Board, appropriate state licensing agency, and National Practitioner Data Bank.[16,17]

[16] Bus. & Prof. Code § 805
[17] 45 CFR §60

c. If an appeal is submitted in a timely manner, IEHP arranges for a review of the appeal to be conducted at the next scheduled meeting of the IEHP Subcommittee (Peer Review or Credentialing) that made the decision to deny.

1) Prior to the meeting, IEHP sends a written notice of the date, time and place of the meeting to the Practitioner via FedEx.

d. The IEHP Subcommittee (Peer Review or Credentialing) meets to complete its evaluation and renders a decision to uphold or overturn the denial. Within thirty (30) calendar days of the decision, the Practitioner is provided written notification of the appeal decision which contains specific reasons for the decision. Written notification also includes:

1) If the appeal decision by the IEHP Subcommittee (Peer Review or Credentialing) is to overturn the original denial of the Practitioner's participation in the IEHP network, the Practitioner is notified in writing within thirty (30) calendar days of the decision.

2) If the appeal decision by the IEHP Subcommittee (Peer Review or Credentialing) is to uphold the original denial of the Practitioner's participation in the IEHP network, the Practitioner is notified in writing within thirty (30) calendar days of the decision. The written notice will include:

- The decision, including a brief description of the decision and the reasons for it.
- A statement that the Practitioner may request for an IEHP Peer Review Process and Level II Appeal, in accordance to this policy.
- A copy of the IEHP Peer Review Process and Level II Appeal (See Attachment, "IEHP Peer Review Process and Level II Appeal" in Section 5).
- A statement that the Practitioner may request an IEHP Peer Review Process and Level II Appeal, in accordance with this policy. The request must be in writing, addressed to the IEHP Committee Chairperson or Medical Director designee, and must be received within ~~thirty (~~30~~)~~ days of the date of receipt of the notice.
- The Practitioner is notified that a request for an IEHP Peer Review Process and Level II Appeal, must be requested by the Practitioner in writing, addressed to the IEHP Committee Chairperson or Medical Director designee.
- The Practitioner is notified that the Practitioner's request for an IEHP Peer Review Process and Level II Appeal, must be received within ~~thirty (~~30~~)~~ days of the date of receipt of the notice.

- At the hearing, the Practitioner can be represented by an attorney or another person of the Practitioner's choice. IEHP cannot have an attorney if the practitioner does not have attorney representation.

e. A Practitioner not requesting an appeal within the required timeframe and as specified above waives the right to further appeals, and the decision of the IEHP Subcommittee is final.

1) The decision is adopted as the final action; and

2) IEHP reports the final decision to the IEHP Governing Board, appropriate state licensing agency, and National Practitioner Data Bank.[18,19]

- IEHP complies with the reporting requirements of the relevant licensing agencies and National Practitioners Data Bank (NPDB) as required by law. IEHP also complies with the reporting requirements of the California Business and Professions Code and the Federal Health Care Quality Improvement Act regarding adverse credentialing actions. Practitioners are notified of the report and its contents in accordance with law.

f. The following types of Providers require 805 and 805.01 reporting: Medical Doctors (MD), Dentists (DDS), Osteopaths (DO), Podiatrists (DPM), Marriage Family Therapists (MFT), Licensed Clinical Social Workers (LCSW), Psychologists (Psy.D., Ph.D.) and Physician Assistants (PA).[20,21]

1) 805 Reports

IEHP is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a Physician and Surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of podiatric medicine, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension

- If an 805 is reported, it shall include the following information:

[18] Bus. and Prof. Code § 805
[19] Title 45 CFR § 60
[20] Bus. and Prof. Code § 805 and 805.1
[21] Title 45 CFR § 60

- The name of the licentiate;
- The license number of the licentiate;
- A description of the facts and circumstances of the medical disciplinary cause or reason;
- Any other relevant information deemed appropriate by the reporter.

- IEHP must file an 805 report with the relevant agency within fifteen (15) days after the effective date on which any of the following occur as a result of an action of a peer review body:
  - A licentiate's application for staff privileges or membership is denied or rejected for medical disciplinary cause or reason.
  - A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
  - Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more for any ~~twelve (~~12~~)~~ month period, for a medical disciplinary cause or reason.
- If a licentiate takes any of the actions listed below after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the Chief Medical Officer (CMO) or a medical or professional staff or other Chief Executive Officer (CEO), Medical Director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within ~~fifteen (~~15~~)~~ days:
  - Resigns or takes a leave of absence from membership, staff privileges or employment.
  - Withdraws or abandons his or her application for staff privileges or membership.
  - Withdraws or abandons his or her request for renewal of staff privileges or membership.

2) 805.01 Reports

IEHP must file an 805.01 report within ~~fifteen (~~15~~)~~ days after a peer review body makes a final decision or recommendation of termination, suspension or restriction of staff privileges, membership or employment due to an investigation for at least one (1) of the following reasons:

- Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one (1) or more patients in such manner as to be dangerous or injurious to any person or the public.
- The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
- Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
- Sexual misconduct with one (1) or more patients during a course of treatment or an examination.

3) National Practitioner Data Bank (NPDB)

- Reports must be submitted to the NPDB within ~~thirty (~~30~~)~~ days of the action.

4) Health Plan Reporting

- Delegate Reports must be submitted to IEHPs Credentialing Manager within ~~thirty (~~30~~)~~ days of the action.

B. IEHPs policies and procedures regarding suspension or termination of a participating Physician require IEHP to ensure that the majority of the hearing panel members are peers of the affected Physician.[22,23]

1. A Peer is an appropriately trained and licensed Physician in a practice similar to that of the affected Physician.
2. Panel members do not have to possess identical specialty training.
3. Policies and procedures do not always have to state the word “majority”, but at least 51%

[22] Medicare Managed Care Manual, Chapter 6, “Suspension, Termination, or Nonrenewal fo Physician Contract,”, Section 60.4
[23] 42 CFR § 422.202

of the members must be peers.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2013	
Revision Effective Date:	January 1, ~~2023~~2024	

~~INLAND EMPIRE HEALTH PLAN~~		
~~**Chief Approval:** *Signature on File*~~	~~**Original Effective Date:**~~	~~January 1, 2020~~
~~**Chief Title:** Chief Operating Officer~~	~~**Revision Date:**~~	~~January 1, 2024~~3

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

7. Assessment of Organizational Providers

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers contracted under IEHP's Direct Network.

POLICY:

A. IEHP has written policies and procedures for the initial and ongoing assessment of Providers with whom IEHP contracts. IEHP must assess all health care delivery Providers before contracting with a Provider, and for at least every ~~thirty (~~36~~)~~ months thereafter. IEHP will confirm the Provider is in good standing with State and Federal regulatory bodies; confirm the Provider has been reviewed and approved by an accrediting body; and conduct an onsite quality assessment if the Provider is not accredited.[1]

B. IEHP is responsible for the initial and on-going assessment of subcontracted Providers that render services to Members. IEHP is also responsible for claims payment for those Health Care Delivery Organization Providers. IEHP retains oversight responsibilities for all subcontracted Providers. The Provider types included in IEHP's assessment include, but are not limited to: Hospitals[2], Home Health Agencies[3], Skilled Nursing Facilities[4], Free-Standing Surgical Centers,[5] Behavioral Health Providers, Hospice, Clinical Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy Providers, Outpatient Speech Pathology Providers, Providers of End-stage Renal Disease Services (Dialysis), Outpatient Diabetics Self-Management Training Providers, Portable X-Ray Supplier, Freestanding Birthing Center (FBC), Indian health Facilities (IHF), Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC).[6]

C. IEHP includes Behavioral Healthcare Facilities, providing mental health or substance abuse services in an inpatient setting in their scope of Providers. Residential Treatment Facilities and Ambulatory Behavioral Health Facilities are not covered by this policy as these are not a covered IEHP benefit.[7]

PURPOSE:

A. IEHP evaluates the quality of organizational Providers with whom IEHP contracts.

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[1] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 7, Element A, Factors 1-3
[2] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 1
[3] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 2
[4] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 3
[5] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 4
[6] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-006 Supersedes APL 20-003, "Network Certification Requirements"
[7] NCQA, 2023 HP Standards and Guidelines, CR 7, Element C, Factors 1-3

B. All Providers must adhere to all procedural and reporting requirements under State and Federal laws and comply with the most recent NCQA, state and regulatory guidelines for subcontracted organizational Providers, as well as IEHP requirements.

C. IEHP audits organizations who are delegated the credentialing activities for the assessment of Organizational Providers to ensure compliance with IEHP requirements on an annual basis, using the IEHP Delegation Oversight Audit Tool beginning with a pre-contractual assessment, in accordance with Policy 25A1, "Delegation Oversight - Delegated Activities." Delegated IPAs are subject to corrective action as defined in Policy 25A3, "Delegation Oversight - Corrective Action Plan Requirements."

D. IEHP reserves the right to perform facility site audits when quality of care issues arises and to deny contracted or subcontracted Providers participation in the IEHP network in the event IEHP requirements for participation are not met.

E. Contracted and/or subcontracted Provider's failure to meet IEHP's requirements may result in adverse action up to and including non-renewal or termination of the delegated entity contract or IEHP contract.

F. IEHP must offer to contract with each of the following mandatory Provider types in each of our services counties, where available: FQHCs, RHCs, FBCs.[8]

G. IEHP is required to offer a contract with each IHF in our services area as a mandatory Provider type, as well as allow eligible Members to obtain services from an out-of-Network (OON) IHF.[9]

DEFINITION:

A. Free-Standing facility: An outpatient center that is separate from a Hospital or other inpatient facility and whose primary focus is providing immediate or short-term medical services on an outpatient basis.[10]

B. Organizational Provider (OP): refers to facilities providing services to Members and where Members are directed for services rather than being directed to a specific Practitioner. This element applies to all OPs with which the organization contracts (e.g., Telemedicine Providers, Urgent Care Centers).[11]

C. Organizational Provider Credentialing: Credentialing of facilities including hospitals, home

[8] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-006 Supersedes APL 20-003, "Network Certification Requirements"
[9] Title 22 of the California Code of Regulations (CCR) § 55120 and§ 55120
[10] NCQA, 2023 HP Standards and Guidelines, Glossary
[11] Ibid.

health agencies, skilled nursing facilities & rehabilitation facilities, etc.

PROCEDURES:

A. IEHP must assess all health care delivery Providers before contracting with a Provider, and for at least every ~~thirty (~~36~~)~~ months thereafter, IEHP will confirm the provider is in good standing with state and federal regulatory bodies; confirms the Provider has been reviewed and approved by an accrediting body; and conducts an onsite quality assessment if the Provider is not accredited. A Provider is considered excluded, sanctioned, or ineligible, if the Provider is named by the appropriate State or Federal departments or agencies on exclusionary lists, IEHP reserves the right to terminate the contract for cause, with appropriate notice as defined in the IEHP Agreement.[12]

1. The following sources are used to confirm that Providers are in good standing with state and federal requirements, that include, but are not limited to:[13]

   a. State (Department of Health Care Services) regulatory body

      1) Copies of Credentials (e.g., A copy of the license and expiration date) from the Provider. The Health Care Delivery Organization Provider is responsible for providing IEHP with copies of its renewed license and accreditation within sixty (60) days following the expiration of the license and accreditation. IEHP expects the Health Care Delivery Organizational Providers to maintain accreditation and license status in good standing and/or current at all times during participation in the IEHP network.

      2) A current and unencumbered license; must also be appropriately licensed and no other negative license actions that may impact participation.

         - Physician-owned clinics are not required to be licensed by DHCS, but they must be accredited by an agency approved by the Medical Board. (If the physician-owned clinic is appropriately accredited, they would be compliant of the Knox-Keene Act of Title 28)[14]

      3) If a State license is not issued by the Department of Health Care Services, the facility should have a business license or certificate of occupancy.

   b. Federal Regulatory Bodies

      1) Provider must have no sanctions that may impact participation IEHP must verify the identity and determine the exclusion status of all Providers by conducting the following Federal and State Database Checks conducted through our vendor

[12] California Welfare and Institutions Code (Welf. & Inst. Code), § 14043.6 and 14123
[13] NCQA, 2023 HP Plan Standards and Guidelines, CR 7, Element A, Factor 1
[14] Knox-Keene Health Care Service Plan Act of Title 28

OIG Compliance Now, who reviews the following databases: The Department of Health & Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities List (LEIE).

2) Review of OIG or Medicare/Medicaid Sanctions must be completed and documented on the spreadsheet or the file. The monthly review of the OIG report as part of the "Ongoing Monitoring" qualifies as compliant for this section if the facilities are included on the OIG Report.[15]

- IEHP prohibits employment or contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation (Practitioners or entities found on OIG Reports).[16,17]
- CMS' Medicare Exclusion Database (MED) is the source that is used to populate the LEIE list. IEHP will use the LEIE to verify if practitioners are identified on the MED.[18]

3) CMS signed participating agreement letter, if applicable.[19]

4) An attestation from a Provider to the organization regarding the Provider's regulatory status is not acceptable.

2. IEHP accepts an accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the Provider as evidence that the Provider has been reviewed and approved by an accrediting body. Accreditation and licensure must be maintained throughout the duration of the subcontractors' participation in the IEHP network. IEHP recognizes the following accreditations by Organizational Provider type:

a. Hospitals

1) The Joint Commission (TJC)

2) Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)

3) Det Norske Veritas National Integrated Accreditation of Healthcare Organization (DNVNIAHO)

[15] Medicare Managed Care Manual, Chapter 6, "Confirmation of Eligibility for Participation in Medicare: Excluded and Opt-Out Provider Checks", Section 60.2
[16] DHCS APL ~~19~~21-~~004~~003
[17] ~~DHCS APL 21-003~~Ibid.
[18] Ibid.
[19] Medicare Managed Care Manual, Chapter 6 "Institutional Provider and Supplier Certification", Section 70

4) Center for Improvement in Healthcare Quality (CIHQ)

b. Home Health Agencies
   1) The Joint Commission (TJC)
   2) Community Health Accreditation Program (CHAP)
   3) Accreditation Commission for Health Care Inc (ACHC)

c. Skilled Nursing Facilities
   1) The Joint Commission (TJC)
   2) Commission on Accreditation or Rehabilitation Facilities (CARF)
   3) Continuing Care Accreditation Commission (CCAC)

d. Free-Standing Surgical Centers
   1) The Joint Commission (TJC)
   2) American Association for Accreditation for Ambulatory Surgical Facilities (AAAASF)
   3) Accreditation Association for Ambulatory Health Care (AAAHC)
   4) Healthcare Facilities Accreditation Program (HFAP) As of October 2015, the Healthcare Facilities Accreditation Program (HFAP) is no longer owned by the AOA, it is now managed by the Accredited Association for Ambulatory Health Care, Inc. (AAAHC)
   5) The Institute for Medical Quality's (IMQ's) (CMS approved accrediting body verified by IEHP)[20]

e. Behavioral Health Providers (Intensive Programs and Inpatient Treatment Programs)
   1) The Joint Commission (TJC)
   2) Commission on Accreditation or Rehabilitation Facilities (CARF)
   3) Healthcare Facilities Accreditation Program (HFAP)
   4) Council on Accreditation (COA)

f. Hospice
   1) The Joint Commission (TJC)
   2) Community Health Accreditation Program (CHAP)

[20] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 2

3) Accreditation Commission for Healthcare INC (ACHC) (CMS approved accrediting body verified by IEHP)

g. Clinical Laboratories

1) The Joint Commission (TJC)

2) Clinical Laboratory Association Improvement (CLIA) Certificate or CLIA Waiver

3) Commission on Office Laboratory Accreditation (COLA)

4) College of American Pathology (CAP)

h. Comprehensive Outpatient Rehabilitation Facilities

1) The Joint Commission (TJC)

2) Commission on Accreditation or Rehabilitation Facilities (CARF)

i. Outpatient Physical Therapy Providers

1) American Association for Accreditation of Ambulatory Surgical Services (AAAASF)

2) If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

j. Outpatient Speech Pathology Providers

1) American Association for Accreditation of Ambulatory Surgical Services (AAAASF)

2) If no Accreditation, must be certified by Medicare (Must have Medicare Part A)

k. Providers of End-stage Renal Disease Services (Dialysis)

1) The Joint Commission (TJC)

2) If no Accreditation, must be certified by Medicare

l. Birth Centers

1) Commission for the Accreditation of Birth Centers (CABC)

m. Congregate Living Health Facility

1) The Joint Commission (TJC)

n. Outpatient diabetes self-management training Providers

1) American Association of Diabetes educators (AADE)

2) Indian Health Service (IHS)

o. Portable X-Ray Supplier

1) Federal Drug Administration (FDA) Certification

p. Rural Health Clinics

1) The Joint Commission (TJC)

2) American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)

3) If no Accreditation, must be certified by Medicare

q. Federally Qualified Health Centers

1) The Joint Commission (TJC)

2) If no Accreditation, must be certified by Medicare

r. Palliative Care

1) The Joint Commission (TJC)

2) Community Health Accreditation Program (CHAP)

3. An onsite quality assessment must be conducted if the Provider is not accredited. IEHPs onsite quality assessment criteria for each type of non-accredited Provider includes, but is not limited to:

a. A process ensuring that the Providers credential their Practitioners.

b. A CMS or state quality review in lieu of a site visit under the following circumstances (if IEHP chooses to substitute the site visit with a CMS or state quality review), if it meets the following requirements:

1) The CMS or state review is no more than three (3) years old.

- If the CMS or state review is older than three (3) years, IEHP's Quality Management (QM) will assess the Provider by conducting its own onsite quality review and present their findings for review and approval to the Credentialing Subcommittee.

2) IEHP obtains a survey report or letter from CMS or the state, from either the Provider or the agency, stating that the facility was reviewed and passed inspection.

- The report meets IEHP's quality assessment criteria or standards.

3) A Medicare certification number is not acceptable for use in lieu of a site visit if a facility is not accredited.[21]

[21] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 3

4) IEHP is not required to conduct a site visit if the state or CMS has not conducted a site review of the Provider and the Provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html).[22]

B. The following organizational Providers types are contracted and IEHP is responsible for claims payment, therefore these Providers require an assessment, including, but not limited to:

1. Hospitals[23]
2. Home Health Agencies[24]
3. Skilled Nursing Facilities[25]
4. Free-Standing Surgical Centers[26]
5. Clinical Laboratories
6. Hospice
7. Comprehensive Outpatient Rehabilitation Facilities
8. Outpatient Physical Therapy Providers
9. Outpatient Speech Pathology Providers
10. Providers of End-stage Renal Disease Services (Dialysis)
11. Outpatient Diabetics Self-Management Training Providers
12. Portable X-Ray Supplier
13. Freestanding Birthing Center
14. Indian Health Facilities
15. Rural Health Clinics[27]
16. Federally Qualified Health Centers[28]
~~16.~~17. Palliative Care

C. IEHP's delegation arrangements with Delegates, "carves out" behavioral healthcare services, therefore, IEHP is responsible for the initial and ongoing assessment for behavioral healthcare

[22] NCQA, 2023 HP Standards and Guidelines, CR 7, Element A, Factor 3
[23] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 1
[24] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 2
[25] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 3
[26] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 4
[27] Medicare Managed Care Manual, Chapter 6 "Institutional Provider and Supplier Certification", Section 70
[28] Medicare Managed Care Manual, Chapter 6 "Relationships with Providers", Section 70

facilities providing mental health or substance abuse services in the Inpatient setting. Behavioral Healthcare Facilities providing mental health or substances abuse services in Residential and Ambulatory settings are not covered as an IEHP benefit, therefore IEHP is not responsible for the initial and ongoing assessment.[29,30]

D. IEHP must assess contracted medical health care Providers, Organizational Providers, against the requirements and within the time frame. IEHP uses:[31]

1. A comprehensive spreadsheet or log showing credentialing of Medical organizational Providers, to calculate compliance and completion of the File Review.
2. IEHP has a tracking mechanism for ensuring that license and certificates are current and reviews are compliant with the ~~thirty-six (~~36~~)~~ month time frame.

E. IEHP assesses contracted behavioral health care Providers against the requirements and within time frame, for the Provider types providing care in the Inpatient setting.

1. IEHP use a comprehensive spreadsheet or log showing credentialing of Behavioral organizational Providers, to calculate compliance and completion of the File Review.

F. IEHP has documentation of assessment of free-standing surgical centers to ensure that if the organizational Provider is not accredited by an agency accepted by the State of California, the organization is certified to participate in the Medicare Program. The following sources are included in the assessment of non-accredited free-standing surgical centers:[32,33]

1. Certification letter from Medicare stating the facility is certified.
   a. If certification letter is not present, attestation in file or Medicare certification number will be noted on the spreadsheet; and
   b. A CMS Survey, which include the certification number, is also present in the file.
2. If a surgical center is associated with a TJC (The Joint Commission) American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), accreditation Association for Ambulatory Healthcare (AAAHC) accredited hospital or Healthcare Facilities Accreditation Program (HFAP), accrediting program approved by the American Osteopathic Association (AOA), then the assessment of the free-standing surgical center does not apply.

G. IEHP must conduct Federal and Database checks during the Provider's initial assessment and reassessment process, and monthly thereafter. Each Provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any Provider terminated from the Medicare

[29] NCQA, 2023 HP Standards and Guidelines, CR 7, Element C, Factor 1
[30] Medicare Managed Care Manual, Chapter 11, "Delegation requirements," Section 110.2
[31] NCQA, 2023 HP Standards and Guidelines, CR 7, Element D3
[32] Health and Safety Code § 1248.1
[33] NCQA, 2023 HP Standards and Guidelines, CR 7, Element B, Factor 4

or Medicaid/Medi-Cal program may not participate in the IEHP network.

1. IEHP conducts Federal and State Database checks for the following databases:
    a. Social Security Administration's Death Master File (SSADMF) applies to screening Practitioners against the (SSADMF); however Organizational Providers are not reviewed for individual practitioners, therefore the does not apply to the Provider types referenced in this policy.
    b. National Plan and Provider Enumeration System (NPPES). IEHP ensures the Provider has an active and current Organization NPI.
    c. List of Excluded Individuals/Entities (LEIE). IEHP ensures our vendor, OIG Compliance Now, collects and reviews information for Medicare and Medicaid Sanctions, on a monthly basis, within ~~thirty (~~30~~)~~ days of its release.
        1) If a Practitioner is identified, Contracting will review the OIG Exclusions Report and confirm the findings.
            - Practitioners identified on the HHS-Office of Inspector General (OIG) Exclusions Report will be administratively terminated for all lines of business, without appeal rights due to IEHP prohibiting employment of contracting with Practitioners (or entities that employ or contract with such Practitioners) that are excluded/sanctioned from participation.[34, 35, 36]
            - Members will be reassigned to new Practitioners.
            - The Provider will be presented to Compliance as an administrative termination, for further review and discussion.[37]

H. System for Award Management (SAM). IEHP uses OIG Compliance Now as the vendor to collect data and alert services, to include but is not limited to the System for Award Management (SAM) in their scope of review.

1. The OIG LEIE includes all health care Providers and suppliers that are excluded from participation in federal health care programs, including those health care Providers and suppliers that might also be on the SAM (previously EPLS). In addition to health care Providers (that are also included on the OIG LEIE) the EPLS includes non-health care contracts.[38]
    a. If a Practitioner is identified on the SAM, The Provider will be presented to

[34] Medicare Managed Care Manual, "Relationships with Providers", Chapter 6 § 60.2
[35] DHCS APL ~~19-004~~21-003
[36] ~~DHCS APL 21-003~~Ibid.
[37] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 5
[38] Medicare Managed Care Manual, Chapter 21 "Compliance Program Guidelines and Prescription Drugs Benefit Manual", Section 50.6.8

Compliance, for further review and discussion.[39]

b. CMS' Medicare Exclusion Database (MED). The MED database is the source that is used to populate the LEIE list. Therefore, IEHP will use the LEIE to conduct their assessment of the MED database.

c. DHCS' Suspended and Ineligible Provider List. IEHP ensures OIG Compliance Now collects and reviews the Medi-Cal Suspended and Ineligible List, published monthly by the Department of Health Care Services (DHCS), as the verification source for Medicaid Sanctions. Delegate must review the Suspended & Ineligible List on a monthly basis, within ~~thirty (~~30~~)~~ days of its release.

1) If a Practitioner is identified, Contracting will review the Medi-Cal Suspended and Ineligible List and confirm the findings. Providers identified on the Medi-Cal Suspended and Ineligible List will be automatically terminated for all lines of business, without appeal rights.[40]

- All Members assigned to the suspended Provider will be reassigned to new Practitioners.[41]

d. Restricted Provider Database. Contracting will obtain the Restricted Provider Database report monthly, by the 5th of each month. Providers identified on the RPD will be presented to Compliance for review and discussion. The following actions will be required to ensure compliance with DHCS guidelines:

1) Payment Suspension: Providers are placed under a payment suspension while under investigation based upon a credible allegation of fraud.

- IEHP may continue contractual relationship; however, reimbursements for Medi-Cal covered services will be withheld; or
- If IEHP chooses to continue the contractual relationship with Providers who are placed on payment suspensions, IEHP must allow out-of-network access to members currently assigned to the Provider by approving the request.
    - IEHP may choose to terminate the contract by submitting appropriate documentation as outlined in APL 21-003.[42]

2) Temporary Suspension: Providers placed on a temporary suspension while under investigation for fraud or abuse, or enrollment violations.

- IEHP must terminate the contract and submit appropriate documentation as

[39] NCQA, 2023 HP Standards and Guidelines, CR 5, Element A, Factor 5
[40] DHCS APL 21-003
[41] ~~DHCS APL 19-004~~Ibid.
[42] ~~DHCS APL 21-003~~Ibid.

outlined on APL 21-003.[43]

I. IEHP's has a documented process for informing IEHP's Compliance Department of any Providers identified with a disciplinary action or on a exclusionary list.

J. If during the contract period, Contracting becomes aware of a change in the accreditation and/or CMS Site Survey, license, certification status, sanctions, fraudulent activity or other legal or remedial actions have been taken against any Provider, Contracting must:[44]

1. Notify IEHP's Compliance Department by emailing compliance@iehp.org or fax (909) 477-8536 or via Compliance Hotline (866) 355-9038 within five (5) days business of discovering any of our Providers have been added to disciplinary or exclusionary lists.
2. The Director of Provider Contracting informs the Provider in writing that it is in violation of its contract with IEHP and begins the cure process. Depending on the seriousness of the offense, IEHP:
   a. Reserves the right to temporarily suspend or terminate the contract for cause, with appropriate notice as defined in the IEHP Provider Agreement.
   b. May report the termination of the contract to regulatory agencies as per contractual requirements. Any services provided after the date of exclusion shall not be reimbursable or may be subject to recoupment.

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA

[43] Ibid.
[44] California Welfare and Institutions Code (Welf. & Inst. Code), 14043.6 and 14123

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

7. Assessment of Organizational Providers

Original Effective Date:	January 1, 2020
Revision Effective Date:	January 1, ~~2023~~2024

~~INLAND EMPIRE HEALTH PLAN~~		
~~**Chief Approval:** *Signature on File*~~	~~**Original Effective Date:**~~	~~January 1, 2020~~
~~**Chief Title:** Chief Operating Officer~~	~~**Revision Date:**~~	~~January 1, 2023~~

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
8. Delegation of Credentialing

APPLIES TO:

A. This policy applies to all IEHP delegated relationships for the DualChoice (HMO D-SNP) line of business.

POLICY:

A. IEHP ensures there is a delegation agreement in place for all delegation arrangements in place.[1]

B. For new delegation agreements initiated, IEHP will evaluate the Delegates capacity to meet National Committee for Quality Assurance (NCQA), State, and Federal regulatory requirements before delegation began.[2]

C. For delegation arrangements in effect for ~~twelve (~~12~~)~~ months or longer, IEHP will conduct oversight reviews of the Delegate's Credentialing Activities.[3]

D. If there are any opportunities for improvement identified during the review of delegated credentialing activities, IEHP will identify, notify and follow-up with the Delegate to ensure the opportunities have been addressed.[4]

PURPOSE:

A. If the Delegated entities subdelegate their credentialing activities, IEHP will review the Delegates' oversight process over their subdelegates.[5,6]

B. IEHP delegates credentialing activities to outside entities and remains responsible for credentialing and recredentialing its Practitioners, even if it delegates all or part of these activities.[7]

C. IEHP verifies that Delegates perform the functions discussed in the Section 25 of the Provider Manual and in the Delegation Agreement between IEHP and the Delegate.[8]

D. IEHP reserves the right to rescind delegation of credentialing activities based on the outcome of monitoring activities or as determined by IEHP.

E. Within two (2) working days advanced notice to the Delegate, IEHP and any regulatory

[1] National Committee for Quality Assurance (NCQA), 2023 Health Plan Standards and Guidelines, CR 8, Element A, Factors 1-6
[2] NCQA, 2023 HP Standards and Guidelines, CR 8, Element B
[3] NCQA, 2032 HP Standards and Guidelines, CR 8, Element C, Factors 1-6
[4] NCQA, 2023 HP Standards and Guidelines, CR 8, Element D
[5] NCQA, 2023 HP Standards and Guidelines, CR 8
[6] Medicare Managed Care Manual, Chapter 11, "Delegation requirements," Section 110.2
[7] Ibid.
[8] Medicare Managed Care Manual, Chapter 11, "Delegation requirements," Section 110.2

oversight agency has the right to examine the Delegates credentialing/recredentialing files or sites as needed to perform oversight of all Practitioners or to respond to a complaint or grievance.

F. If a Management Service organization (MSO) and an IPA are owned or under the same ownership, this is not considered delegation.

G. If an IPA changes MSOs during the annual audit period, only the current agreement will be reviewed and scored.

H. If a Delegate terminates a delegation arrangement during the annual audit period, only the termination date will be reviewed.

I. Delegates who delegate to a NCQA accredited entity, must audit for Medi-Cal and DMHC requirements. Acceptance of accreditation only will not meet compliance for the additional regulatory requirements.

J. If the Delegate utilizes their sub-delegate for their specialty panel for HIV/AIDS Practitioners, the Delegate must include the Identification of HIV/AIDS Specialists in their annual oversight review.

K. If the Delegate gives another organization the authority to perform certain functions on its behalf, this is considered delegation, e.g., Primary Source Verification of License, collection of the application, verification of Board Certification.

1. Ongoing monitoring or data collection and alert services are NOT seen as delegation. IF the Delegate uses another organization for collecting data for ongoing monitoring or sanctions monitoring, and the Delegate then handles the review of information and intervention, it is not considered delegation.

2. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered delegation.

L. Delegates must provide IEHP all sub-delegation agreements and effective dates.

1. If Delegates have more than four (4) sub-delegation arrangements:

   a. A sample of up to four (4) delegates will be selected and reviewed

   b. The following year, IEHP will audit the rest of the delegates that were not audited from the previous year.

   c. Each audit year different delegates will be selected for review.

2. For Delegates with fewer than four (4) delegates, all delegates are assessed.

M. IEHP does not accept accredited Health Plan audits for pre-delegation audit evaluations for delegation arrangements between IEHP and IPAs.

N. Delegation agreements implemented on or after January 1, 2022, must include a description

of the Delegate's credentialing system security controls.

1. For delegation agreements in place prior to January 1, 2022, the organization may provide other mutually agreed upon documentation or the Delegate's system controls policies and procedures.[9]

DEFINITION:

A. Annual: A ~~twelve (~~12~~)~~ month period, within a two (2) month grace period, defined by NCQA.

B. Audit Date: The date of the file review.

C. Auto-Credit: Credit given to elements that have been audited by previous accrediting authority and meets industry compliance. Those elements will not be subjected to oversight.

D. Credentials Verification Organization (CVO): An organization that conducts primary-source verification of Practitioner credentials for other organizations. An organization may obtain the following certification under NCQA CVO status:

1. Licensure
2. DEA or CDS verification
3. Education and Training
4. Work History
5. Malpractice History
6. Medical Board Sanctions
7. Medicare/Medicaid sanctions
8. Processing application and Attestation content; and
9. Ongoing Monitoring of Sanctions (licensure and Medicare/Medicaid)

E. Delegation: An organization gives an entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate the responsibility of ensuring that the function is performed appropriately.

F. Exit Interview: Auditor discussion of audit results with Delegate via phone, email or in person.

G. Factor: A scored item in an element.

H. Implementation Date: NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

I. Look-back period: Is the date range used for pulling files for a review.

[9] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 1

J. Management Services Organization (MSO): an entity that, under contract provides services such as a facility, equipment, staffing, contract negotiation, administration, and marketing.

K. NCQA CR Accreditation: A provider organization that has achieved an NCQA accreditation in credentialing would receive auto-credit for certain standards of credentialing.

L. NCQA CVO Certification: An organization that has been certified by NCQA to collect primary source verifications. An organization that has obtained this certification will still need to have a full file/policy review but does not need to evaluate on actual verification documentation but on the current and timely verification.

M. NCQA Health Plan Accreditation: A health plan organization that has achieved NCQA accreditation and would receive auto-credit for credentialing. An organization that has obtained this accreditation will still need to have a file/policy review for CMS, or state requirements.

N. If an organization gives another organization the authority to perform certain functions on its behalf, this is considered delegation (e.g. Primary Source Verifications, collection of the application, etc.).

O. Ongoing monitoring or data collection and alert services are NOT seen as delegation. If the organization uses another organization for collecting data for ongoing monitoring or sanction monitoring and the organization then handles the review of information and intervention, it is not considered delegation.

P. If the information is gathered from a company website and the organization is pulling the queries for the Office of the Inspector General (OIG) or other types of queries, it is NOT considered delegation.

Q. NCQA defines “annual” for this section as “a 12-month period, with a 2-month grace period”.

R. Delegate: If IEHP gives another organization (i.e. Credentials Verification Organization (CVO), Independent Practice Association (IPA), Specialty Network, etc.) the authority to perform certain functions on its behalf, this is considered delegation, e.g. Primary Source Verification of License, collection of the application, verification of board certification. The Delegated Entity is referred to as a Delegate.

1. Subdelegate: If the Delegate delegates certain functions on its behalf to another organization (i.e. CVO, MSO etc.), this is considered sub delegation, and the organization would be considered a subdelegate. The Delegate will be responsible for sub delegation oversight.

    a. Ongoing Monitoring or data collection and alert service are NOT seen as delegation.

    b. If information is gathered from a company website and the Delegate staff is pulling the queries for OIG or other types of queries, it is NOT considered delegation.

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

8. Delegation of Credentialing

PROCEDURES:

A. IEHP will review all delegation agreements in place for all delegation and sub-delegation arrangements in place. The delegation agreement describes all delegated credentialing activities. The written delegation arrangement must ensure:

1. Delegation activities are mutually agreed upon before delegation begins, are in a dated, binding document or communication between IEHP and the Delegated entity. There must be evidence that the document was agreed to by both IEHP and the Delegate before the Delegate began performing delegated activities. Evidence of the mutually agreed-upon document shall include:[10]

    a. A signature and a date on an agreement, but it may also be found in a letter, meeting minutes or other form of communication.

    b. The responsibilities of the organization and its Delegates in terms specific to their relationship. At minimum, the document must state which entity (IEHP, the Delegate or both) is responsible for the following tasks:

        1) Accepting applications and attestation;

        2) Collecting all data elements from NCQA approved sources;

        3) Collecting and evaluating ongoing monitoring and complaint information; and

        4) Making credentialing decisions.

    c. To ensure that a consistent and equitable process is used throughout its network, the organization's credentialing and recredentialing policies require a Delegated entity to adhere to at least the same criteria as IEHP.[11,12]

2. The written arrangement must be in a delegation agreement or an addendum thereto or other binding communication between IEHP and the Delegate. If the Delegate subdelegates an activity, the delegation agreement must specify which organization is responsible for the oversight of the subdelegate the credentialing activities and which credentialing activities are:[13]

    a. Performed by the delegate, in detailed language.

    b. Not delegated but retained by the organization.

        1) The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other CR functions not

[10] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 1
[11] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 1
[12] Medicare Managed Care Manual, Chapter 11, "Delegation Requirements," Section 110.2
[13] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 2

specified in this agreement as the Delegate's responsibility).

c. Delegates must adhere to State and Federal Regulation.

1) This language is not required for Credentialing Verification Organization (CVO) Agreements

3. IEHP requires Delegates to submit credentialing activity reports even if the Delegate is accredited at least quarterly. Reports may include, but are not limited to:[14,15]

a. Lists of credentialed and recredentialed Practitioners.

b. Delegates are required to complete and submit quarterly reports in the format provided by IEHP (See ~~Attachment,~~ "Credentialing and Recredentialing Report" ~~in Section 25)~~found on the IEHP website,[16] according to the specified timeframe. (See Attachment, "IPA Reporting Requirements Schedule – IEHP DualChoice", ~~in Section 25)~~ found on the IEHP website. [17]

c. Committee meeting minutes.

d. Facilities credentialed.

4. The written arrangement describes IEHPs process for monitoring and evaluating the Delegates performance.[18,19]

5. IEHP reserves the right to approve, suspend, deny, terminate or otherwise limit individual Practitioners, Providers and sites' participation in the IEHP network for any reason, including up to quality issues.[20]

a. If a Provider is denied participation due to quality of care and an 805 was filed with the appropriate licensing agency and the National Practitioner Data Bank (NPDB), then the Provider is not eligible to reapply.

b. Administrative terminations or denials, he/she may reapply after one (1) year.

c. The delegation agreement does not specify the right to approve language, the Delegate may provide alternate documentation through another communication between the Delegate and sub-delegate, for review for compliance.

6. The delegation agreement specifies consequences if a Delegate fails to meet the terms of the agreement and, at a minimum, circumstances that result in revocation of the agreement. The Delegate must comply with the remedies available to the Delegate if it

[14] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 3
[15] Medi-Cal Exhibit A, Attachment 4 of Plan Contract – QI Activities)
[16] https://www.iehp.org/en/providers/provider-resources?target=forms
[17] ~~https://www.iehp.org/en/providers/provider-resources?target=forms~~Ibid.
[18] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 4
[19] Medicare Managed Care Manual, Chapter 11 "Delegation Requirements," Section 110.2
[20] NCQA, 2023 HP Standards and Guidelines, CR 8, Element A, Factor 5

does not fulfill its obligations, as specified in policy 25A4, "Delegation Oversight - Corrective Action Plan Requirements".[21,22]

B. For new delegation agreements initiated, delegation arrangements in effect within ~~twelve (~~12~~)~~ months of implementation, IEHP will evaluate the Delegates capacity to meet NCQA, State, and Federal regulatory requirements before delegation begins.[23]

1. IEHP's pre-delegation evaluation evaluates the Delegate's capacity to meet NCQA, State, and Federal regulatory requirements within ~~twelve (~~12~~)~~ months prior to implementing delegation. IEHP will conduct a pre-delegation evaluation under the following circumstances:

   a. If the time between the pre-delegation evaluation and implementation exceeds twelve (12) months, IEHP must conduct another pre-delegation evaluation.

   b. If IEHP amends the delegation agreement to include additional credentialing activities, IEHP must perform a pre-delegation evaluation for the additional activities.

   c. If the Delegate changes Management Services Organizations (MSOs), IEHP must evaluate the new MSO prior to contracting.

   d. MSO contracted with multiple IPAs process. When conducting the file review for multiple IPAs who are serviced by the same MSO, IEHP must determine whether all IPAs use the same Credentialing Committee.

      1) If an MSO is contracted with multiple IPAs, has one set of policies and procedures and all the IPAs use the same Credentialing Committee, then IEHP will pull one file sample across all contracted IPAs and apply the same score for CR 3 (CR C3 & CR R3) and CR 4 for each IPA.

      2) If the IPAs share the same committee, but have different Organizational Providers or different delegation agreements, a separate audit must be conducted.

      3) If the MSO is contracted with multiple IPAs, has one set of policies and the Delegate has separate Credentialing Committee, IEHP will pull one file sample for each Delegate.

   e. IPAs combining Credentialing Committee within the annual audit period.

      1) If an IPA merges their credentialing committee with another at any time during the annual audit period, a separate file pull and audit must be conducted for the IPA. The IPA will be audited for the combined committee and will have one

[21] NCQA, 20223 HP Standards and Guidelines, CR 8, Element A, Factor 6
[22] Medicare Managed Care Manual, Chapter 11 "Delegation Requirements," Section 110.2
[23] NCQA, 2023 HP Standards and Guidelines, CR 8, Element B

audit at the next annual audit.

f. New MSO.

1) If a Delegate has changed management companies and the files from the Delegated IPA were forwarded to the new MSO, the files may undergo recredentialing when appropriate.

2) If a Delegate has changed management companies and the files were NOT submitted to the new MSO, the Practitioners must be initially credentialed by the new MSO within six (6) months of acquiring the IPA.

g. IPA purchased by another IPA.[24]

1) If an IPA purchases another IPA and obtains the credentials files, they can continue with the current recredentialing process.

2. IEHP's systematic method for conducting pre-delegation evaluations, especially if more than one (1) delegation is in effect, (See attachment, "Delegation Oversight Audit Preparation Instructions" ~~in Section 25)~~found ~~in~~on the IEHP website.[25] includes the types of documents to be available at the time of the audit and standard forms to be completed and returned to IEHP prior to the audit. The audit can be conducted on-site or as a desk-top audit.

a. File Selection for pre-delegation audits, the IEHP auditor will:

1) Obtain a spreadsheet of all credentialed practitioners from the Delegate and then select ~~forty (~~40~~)~~ initial and ~~forty (~~40~~)~~ recredentialing files for the specified audit time period, using the NCQA 8/30 file methodology. When using the 8/30 NCQA file methodology, IEHP uses the following method:

- After reviewing eight (8) files, if any of those eight (8) files are non-applicable for that element (e.g. Drug Enforcement Administration (DEA)), the IEHP auditor will review additional files to have a total denominator of eight (8).
- After reviewing eight (8) files, if one (1) or more of the elements are non-compliant, the IEHP auditor will review the remaining files for the element's that are non-compliant. If the IPA has not initially credentialed or recredentialed at least ~~thirty (~~30~~)~~ files, IEHP will note that the file pull was exhausted.

b. If the organization is NCQA CR Accredited or Certified, IEHP must obtain a copy of the certification to ensure the delegate is certified to perform the activity being

[24] NCQA, 2023 HP Standards and Guidelines, CR 8, Element B, Factor 1
[25] https://www.iehp.org/en/providers/provider-resources?target=forms

delegated by the organization.

1) The following are not part of the NCQA certification/accreditation review and are not eligible for automatic credit and must be reviewed as part of the delegation oversight process. Delegate must submit copies of the following policies and procedures and other non-file elements.

- CR 1.A. – Practitioner Credentialing Guidelines. The Delegate specifies:
  - The types of Practitioners it credentials and recredentials.
  - The verification sources it uses.
  - The criteria for credentialing and recredentialing.
  - The process for making credentialing and recredentialing decisions.
  - The process for managing credentialing files that meet the organization's established criteria.
  - The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.
  - The process for notifying if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.
  - The process for notifying Practitioners the credentialing and recredentialing decision within ~~sixty (~~60~~)~~ calendar days of the Committee's decision.
  - The Medical Director or other designated Physician's direct responsibility and participation in the credentialing program.
  - The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.
- CR 1.B. – Practitioner Rights. The Delegate specifies Practitioners about their right to:
  - Review information submitted to support their credentialing application.
  - Correct erroneous information (submitted by another source).
  - Receive the status of their credentialing and recredentialing application, upon request.
- CR 1.C. – Credentialing System Controls (Centers for Medicare and Medicaid Services [CMS]/ Department of Health Care Services [DHCS])

- CR 1.D. – Contracts – Opt-Out Provisions (Medicare Opt-Out Policy) (CMS)
- CR 1.E. – Medicare Exclusions/Sanction Policy (CMS/DHCS)
- CR 5.B. – Monitoring Medicare Opt-Out Reports (CMS)
- CR 5.C. – Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)
- CR 6.A. – Actions Against Practitioners
- CR 6.B. – Fair Hearing Panel Composition
- CR 7. – Assessment of Organizational Providers
  - CR 7.A. Review and approval of Providers.
  - CR 7.B. Medical Provider: Accreditation/Certification of Free-Standing Surgical Centers (FSSC).
  - CR 7.D. Assessing Medical Providers.
  - Medical Providers included in Delegates assessment.
- CR 8. – Delegation of Credentialing
  - CR 8.A. Written Delegation Agreement.
  - CR 8.C. Review of Delegate's Credentialing activities, as applicable.
  - CR 8.D. Opportunities for Improvement.
- CR 9.A. – Written Process for Identification of Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS) Specialists (Department of Managed Health Care [DMHC]/ DHCS)
- CR 9.B. – Evidence of Implementation (DMHC/DHCS)
- CR 9.C. – Distribution of Findings (DMHC/DHCS)

2) Delegate submits the following information for file review. Additional files will be requested if there is a deficiency or additional elements are required for the review.

INITIAL CREDENTIALING. Initial credentialing is only for those Practitioners who are initiating a contracted with the Delegate. A recredentialing file that was placed into the initial credentialing file pull due to being out of recredentialing timeframe limit will not be included in the initial credentialing files. It must be included in the universe of recredentialing files. If the Provider was terminated and the break in service was for more than ~~thirty (~~30~~)~~ days, and

was initially credentialed, the file will be audited as an initial credentialing file.

- RECREDENTIALING. If the Delegate does not have the necessary information for recredentialing, it informs the Practitioner that this information is needed at least ~~thirty (~~30~~)~~ calendar days before the recredentialing deadline and without this information, the Practitioner will be administratively terminated. The Delegate includes this notification in the Practitioners credentialing file. If the Practitioner is subsequently terminated for lack of information, the termination notice should be in the practitioner's file.[26] CR C3.A.2. – A valid DEA/CDS certificate (CMS)
    - Verification conducted within ~~one hundred eighty (~~180~~)~~ calendar days of Credentialing Committee decision.
- CR C3.A.5. – Work History (CMS)
    - Verification conducted within ~~one hundred eighty (~~180~~)~~ calendar days of Credentialing Committee decision.
- CR C3.B.2. – Medicare and Medicaid Sanctions (CMS/DHCS)
    - OIG must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.
- CR C3.C.1-6. – Credentialing Application (CMS)
    - Verification of questions completed, and attestation signed within ~~one hundred eighty (~~180~~)~~ calendar days of Credentialing Committee decision.

RECREDENTIALING. This applies to Practitioners who have undergone initial credentialing and are due for recredentialing, ~~thirty-six (~~36~~)~~ months thereafter, at minimum. The ~~thirty-six (~~36~~)~~ months recredentialing cycle begins on the date of the previous credentialing decision.

- CR R3.A.2. – A valid DEA/CDS certificate (CMS)
    - Verification conducted within ~~one hundred eighty (~~180~~)~~ calendar days of Credentialing Committee decision.
- CR R3.B.3. – Medicare and Medicaid Sanctions (CMS/DHCS)
    - OIG must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.
- CR R3.B.4. – Medi-Cal Sanction (DHCS)

[26] NCQA, 2023 HP Standards and Guidelines, CR 4, Element A

- Medi-Cal Suspended and Ineligible List must be the verification source. Date of query and staff initials must be evident on checklist or report must be in file.

- CR R3.C.1-6. – Application and Attestation (CMS)
  - Verification of questions completed, and attestation signed within ~~one hundred eighty (~~180~~)~~ calendar days of Credentialing Committee decision.
- CR R3.D. – Hospital Admitting Privileges (CMS/DHCS)
  - Send Documentation of coverage. Verification of admitting privileges required by IEHP.
- CR R3.E. – Medicare Opt-Out review (CMS)
  - Evidence reviewed via checklist or other documentation that indicates review of information from the most recent CMS.gov Opt-Out sites.
- CR R3.F. – Review of Performance Information (CMS/DHCS)
  - Must include Quality Improvement (QI) Activities and Grievance/Complaints, via checklist, reports, form/sheet detailing the Delegate's findings.

C. For delegation arrangements in effect for ~~twelve (~~12~~)~~ months or longer, IEHP will annually evaluate Delegates, including a review of policies and procedures and the documented process that ensure the Delegate's:[27]

1. Credentialing Committee or organization staff reviews the Delegate's credentialing policies and procedures. At a minimum, IEHP will reviews the sections of the policies and procedures that apply to the delegated functions.
   a. Credentialing Committee of the Delegates' staff annually reviews their subdelegate's credentialing policies and procedures, e.g., audit tool, audit correspondence, audit summary documentation, committee meeting minutes, and email approval noted in their database or other methods.
   b. IEHP does not accept accredited Health Plan audits for annual delegation audit for delegation arrangements between IEHP and IPAs. IEHP will review for evidence that IEHPs health plan audit was reviewed, e.g., audit tool, audit correspondence, committee minutes, email approval noted in their database or other methods indicating acceptance of review.
   c. If the Delegate subdelegates credentialing, IEHP will review the Delegates oversight

[27] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factors 1-6

for the credentialing and recredentialing files against NCQA, state and regulatory standards. IEHP bases its annual audit on the responsibilities of the Delegate described in the delegation agreement and provider manual that includes all the appropriate NCQA, state and regulatory standards.[28]

2. The organization uses one of the following methods to audit the files:[29]
    a. File Selection for pre-delegation audits, the IEHP auditor will:
        1) Generate a pull list from IEHP's Network Development Data Base (NDDB) that includes a list of all credentialed and recredentialed Providers submitted and added to the IEHP network by IPA, based on the look-back period. Then select forty (40) initial and forty (40) recredentialing files for the specified audit time period, using the NCQA 8/30 file methodology. When using the 8/30 NCQA file methodology, IEHP uses the following method:
            - After reviewing eight (8) files if any of those eight (8) files are non-applicable for that element (e.g. DEA), the IEHP auditor will review additional files to have a total denominator of eight (8).
            - After reviewing eight (8) files if one or more of the elements are non-compliant, review remaining files for the element's that are non-compliant. If the IPA has not initially credentialed or recredentialed at least ~~thirty (~~30~~)~~ files, IEHP will note that the file pull was exhausted.
        2) Obtain a spreadsheet or file of ~~ten (~~10~~)~~ initial and ~~ten (~~10~~)~~ recredential files from the Delegate. Additional files will be requested if there is a deficiency within the first eight (8) elements or additional elements are required for the review.
3. IEHP annually evaluates the Delegates performance against NCQA standards for delegated activities.
    a. The audit must include all pieces of the credentialing process (e.g. policies and procedures, file audit, etc.) as outlined in the written delegation arrangement and Credentialing Audit Tool (See Attachment, "Credentialing DOA Audit Tool" ~~in Section 25).~~found on the IEHP website.[30]
    b. If the organization is NCQA CR Accredited or Certified, IEHP must obtain a copy of the certification to ensure the delegate is certified to perform the activity being delegated by the organization.
        1) The following are not part of the NCQA certification/accreditation review, are not eligible for automatic credit and must be reviewed as part of the delegation

[28] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 1
[29] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 2
[30] https://www.iehp.org/en/providers/provider-resources?target=forms

oversight process. Delegate must submit copies of the following policies and procedures and other non-file elements.

- CR 1.A. – Practitioner Credentialing Guidelines. The Delegate specifies:
  - The types of Practitioners it credentials and recredentials.
  - The verification sources it uses.
  - The criteria for credentialing and recredentialing.
  - The process for making credentialing and recredentialing decisions.
  - The process for managing credentialing files that meet the organization's established criteria.
  - The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.
  - The process for notifying if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.
  - The process for notifying Practitioners the credentialing and recredentialing decision within ~~sixty (~~60~~)~~ calendar days of the Committee's decision.
  - The Medical Director or other designated Physician's direct responsibility and participation in the credentialing program.
  - The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.
  - The process for confirming that listings in Practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.
- CR 1.B. – Practitioner Rights. The Delegate specifies Practitioners about their right to:
  - Review information submitted to support their credentialing application.
  - Correct erroneous information (submitted by another source).
  - Receive the status of their credentialing and recredentialing application, upon request.
- CR 1.C. – Performance Monitoring for Recredentialing (CMS/DHCS)
- CR 1.D. – Contracts – Opt-Out Provisions (Medicare Opt-Out Policy)

(CMS)

- CR 1.E. – Medicare Exclusions/Sanction Policy (CMS/DHCS)
- CR 5.B. – Monitoring Medicare Opt-Out Reports (CMS)
- CR 5.C. – Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)
- CR 6.A. – Actions Against Practitioners
- CR 6.B. – Fair Hearing Panel Composition
- CR 7.A. – Assessment of Organizational Providers
  - Review and approval of Providers.
  - Medical Providers included in Delegates assessment.
  - Assessing Medical Providers.
  - Accreditation/Certification of Free-Standing Surgical Centers (FSSC)
- CR 8.A. – Delegation of Credentialing
  - Written Delegation Agreement.
  - Review of Delegate's Credentialing activities, as applicable.
  - Opportunities for Improvement.
- CR 9.A. – Written Process for Identification of HIV/AIDS Specialists (DMHC/DHCS)
- CR 9.B. – Evidence of Implementation (DMHC/DHCS)
- CR 9.C. – Distribution of Findings (DMHC/DHCS)

c. Delegate submits the following information for File Review. Additional files will be requested if there is a deficiency or additional elements are required for the review.

INITIAL CREDENTIALING. Initial credentialing is only for those Practitioners who are initiating a contracted with the Delegate. A recredentialing file that was placed into the initial credentialing file pull due to being out of recredentialing timeframe limit will not be included in the initial credentialing files. It must be included in the universe of recredentialing files. If the Provider was terminated and the break in service was for more than ~~thirty (~~30~~)~~ days, and was initially credentialed, the file will be audited as an initial credentialing file.

If the Delegate does not have the necessary information for recredentialing, it informs the Practitioner that this information is needed at least ~~thirty (~~30~~)~~ calendar days before the recredentialing deadline and without this information, the Practitioner will

be administratively terminated. The Delegate includes this notification in the Practitioners credentialing file. If the Practitioner is subsequently terminated for lack of information, the termination notice should be in the Practitioner's file.

1) CR C3.A.2. – A valid DEA/CDS certificate (CMS)
   - Verification conducted within ~~one hundred eighty (~~180~~)~~ calendar days of Credentialing Committee decision.
2) CR C3.A.5. – Work History (CMS)
   - Verification conducted within ~~one hundred eighty (~~180~~)~~ calendar days of Credentialing Committee decision.
3) CR C3.B.3. – Medicare and Medicaid Sanctions (CMS/DHCS)
   - OIG must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.
4) CR C3.B.4. – Medi-Cal Sanction (DHCS)
   - Medi-Cal Suspended and Ineligible List must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.
5) CR C3.C.1-6. – Application and Attestation (CMS)
   - Verification of questions completed, and attestation signed within 180 calendar days of Credentialing Committee decision.
6) CR C3.D. – Hospital Admitting Privileges (CMS/DHCS)
   - Send Documentation of coverage. Verification of admitting privileges required by IEHP.
7) CR C3.E. – Medicare Opt-Out review (CMS)
   - Evidence reviewed via checklist or other documentation that indicates review of information from the most recent CMS.gov Opt-Out sites.

   RECREDENTIALING. This applies to practitioners who have undergone initial credentialing and are due for recredentialing, ~~thirty-six (~~36~~)~~ months thereafter, at minimum. The thirty-six (36) months recredentialing cycle begins on the date of the previous credentialing decision.
8) CR R3.A.2. – A valid DEA/CDS certificate (CMS)
   - Verification conducted within ~~one hundred eighty (~~180~~)~~ calendar days of Credentialing Committee decision.
9) CR R3.B.3. – Medicare and Medicaid Sanctions (CMS/DHCS)

- OIG must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.

10) CR R3.B.4. – Medi-Cal Sanction (DHCS)

- Medi-Cal Suspended and Ineligible List must be the verification source. Date of query and staff initials must evident on checklist or report must be in file.

11) CR R3.C.1-6. – Application and Attestation (CMS)

- Verification of questions completed, and attestation signed within ~~one hundred eighty (~~180~~)~~ calendar days of Credentialing Committee decision.

12) CR R3.D. – Hospital Admitting Privileges (CMS/DHCS)

- Send Documentation of coverage. Verification of admitting privileges required by IEHP.

13) CR R3.E. – Medicare Opt-Out review (CMS)

- Evidence reviewed via checklist or other documentation that indicates review of information from the most recent CMS.gov Opt-Out sites.

14) CR R3.F. – Review of Performance Information (CMS/DHCS)

- Must include QI Activities and Grievance/Complaints, via checklist, reports, form/sheet detailing the Delegate's findings.[31]

4. IEHP evaluates regular reports, at minimum quarterly, of the credentialing activities delegated to the Delegate, to include reporting of the names or files of Practitioners or Providers processed by the delegate. The Quality or Credentialing Committee minutes may be assessed for this information.

   All Delegates are required to submit their quarterly reports via Secure File Transfer Protocol (SFTP) server. (See ~~Policy~~25B10, "Credentialing Standards – Credentialing Quality Oversight of Delegates"~~, in Section 25~~).

   a. Lists of credentialed practitioners.

      1) Delegates are required to submit quarterly reports that include all credentialing activities within the look-back period. The credentialing dates provided on this report is used to generate the audit pull list for the Annual Credentialing Delegation Oversight Audit.

   b. Lists of recredentialed practitioners.

      1) Delegates are required to submit quarterly reports that include all recredentialing

[31] NCQA, ~~2022~~ 2023 HP Standards and Guidelines, CR 8, Element C, Factor 3

activities within the look-back period. The recredentialing dates provided on this report is used to generate the audit pull list for the Annual Credentialing Delegation Oversight Audit.

- IEHP will review these reports and ensure all recredentialing packets due are accounted for.
    - IEHP will notify the Delegate for any missing packets, if a trend is identified, the Delegate may be required to submit a corrective action, to ensure the Delegates plan to ensure compliance is in place.

c. Terminations[32]

1) Delegates are required to report all terminations during the look back period to ensure the Delegates reported termination to IEHP timely.

2) For all terminations due to quality of care, IEHP will review appeals process for compliance.

d. Any compliance risks and areas of opportunities identified on the quarterly reports will be communicated to the Delegate, which may result in a Corrective Action Plan for the respective Delegate.[33]

1) Delegates identified for noncompliance due to untimely reporting, low performance, or incomplete and inaccurate reports will be required to submit monthly reports until the Delegate demonstrates improvement.

5. IEHP annually monitors the Delegate's system security controls to ensure that the Delegate monitors its compliance with the delegation agreement or with the Delegate's policies and procedures at least annually.[34]

a. IEHPs process for monitoring system security controls covers Delegates that store, create, modify, or use CR data on its behalf. If the organization contracts with such delegates, it:

1) Has a process for annually monitoring the delegate's CR system security controls in place to protect data from unauthorized modification?

2) Ensures that the Delegate annually monitors that it follows the delegation agreement or its own policies and procedures.

b. IEHP reviews all modifications made in all Delegates' CR systems during the look-back period that did not meet the modification criteria allowed by the delegation

[32] Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Supersedes APL 16-001, "Medi-Cal network Provider and Subcontractor Terminations"
[33] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 4
[34] NCQA, 2023 HP Standards and Guidelines, CR 1, Element C, Factor 1-5

agreement or by the delegates' policies and procedures.

1) If the Delegate's CR system does not allow modifications, the Delegate:

- Describes the functionality of the system that ensures compliance with the established policy.
- Provides documentation or evidence of advanced system control capabilities that automatically record dates and prevent modifications that do not meet modification criteria.

c. Auditing is allowed only if IEHP or the Delegate does not use a CR system that can identify all noncompliant modifications.[35]

1) Documentation includes the staff roles or department involved in the audit.

2) IEHP or the Delegate identifies all CR system modifications, but may use sampling to identify potential noncompliant changes for the audit.

3) The organization uses one of the following methods to audit files:

- Five (5) percent or ~~fifty (~~50~~)~~ of its files, whichever is less, to ensure that information is verified appropriately.
    - At a minimum, the sample includes at least ~~ten (~~10~~)~~ credentialing files and ~~ten (~~10~~)~~ recredentialing files. If fewer than ~~ten (~~10~~)~~ practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than the sample.

6. IEHP acts on all findings from Factor 5 for each Delegate and implements a quarterly monitoring process until each Delegate demonstrates improvement for one finding over three (3) consecutive quarters.

a. IEHP identifies and documents all actions it has taken, or plans to take, to address all modifications that did not meet the delegation agreement or the Delegate's policies and procedures, if applicable. One action may be used to address more than one finding for each Delegate or across multiple Delegates, if appropriate.

1) IEHP implements a quarterly monitoring process for each Delegate to assess the effectiveness of its actions on all findings.

- IEHP must continue to monitor each Delegate until the Delegate demonstrates improvement of at least one (1) finding over three (3) consecutive quarters.
- If a Delegate did not demonstrate improvement of at least one (1) finding during the look-back period, it submits all quarterly monitoring reports

[35] NCQA, 2023 HP Standards and Guidelines, CR 8, Element C, Factor 5

demonstrating ongoing monitoring.

- If IEHP identified findings less than three (3) quarters before the survey submission date, it submits all monitoring information it has available.

D. For delegation arrangements that have been in effect for more than ~~twelve (~~12~~)~~ months, at least once in each of the past two (2) years, the Delegate must follow up on opportunities for improvement.[36]

1. Findings from the Delegates pre-delegation evaluation, annual evaluations, file audits, or ongoing reports can be sources for identifying areas of improvement for which it takes actions.
2. The Delegate can use an accredited Health Plans' audit to look for opportunities of improvement.
   a. If the Delegate sees that the accredited Health Plan found opportunities for improvement, the Delegate reviews the following:
      1) The corrective action plan (CAP) from the subdelegated entity.
      2) Reviews to see if the audit and CAP were reviewed and approved, i.e. committee minutes, email approval or other method indicating acceptance of review of the CAP.

[36] NCQA, 2023 HP Standards and Guidelines, CR 8, Element D, Factor 1

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
8. Delegation of Credentialing

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2020	
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~~INLAND EMPIRE HEALTH PLAN~~		
~~**Chief Approval:** *Signature on File*~~	~~**Original Effective Date:**~~	~~January 1, 2020~~
~~**Chief Title:** Chief Operating Officer~~	~~**Revision Date:**~~	~~January 1, 2023~~

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards
9. Identification of HIV/AIDS Specialists

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers contracted under IEHPs Direct Network.

POLICY:

A. IEHP identifies Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS) Specialists during the credentialing and recredentialing process, and on an annual basis, reconfirms these Providers are appropriately qualified and continue to meet the definition of an HIV/AIDS Specialist.

PURPOSE:

A. To identify and reconfirm appropriately qualified network Providers, who meet the definition and requirements of an HIV/AIDS Specialist on an annual basis.

DEFINITION:

A. "Category 1 continuing medical education" means:[1]

1. For Physicians, continuing medical education as qualifying for category 1 credit by the Medical Board of California;
2. For Nurse Practitioners (NPs), continuing medical education contact hours recognized by the California Board of Registered Nursing; and
3. For Physician Assistants (PAs), continuing medical education units approved by the American Association of Physician Assistants.

PROCEDURES:

A. All credentialing and recredentialing applications include an HIV/AIDS form for all Practitioners to review and complete if they would like to be identified as an HIV/AIDS Specialist Provider (See ~~Attachment,~~ "Verification of Qualifications for HIV/AIDS Physician Specialists~~,~~" found on the IEHP website~~in Section 5~~[2]).

1. For all Physicians who complete the form and indicate "Yes, I do wish to be designated as an HIV/AIDS Specialist based on the criteria below," Credentialing will obtain the documents to support the criterion the Practitioner identified on the form.
    a. All Physicians who indicated "Yes, I do wish to be designated as an HIV/AIDS Specialist based on the criteria below," and met the criterion set forth in this policy

[1] Title 28~~,~~ California Code of Regulations (CCR)§ 1300.74.16(c)
[2] https://www.iehp.org/en/providers?target=forms

will be designated as an HIV/AIDS Specialist.

b. If the Physician indicated "Yes, I do wish to be designated as an HIV/AIDS Specialist based on the criteria below," and does not include the supporting documentation, the Credentialing Specialist will:

1) Make a minimum of three (3) attempts to collect this information from the Physician, which will be documented in the Practitioners file.

- If the Credentialing Specialist is unable to obtain the information from the Practitioner, the Practitioner will then be notified that they will not be listed in IEHPs network, as an HIV/AIDS Specialist due to not meeting the HIV/AIDS Specialist criterion as noted in this policy.

c. For all Physicians who indicated "No, I do not wish to be designated as an HIV/AIDS Specialist" or do not complete a form at all, they will not be identified as an HIV/AIDS Specialist in the IEHP network.

B. IEHP identifies and verifies the appropriately qualified Physicians who meet the definition of an HIV/AIDS Specialist. An "HIV/AIDS Specialist" is a Physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the State of California, who meets any one of the four (4) criteria below:[3]

1. Is credentialed as an HIV Specialist by the American Academy of HIV Medicine (AAHIVM);

   a. IEHP will verify the Physician's credentials on the American Academy of HIV Medicine website https://aahivm.org/.

2. Is board-certified, or has earned Certificate of Added Qualifications, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualifications, in the field of HIV medicine; or

   a. IEHP will verify the Physicians board certification(s) using the sources in Policy 05A1, "Credentialing Standards – Credentialing Policies"

3. Is board-certified in the field of Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

   a. In the immediately preceding ~~twelve (~~12~~)~~ months has clinical managed medical care to a minimum of ~~twenty-five (~~25~~)~~ patients who are infected with HIV; and

   b. In the immediately preceding ~~twelve (~~12~~)~~ months has successfully completed a minimum of ~~fifteen (~~15~~)~~ hours of category 1 continuous medical education (CME) in the prevention of HIV infection, combined with diagnosis, treatment, or both, of the HIV-infected patients, including a minimum of five (5) hours related to

[3] 28 CCR § 1300.74.16

antiretroviral therapy per year.

1) IEHP will verify the Physicians board certification(s) using the sources in Policy 05A1, "Credentialing Standards – Credentialing Policies"; and

2) IEHP will request for copies of those Continuing Medical Education (CME) credits and verify:

- The appropriate number of CMEs hours in the HIV Medicine or antiretroviral therapy, were completed.

4. Meets the following qualifications:

a. In the immediately preceding ~~twenty-four (~~24~~)~~ months has clinically managed medical care to a minimum of ~~twenty (~~20~~)~~ patients who are infected with HIV; and

b. Has completed any of the following:

1) In the immediately preceding ~~twelve (~~12~~)~~ months has obtained board certification or recertification in the field of infectious disease from a member board of the American Board of Medical Specialties; or

2) In the immediately preceding ~~twelve (~~12~~)~~ months has successfully completed a minimum of ~~thirty (~~30~~)~~ hours of category 1 CME in the prevention of HIV infection, combined with diagnosis, treatment of both, of HIV-infected patients.

- IEHP will verify the Physicians board certification(s) using the sources in Policy 05A1, "Credentialing Standards – Credentialing Policies";
- IEHP will request for copies of those Continuing Medical Education (CME) credits and verify; and
- The appropriate number of CMEs hours in the Prevention of HIV Infection, combined with diagnosis, treatment of both of HIV-infected patients, were completed.

3) In the immediately preceding ~~twelve (~~12~~)~~ months has successfully completed a minimum of ~~fifteen (~~15~~)~~ hours of category 1 CME in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competence Examination administered by the American Academy of HIV Medicine.

4) IEHP will request for copies of those CME credits and verify:

- The appropriate number of CMEs hours in the Prevention of HIV Infection, combined with diagnosis, treatment of both of HIV-infected patients, were completed.

5) IEHP will request for a copy of the Exam Verification of the HIV Medicine Competence Examination administered by the American Academy of HIV

Medicine.

C. On an annual basis, IEHP sends a blast fax to all Direct Network Providers, to confirm which Providers would like to be listed as HIV/AIDS Specialist Providers, ensure IEHP identifies or reconfirms the appropriately qualified Physician who meet the definition of an HIV/AIDS Specialist.

1. The annual screening is faxed to all Direct Primary Care Providers (PCPs) and Specialists.
2. The blast fax is sent by IEHPs Provider ~~Services Administration~~Communications Team and then the list of Providers is provided to the Credentialing Department track the Physician responses.
3. The annual screening is completed within ~~twelve (~~12~~)~~ months of the prior year's annual screening.
4. For Physicians currently listed in the network as an HIV/AIDS Specialist, the Credentialing Department will reconfirm if the Provider still meets the criterion to be listed as a HIV/AIDS Specialist.

D. The list of identified qualifying Physicians is provided to the department responsible for authorizing standing referrals through our Network Development Database in real time and is available upon request to the Credentialing Department.[4,5]

[4] 28 CCR §1300.74.16
[5] Department of Health Care Services (DHCS) All Plan Letter (APL) 02-001, "Medi-Cal HIV/AIDS Home and Community Based Services Waiver Program"

5. CREDENTIALING AND RECREDENTIALING

A. Credentialing Standards

9. Identification of HIV/AIDS Specialists

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
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5. CREDENTIALING AND RECREDENTIALING

B. Hospital Privileges

APPLIES TO:

A. This policy applies to all IEHP DualChoice (HMO D-SNP) Providers.

POLICY:

A. IEHP and IPAs must ensure that all of their contracted and subcontracted Practitioners have Hospital admitting arrangements at a designated IEHP contracted Hospital,[1] within a fifteen (15) mile radius or thirty (30) minute travel time from their assigned Member's residence.[2,3] In rural areas, or in specific situation IEHP may approve PCP links to Hospitals outside of these standards (See Policy 18H, "Hospital Affiliations").

B. IEHP and its Delegates must ensure that all their contracted and subcontracted Specialist Practitioners (in the appropriate specialties) must have a formal inpatient coverage arrangement at an IEHP contracted Hospital, with a specialist within the same practice and specialty. If the Practitioner does not have clinical admitting privileges, a written statement delineating the inpatient coverage arrangement, which must be documented in the Provider's file.[4]

C. Practitioners who provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services (i.e. Certified Nurse Midwives, Obstetrics/Gynecology [OB/GYN], Family Practice 1, Family Practice 2, Licensed Midwives) must have appropriate hospital arrangements in place.[5]

PURPOSE:

A. No enrollment is given to any PCP until appropriate and complete arrangements for Hospital admissions are in place and verified by IEHP.

B. In the event it is discovered that a PCP with assigned enrollment does not have privileges at the designated IEHP contracted Hospital, and the IPA has not made arrangements with other Practitioners to provide admitting and inpatient care services for that Practitioner, IEHP may freeze the membership of the PCP and/or transfer these Members immediately. The IPA may request to unfreeze or open the Provider's panel once they provide appropriate arrangements with other Practitioners to provide admitting inpatient care services for that Practitioner.

C. IEHP and its IPAs must have established processes for outpatient and inpatient Utilization Management.

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[1] Title 28, California Code of Regulations (CCR) §1300.51 (d)(H)(iii)
[2] Knox-Keene Health Care Service Plan Act of 1975, § 1300.67.2.2~~KKA § 1300.67.2.2~~
[3] Department of Health Care Services (DHCS) All Plan Letter (APL) ~~21-006~~23-001 Supersedes APL ~~20-003~~21-006, "Network Certification Requirements"
[4] 28 CCR §1300.51 (d)(H)(iii)
[5] Ibid.

5. CREDENTIALING AND RECREDENTIALING

B. Hospital Privileges

DEFINITIONS:

A. Hospitalist: A doctor who primarily takes care of patients when they are in the hospital. This doctor will oversee a Member's care when the Member is inpatient, keeping the Member's primary doctor informed about the Member's progress, and will return the Member to the care of your primary care doctor when the Member is discharged from the hospital.[6]

B. Hospitalists do not need to be credentialed. They are Practitioners who practice exclusively in an inpatient setting and provide care for organization Members only because Members are directed to the hospital or another inpatient setting.

C. Admitting Physician: The doctor responsible for admitting a patient to a Hospital or other inpatient health facility.[7]

PROCEDURES:

~~A. IEHP requires its IPAs to ensure that all of their contracted and subcontracted Practitioners have privileges at a designated IEHP contracted Hospital.[8] The contracted Hospital must be within a thirty (30) mile radius or forty-five (45) minute travel time from their assigned Members' residence.[9] In rural areas, or in specific situations, IEHP may approve PCP links to Hospitals outside of these standards.~~

A. PCP will be added to the Hospitals requested by IEHP or its IPA, where they meet the following requirements:

1. Mileage and time standards, set forth in this policy
2. Practitioner has an acceptable hospital admitting arrangement for that Hospital documented on the Provider profile, upon initials submission to the IEHP network, that includes one (1) of the following:

~~1)~~a. Practitioner holds their own admitting privileges in the specialty they are practicing; or

~~2)~~b. Practitioner utilizes a physician within the same practice, specialty, who is credentialed and contracted within the same network, contingent that they hold admitting privileges to the respective hospital; or

~~3)~~c. Practitioner utilizes the IPAs Hospitalist (applicable to PCPs only) for that Hospital and IEHP has been provided a copy of one of the following:

[6] CMS.gov (Glossary)
[7] Ibid.
~~[8] 28 CCR §1300.51 (d)(H)(iii)~~
~~[9] CMS Medicare-Medicaid Plan (MMP) Application & Annual Requirements, CY 2020 MMP Health Service Delivery Network Adequacy Standards Criteria Reference Table~~

~~1.~~• A completed Hospital Admitter Arrangement Attestation – Hospitalist (See Attachment, "Hospital Admitting Arrangement Attestation – Hospitalist" ~~in Section 5~~found on the IEHP website.[10]); or

~~2.~~• Submit a written agreement between the IPA and Hospitalist Group that includes the following:

- Name of the IPA and Hospitalist;
- Hospitalist \ covered age range;
- Hospitals where the Hospitalist will admit;
- Hospitalist Phone;
- Hospitalist Fax Number;
- Hospitalist National Provider Identifier (NPI);
- Hospitalist W-9;
- The agreement must stipulate a minimum of thirty (30) days advance notice of intent to terminate by either party. Notice of termination must be submitted to IEHP within five (5) days of the IPAs knowledge of pending termination; and
- The agreement must also specify that bills for services rendered are submitted to and paid by the IPA.

~~4)~~d. Practitioner utilizes an Admitter contracted by the IPA (applicable to PCPs only), for that Hospital and IEHP has been provided a copy of one of the following:

~~1.~~• A completed Hospital Admitting Arrangement Attestation – Admitting Physician Attestation (See Attachment, "Hospital Admitting Arrangement Attestation – Admitting Physician" ~~in Section 5~~found on the IEHP website[11]); or

~~2.~~• Submit a written agreement between the IPA and Admitting Physician, that includes the following:

- Name of the IPA and Admitter
- Admitter's covered age range;
- Hospitals where the Admitter will admit;
- Admitter's Phone Number;
- Admitter's Fax Number;

[10] https://www.iehp.org/en/providers/provider-resources?target=forms
[11] Ibid.

- Admitter's NPI;
- Admitter's W-9 & TIN;
- Name(s), Specialties and NPI's of the Physicians affiliated with the Admitter Agreement
- The agreement must stipulate a minimum of thirty (30) days advance notice of intent to terminate by either party. Notice of termination must be submitted to IEHP within five (5) days of the IPAs knowledge of pending termination; and
- The agreement must also specify that bills for services rendered are submitted to and paid by the IPA.

~~5)~~e. IEHP does accept utilization of a rotating on-call Hospitalist arrangement, however these arrangements are subject for review and approval. The following arrangements have been reviewed and accepted by IEHP:

- Arrowhead Regional Medical Center
- Loma Linda University Medical Center
- Riverside County Regional Medical Center

f. Utilization of a rotating on-call Hospitalist arrangement are subject to IEHP review and approval. For consideration, please submit the following:

- Name of the IPA and Name of On-Call Hospitalist;
- On-Call Hospitalist covered age range;
- Hospitals where the On-Call Hospitalist will admit;
- On-Call Hospitalist Phone;
- On-Call Hospitalist Fax Number;
- On-Call Hospitalist NPI; and
- On-Call Hospitalist W-9.

~~2.~~3. Upon receipt of the written admitting arrangements, IEHP verifies:

a. The Hospitalist Admitting arrangements can collectively cover admissions for all ages for the IPA and respective Hospital;

b. The Hospitalist Admitter arrangements have confirmed admitting privileges to Hospitals they are admitting to, are in place and in good standing; and

~~3.~~4. If there are any gaps or missing information, the Credentialing Specialist will reach out to the IPA and Provider Services Representative (PSR) and notify them of the discrepancy.

a. The IPA will be responsible for providing the alternate arrangements. The Credentialing review process resumes after the gap has been addressed accordingly.

~~4.~~5. Once the information is confirmed with the Credentialing Specialist and Provider Services Representative, the PCP is added to the network, with an effective date on the 1st of the following month.

B. IEHP and its Delegates must ensure that all of their contracted and subcontracted Specialist Practitioners (in the appropriate specialties) (See Attachment, "Hospital Admitting Privileges Reference by Specialty" ~~in Section 5~~found on the IEHP website[12]) must have a formal inpatient coverage arrangement[13] at an IEHP contracted Hospital, with a specialist within the same practice and specialty. If the Practitioner does not have clinical admitting privileges, IEHP and its Delegates must obtain a written statement delineating the inpatient coverage arrangement which must be documented in the Provider's file.

~~A.~~1. The Admitting Physician used for Specialists must be within the same practice and specialty as the non-admitting Physician.

~~B.~~2. All Specialists who are using an Admitting Physician to admit on his/her behalf, the hospital admitting arrangement will be added to the Hospitalist Admitter Report for review and maintenance by the Delegates on a monthly basis, thereafter.

C. Practitioners who provide care of mothers and newborns through the maternity cycle of pregnancy, labor, birth and delivery services (i.e. Nurse Midwives, Obstetrics/Gynecology, Family Practice 1, Family Practice 2 Providers, Licensed Midwives) must have the following arrangements in place:

1. Nurse Midwives (NM) Providers must meet the following criteria:

   a. In lieu of having full hospital delivery privileges, provide a written agreement with an OB Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc.), must be available for consultations, as needed.

      1) The Agreement must include back-up Physician's full delivery privileges at IEHP network hospital, in the same network as the NM Provider.

         - The OB Provider must be credentialed and contracted within the same practice and network.

2. Family Practice 1: Family Practice that includes Outpatient OB services must:

   a. Provide a copy of a signed agreement that states member transfers will take place within the first twenty-eight (28) weeks of gestation and a protocol for identifying and transferring high risk Members with a contracted and credentialed OB (See Attachment, "Patient Transfer Agreement"', ~~in Section 5~~found on the IEHP

[12] https://www.iehp.org/en/providers/provider-resources?target=forms
[13] 28 CCR §1300.51 (d)(H)(iii)

website[14]).

b. The OB must be within the same network as the Family Practice Provider and hold admitting privileges to the IEHP contracted Hospital linked with that IPA network.

3. Family Practice 2: Family Practice that includes full OB services and delivery must:
   a. Have and maintain full delivery privileges at an IEHP contracted Hospital.
   b. Provide a written agreement for an available OB back up Provider is required.
      1) The OB Provider must be credentialed, contracted and hold admitting privileges to the IEHP Hospital linked with the Family Practice Provider; and
      2) Provide a protocol for identifying and transferring high risk Members and stated types of deliveries performed (i.e. low-risk, cesarean section, etc).
4. OB/GYN Providers who would like to participate as a PCP only, will provide outpatient well woman services only with no Hospital or surgical privileges, must provide the following information for consideration:
   a. In lieu of having full Hospital delivery privileges, provide a written agreement with an OB/GYN Provider, that includes a protocol for identifying and transferring high risk Members, stated types of deliveries performed (i.e. low-risk, cesarean section etc), must be available for consultations as needed and that the OB will provide prenatal care after twenty-eight (28) weeks gestation including delivery (See Attachment, "Patient Transfer Agreement" ~~in Section 5~~found on the IEHP website[15]).
      1) The Agreement must include back-up Physician's full delivery privileges at IEHP network Hospital, in the same network as the non-admitting OB Provider.
      2) The OB Provider must be credentialed and contracted within the same network.
   b. These OB/GYNs provide outpatient well woman services only with no Hospital or surgical privileges. This exception must be reviewed and approved by IEHP Medical Director or Chief Medical Officer. Further review may be completed by the Peer Review Subcommittee who will either approve or deny.
5. Obstetrics/Gynecology (OB/GYN) Specialists must provide have full delivery privileges at an IEHP network hospital or have an arrangement with a Obstetrics/Gynecology Specialist practicing within their same practice, credentialed and contracted with IEHP, who will admit patients on their behalf. This arrangement must be documented in the Provider's credentialing application.[16]
6. Licensed Midwives (LM) Providers who are authorized to attend cases of normal

[14] https://www.iehp.org/en/providers/provider-resources?target=forms
[15] Ibid.
[16] 28 CCR §1300.51 (d)(H)(iii)

pregnancy and childbirth, and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. To assist a woman in childbirth as long as progress meets criteria accepted as normal. LMs must meet the following criteria:

a. In lieu of having full hospital delivery privileges, provide a completed Licensed Midwife Attestation, (See Attachment, "Licensed Midwife Attestation", ~~in Section 5~~found on the IEHP website[17]).

[17] https://www.iehp.org/en/providers/provider-resources?target=forms

INLAND EMPIRE HEALTH PLAN		
Regulatory/ Accreditation Agencies:	☐ DHCS	☐ CMS
	☐ DMHC	☐ NCQA
Original Effective Date:	January 1, 2007	
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~~INLAND EMPIRE HEALTH PLAN~~		
~~**Chief Approval:** *Signature on file*~~	~~**Original Effective Date:**~~	~~January 1, 2007~~
~~**Chief Title:** Chief Operating Officer~~	~~**Revision Date:**~~	~~January 1, 2023~~