

CENCAL HEALTH POLICY AND PROCEDURE	
Title: Provider Credentialing and Recredentialing	Policy No.: PS-CR03
Department: Provider Services	
Cross Functional Departments: Quality	
Effective Date: 01/2024	Last Revised Date: 05/2024
P&P Require DHCS Approval? Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Director/Officer Signature: Luis Somoza, Director of Provider Services	Officer Signature: Jordan Turetsky Chief Operations Officer

I. Purpose:

To ensure that CenCal Health’s Network Providers and practitioners meet and will continue to meet all professional licensing and performance credentialing requirements necessary in order to provide CenCal Health members at all times with the highest level of medical, hospital and behavioral health care possible. Also, to ensure that participating providers, practitioners, and physician executives meet basic qualifications before providing services to members of CenCal Health programs.

II. Policy:

- A. CenCal Health and its fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors shall maintain written policies and procedures for the initial credentialing, recredentialing, recertification and reappointment of all Network Providers and practitioners that render acute, primary, and/or behavioral health services to assigned members, in accordance with 42 CFR section 438.214 and Part 2 of the Department of Health Care Services (DHCS) APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.
- B. CenCal Health ensures Network Providers and practitioners who deliver covered services to Members are qualified in accordance with applicable standards and are licensed, certified or registered, as appropriate. This policy also defines the credentialing of physicians and physician executives who serve in an administrative capacity for CenCal Health, and who make decisions regarding Utilization Management, Case Management, Quality Improvement, Member Satisfaction, Peer Review, Pharmacy & Therapeutics, or other decisions affecting clinical care or services for members of CenCal Health programs. Providers and practitioners are informed of the credentialing policy and procedure through their Provider contract agreements and amendments, CenCal Health’s Provider Manuals, CenCal Health’s website, Provider Bulletin articles, and other materials issued by CenCal Health.

III. Procedure:

- A. The CenCal Health credentialing and recredentialing functions are a component of the Quality Improvement and Health Equity Transformation Program which is overseen by the Quality Improvement and Health Equity Committee (QIHEC). The Provider Credentials Committee (PCC) is a subcommittee of the QIHEC, chaired by the CenCal Health Chief Medical Officer or designee, and comprised of at least six (6) credentialed Network Providers or practitioners. The PCC's functions include:
1. Reviewing provider's and practitioner's requests for participation in CenCal Health's provider network; and
 2. Providing final decisions regarding initial or subsequent credentialing based on clinical competency and professional conduct.
- B. Providers To Be Credentialed
1. The scope of the Network Providers and practitioners to be credentialed and recredentialled by CenCal Health under this policy include all licensed and contracted Medical Doctors (MDs), Doctors of Osteopathy (Dos), Doctors of Podiatric Medicine (DPMs), Doctors of Chiropractic (DCs), doctoral level behavioral health practitioners (PhDs, PsyDs), any dentists who provide services under medical benefits (e.g., oral surgeons, DDSs); non-physician behavioral health practitioners such as licensed marriage and family therapists (LMFTs), licensed clinical social workers (LCSWs), professional clinical counselors, (PCCs), board certified behavior analysts (BCBAs); non-physician medical practitioners such as nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNMs) and certified nurse anesthetists (CRNAs); and non-physician non-licensed independent practitioners such as registered dietitians (RDs) and physical therapists (PTs). CenCal Health will credential and recredential:
 - a. All Network Providers and practitioners who have a contracted, independent relationship with CenCal Health
 - b. All Network Providers and practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities.
 - c. All physician executives who serve in an administrative capacity for CenCal Health or contracted groups.
 - d. All Network Providers and practitioners who are hospital-based but see CenCal Health's members as a result of their independent relationship with CenCal Health. An example of this type of practitioner would be an anesthesiologist with pain management practice.
 2. CenCal Health will *not* credential or recredential:
 - a. Providers or practitioners who practice exclusively within the inpatient setting and who provide care for CenCal Health's members only as a result of the members obtaining care at the hospital or inpatient setting.
 - b. Providers or practitioners who practice exclusively within freestanding facilities and who provide care for CenCal Health's members only as a result of the members obtaining care at the facility.

C. Non-Discrimination Policy for Network Providers and Practitioners

1. No provider or practitioners shall be denied an agreement with CenCal Health, have any corrective actions imposed, or have his/her agreement suspended or terminated solely on the basis of race, color, age, gender, marital status, sexual orientation, religious creed, ancestry, national origin, physical or mental disability, or the types of procedures or the patients in which the provider or practitioner specializes. The PCC membership is heterogeneous, and all members are required to sign a non-discrimination statement.

D. Confidentiality of Credentialing Information

1. Applications and supporting documents are saved in folders with access limited to credentialing staff and CenCal Health medical directors responsible for the credentialing process.
2. Credentialing data from the applications and supporting documents is entered and stored electronically on CenCal Health's secured credentialing database.
 - i. Access to the database is set to user functions, with "write" functionality authorized only for credentialing staff.
3. Completed electronic files are saved to subfolders within the access-limited credentialing folder designated for the credentialing manager/supervisor for review, then for the medical directors for review and recommendation.
4. "Clean" files are approved via the medical director signature and saved to a corresponding access-limited subfolder.
5. Files requiring review by the CenCal Health Provider Credentials and Peer Review Committee (PCC) are held in the access-limited review subfolder pending the PCC's decision.
6. Credentialing staff work virtually and are unable to connect to an external printer or print documents remotely.

E. Provider Directory Data

1. Provider data published in the print and online versions of the Provider Directory is derived from the credentialing process.
2. Following approval of initial or recredentialing, provider data verified through the credentialing process is provided to the Provider Services Data Specialists for entry into the provider data subsystem. This includes, but is not limited to licensure, specialty, board certification, and hospital affiliation. This subsystem is the source of all provider data reporting, including Provider Directory data.
3. In addition to data entry audits performed monthly by Provider Services staff, a quarterly comparison is made between the provider data subsystem and the credentialing database.
4. More information on Provider Directory creation and maintenance can be found in CenCal Health's PS-PS101 Provider Directory Creation and Maintenance policy.

F. Credentialing Application and Letter

1. A credentialing application, attestation, and contract agreement must be completed, signed, and returned to CenCal Health by each provider and practitioner interested in participation.
2. The application and cover letter outline:
 - a. The provider's/practitioner's right to review the information obtained from outside sources (e.g., malpractice insurance carriers, state licensing boards) to support their credentialing application. CenCal Health is not required to make available:
 - References
 - Recommendations
 - Peer-review protected information
 - b. The provider's/practitioner's right to correct erroneous information, including:
 - The time frame for making corrections.
 - The format for submitting corrections.
 - Where to submit corrections
3. CenCal Health is not required to reveal the source of information that was not obtained to meet verification requirements if federal or state law prohibits disclosure.
4. CenCal Health documents receipt of corrected information in the practitioner's credentialing file.
 - a. The provider's/practitioner's right to be informed of the status of his/her application during the credentialing process, upon request. This includes which information CenCal Health is allowed to share with practitioners and the process for responding to requests for application status.
5. The application for Network Provider and practitioner credentialing requires a signed and dated attestation, which includes, but is not limited to, the following statements by the applicant regarding:
 - a. Any limitations or disabilities that affect the practitioner's ability to perform any of the position's essential functions, with or without accommodation.
 - b. Lack of present illegal drug use
 - c. History of loss of license and felony convictions
 - d. History of loss or limitation of privileges or disciplinary activity
 - e. Current adequate malpractice insurance coverage as per the Physician Service Agreement
 - f. The application's accuracy and completeness.
6. The application requests a copy of the current Drug Enforcement Administration (DEA) certificate (if applicable), malpractice insurance policy face sheet indicating term and liability limits, and written documentation of:
 - a. All work history activities since completion of postgraduate training, either on the application or a Curriculum Vitae, with a written or verbal

explanation of any gaps of six (6) months or more in the work history (gaps in work history exceeding one year must be explained in writing)

- b. An explanation of all positive answers to attestation questions on the application.
7. The application also requests information regarding board certification, professional training, Educational Commission of Foreign Medical Graduates (ECFMG) (if applicable), clinical privileges, felony convictions, malpractice history, Medicare and Medi-Cal certificate numbers, and pertinent information regarding office features.

G. Initial Credentialing

1. All Network Providers must have executed Network Provider agreements with CenCal Health and must be qualified in accordance with current applicable legal, professional, and technical standards, including appropriate licensure, certification, or registration as required by state and federal law.
2. All Network Providers and practitioners must have a valid National Provider Identifier (NPI) number.
3. All contracted Laboratory Testing Sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.
4. CenCal Health shall conduct onsite reviews of its Network Provider sites but may accept evidence of National Committee on Quality Assurance (NCQA) Provider Organization Certification (POC) in lieu of a monitoring visit at the Network Provider's site. Conversely, CenCal Health may choose to seek POC from the NCQA which would allow CenCal Health to be exempt from DHCS' medical review audit of credentialing practices, while retaining overall responsibility for ensuring that credentialing requirements are met.
5. All verifications, attestations, and information releases will be less than 180 days old (or for some, 365 days) at the time of the credentialing decision as per NCQA standards.

H. Initial Primary Source Verification

1. At time of credentialing, at least the following information is verified from the primary source or an NCQA approved verification source:
 - a. A current valid license to practice in the State of California, verified with the Medical Board of California, Dental Board of California, the California Board of Chiropractic Examiners, or Board of Registered Nurses. Alternate means of verification include entry in the AOA or AMA Physician Master Files. CenCal Health retains the right to decline to accept an initial credentialing application from a practitioner whose license is on probation or otherwise not free and unencumbered.
 - b. The status of clinical privileges at any contracted inpatient facility within CenCal Health's service area is listed by the practitioner on the application, if applicable, by contacting the facility's medical staff office. If an applicant does not have adequate clinical privileges, as determined

by the practitioner's agreement with CenCal Health, the practitioner must supply the name(s) of any practitioner(s) who will admit members to a contracted inpatient facility on their behalf, (known as a "covering practitioner"). Covering practitioners must be participating practitioners in CenCal Health's network and must have a specialty that is comparable to that of the practitioner he is covering. A practitioner may also designate the hospitalist program at a contracted inpatient facility as his inpatient coverage.

- c. A valid DEA certificate, as applicable, obtaining a photocopy of the original certificate. Alternate means of verification include documented visual inspection of the original certificate, or entry in the AMA or AOA Physician Master Files. If a practitioner does not have all schedules on their DEA certificate, CenCal Health will contact the practitioner for an explanation of the missing schedules and the practitioner's plan for continuity of care.
2. Education and training of Network Providers. If the practitioner is not board certified, CenCal Health verifies the practitioner's highest level of education and training, by contacting the school or residency program. Practitioners' specialties will be listed in CenCal Health's Provider Directory according to their highest level of education and training: i.e., board certification or completed residency in their indicated specialty. Any practitioner not meeting the above criteria will be listed as a General Practitioner in the Provider Directory. A practitioner wishing to contract as a Primary Care Provider (PCP) must have completed a residency in a field that qualifies them to act as a PCP. CenCal Health has determined that residency programs meeting these criteria include Internal Medicine, Family Practice, and Pediatrics.
 3. If the Network Provider or practitioner has been identified as an HIV/AIDS Specialist, the following additional criteria are verified prior to indicating this sub-specialty in provider listings:
 - a. Provider or practitioner is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; OR
 - b. Is board certified, or has earned a Certificate of Added Qualification, 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 Qualification, in the field of HIV medicine; OR
 - c. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
 - i. In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; AND
 - ii. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing

- medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of five (5) hours related to antiretroviral therapy per year; OR
- iii. Meets the following qualifications:
 - a) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; AND
 - b) Has completed any of the following:
 - 1) In the immediately preceding 12 months has obtained board certification or re-certification in the field of infectious diseases from a member board of the American Board of Medical Specialties; OR
 - 2) In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; OR
 - 3) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category one (1) continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.
 - iv. Board certification. If the Network Provider or practitioner states that he/she is board certified on the application, certification is verified through the specific board, the ABMS, or entry in the AMA or AOA Physician Master Files.
 - v. History of professional liability claims by querying the NPDB. Sanction information by querying the NPDB, HIPDB, CIN-BAD, the appropriate state medical boards, and/or the AMA/AOA Physician Master Files.
 - vi. Medicare/ Medicaid sanctions by querying the NPDB, CIN-BAD, or OIG. Also monitored via Suspended & Ineligible Provider List & Excluded Parties List System.
 - vii. All Network Providers and practitioners must have good standing in the Medicare and Medicaid/Medi-Cal programs. Providers and practitioners that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in CenCal Health's provider network.
6. Initial Credentialing Site Visits. For all PCPs, a Facility Site Review of the provider's primary care office location(s), including an audit of patients'

medical records, is performed by a CenCal Health nurse reviewer who is certified by DHCS to perform these site and medical record reviews. The facility review evaluates the office or clinic as compared to CenCal Health's and the Department of Health Care Services' standards. The medical record review evaluates the documentation of appropriate care to ensure conformity with CenCal Health's and the Department of Health Care Services' standards.

I. Recredentialing

1. The Recredentialing process is repeated at least every three years but may be repeated more frequently when required by a change in relevant information or at the direction of the PCC. Network Providers, practitioners and physician executives are recredentialed within three years of their last credentialing date, which is the date the PCC rendered their decision regarding the provider's or practitioner's participation.
2. Recredentialing Primary Source Verification. During recredentialing, at least the following information is verified from the same primary sources as those used for initial credentialing:
 - a. A valid California state license to practice
 - b. A valid DEA certificate (if applicable). If a practitioner does not have all schedules on his DEA Certificate, CenCal Health will request an explanation of the missing schedules and the practitioner's plan for continuity of care.
 - c. Malpractice insurance is current and adequate.
 - d. The status of clinical privileges at all contracted hospitals within CenCal Health's service area that the practitioner lists on the application (as applicable)
 - e. Board certification if the practitioner states that he/she is board certified.
 - f. If the practitioner has been identified as an HIV/AIDS Specialist, the criteria described in the "Initial Primary Source Verification" section of this policy is re-verified in order to continue indicating this sub-specialty in provider listings.
3. History of professional liability claims.
4. Sanctions Information. The Medical Board of California, the NPDB, and CIN-BAD (as applicable) are queried for any reported sanctions or actions against the practitioner's license since the last review. Sanction information may also be identified through querying the HIPDB or entry in the AMA/AOA Physician Master Files. If the practitioner has been licensed in another state within the past five years, that state's medical board will be contacted for status and sanction history.
5. For PCPs and specialty care providers, the Provider Credentials Committee incorporates the following minimum quality data in its recredentialing review:
 - a. Member grievance data as reported by Member Services Department. All member complaints in the previous credentialing cycle will be

documented in the practitioner's file, but only those complaints that meet or exceed the following criteria are brought to the PCC for review:

- i. *Pattern*: 3 or more complaints of the same type in the previous credentialing cycle
 - ii. *Severity*: 3 or more "with merit" in the previous credentialing cycle
6. Provider complaint data as reported by Provider Services Department
 7. Information from quality improvement activities, which may include routine medical record audits as appropriate, and any quality-of-care concerns known to CenCal Health that may be useful to the Committee in making an informed recommendation regarding clinical competency and/or professional conduct. Quality of care concerns include those reviewed by the Chief Medical Officer, Health Services Department, and by other committees of CenCal Health, including but not limited to peer review. Peer review activities are overseen by CenCal Health's Chief Medical Officer or medical director designee, in coordination with all credentialing considerations.
 8. Recredentialing Site Visits. An office visit and assessment of medical record keeping practices is conducted for all PCP practice sites within the three-year period before a recredentialing decision. PCPs must attain a passing score on facility and chart audit or submit a corrective action plan if required within the specified time frame.
 9. Continuous Monitoring of credentials. In order to verify that all providers' and practitioner's licenses, DEA certificates, and liability coverage have not lapsed during the three-year recredentialing cycle, CenCal Health will routinely request current documentation either via the internet or by contacting the provider or practitioner.
 10. Continuous Monitoring of quality and performance. The Health Services Division staff and Chief Medical Officer (CMO) also routinely monitor quality issues that may impact on the credentialing process, including member/provider complaints and other quality of care concerns.
 - a. Under the direction of the CMO, Quality Improvement nurses provide a report for review by credentialing staff and the PCC, detailing all Quality-of-Care issues and adverse events, including injury sustained by a member while receiving health care from a network practitioner. See also CenCal Health's QU-20 Quality of Care Investigations policy.
 11. Continuous Monitoring of sanctions. CenCal Health routinely monitors medical board actions by obtaining real-time reports via e-mail subscription.

J. Provider/Practitioner Rights

1. Provider/Practitioner Rights (Addendum A of the application) is sent with initial credentialing and/or recredentialing applications. This includes:
 - a. If any information obtained during the initial credentialing and/or recredentialing primary source verification varies substantially from the information provided, a letter or email will be sent notifying them of the discrepancy.

- b. The Provider/Practitioner is allowed 30 business days to provide a written explanation to the Medical Director or designee and/or correct any erroneous information.
- c. The letter will indicate to the Provider/Practitioner that not responding within the defined timeframe might cause a delay in processing their application.
- d. On request, the Credentialing Specialist notifies Providers/Practitioners of the status of their credentialing/recredentialing application.

K. Provider/Practitioner Application Recommendations and Actions

- 1. A file with no issues, or “clean” files may be approved via Medical Director signature. NCQA recognizes the Medical Director sign-off date as the approval date. A clean file is defined as the following:
 - a. Education and Training Verification:
 - i. Confirmation of relevant education credentials.
 - ii. Validated completion of required residency or fellowship programs, if applicable.
 - iii. Alignment with specialty or practice area requirements.
 - b. Licensure and Certification:
 - i. Valid and unrestricted state licensure or certificate with no current disciplinary actions or sanctions. No history of loss of licensure or felony convictions.
 - ii. Current, unrestricted DEA certification if applicable. Must not be involuntarily excluded from any schedules. Practitioners may voluntarily not hold all schedules or have prescribing coverage from another credentialed provider.
 - iii. Verified board certification (board certification not required to join provider network).
 - c. Work History and Professional Experience:
 - i. Complete 5-year work history present with employment dates in MM/YYYY – MM/YYYY format. Explanations provided for any gaps greater than 6 Months.
 - ii. Verified clinical admitting privileges or alternative arrangements without history of loss, limitation, or disciplinary actions.
 - iii. No Quality of Care (QOC) concerns identified by Health Services staff during recredentialing cycle.
 - d. Malpractice Claims History Within the Past 7 Years* Must Be Clear of the Following:
 - i. Financial: Settlements or judgments over \$50,000 paid by or for the provider.
 - ii. Frequency: More than two cases annually.
 - iii. Severity: One or more cases involving proven patient injury or death.
 - iv. Pattern: Two or more cases linked to the same procedure or diagnosis within the past two years.

- v. Performance: Lawsuits related to documented peer-reviewed improvement opportunities.
- vi. Necessity: Lawsuits linked to non-indicated procedures.
- vii. Research: Cases associated with experimental procedures.
- viii. Failure to Disclose: Cases known to the physician but not disclosed.
 - a) * Cases predating the 7-year look-back may be assessed if there is evidence of a pattern or excessive number of cases, especially involving serious injury or death outcomes.
- e. Sanctions and Disciplinary Actions:
 - i. No sanctions, exclusions, or disciplinary actions reported by regulatory bodies or professional organizations according to NPDB records.
- f. Attestation Questions:
 - i. Attestation responses should not indicate any potential Quality of Care (QOC) risk.
- g. Compliance with the following at the time of the Medical Director Sign-Off:
 - i. All Primary Source Verifications obtained within the past 6 months.
 - ii. Attestation and Release of Information signed and dated within the past 12 months.
 - iii. Current proof of malpractice insurance with limit of liability amounts present (specific amounts not required).
 - iv. SPN Agreement, DOSA, or Practice-Level Agreement for eligible APPs.
- 2. If it is established that the applicant has verification or clinical issues for discussion, the PCC must review the file and render a decision with or without restrictions, including but not limited to full approval, approval for a shortened timeframe, or request for additional information.
- 3. The PCC decision is final. The PCC may still credential a provider or practitioner despite documentation of unfavorable information (e.g., malpractice claims, deficient site audits, sanctions).
- 4. The decisions of the PCC are based on a risk of harm to CenCal Health's members. Such a risk may be based on (but is not limited to) one or all of the following:
 - a. Clinical incompetence
 - b. Improper professional conduct
 - c. Malpractice claims history.
 - d. Disciplinary actions and sanctions
 - e. Lack of work history or unexplained gaps in work history
 - f. A history of restrictions and/or revocations of licensure, DEA certification, clinical privileges, and/or participation in other medical organizations

- g. Felony convictions and/or illegal drug use
 - h. Member complaints and/or unsatisfactory member surveys
 - i. Fraudulent credentials or misrepresentation of credentials
 - j. Noncompliance/nonresolution with CenCal Health's quality improvement plan and quality of care issues
- L. To address quality of care concerns, the PCC may impose various corrective actions as part of their decision, including:
- 1. credentialing approval of less than the full 3 years, with or without quarterly monitoring
 - 2. a peer-to-peer discussion between a CenCal Health Medical Director and the practitioner
 - 3. a request for a written explanation or response to the concern
 - 4. referral for peer review by the PCC
 - 5. formal corrective action plan, appropriately customized to the level of severity of the concern.
 - 6. freezing of member assignment
 - 7. suspension of less than 30 days
 - 8. termination from the network and statutory reporting when required.
- M. Disciplinary Actions Against Network Providers and Network Providers Appeal Corrective Actions
- 1. The PCC may impose corrective actions, after a governmental agency takes action against a provider or practitioner that affects the provider's/practitioner's license or credentials to practice or authorization to prescribe controlled substances.
- N. Provider Right to Appeal
- 1. If the PCC denies participation of an applicant or terminates participation of a contracted provider or practitioner, the Plan will notify the provider/practitioner in writing their right to appeal this decision as stated in CenCal Health's policy titled Provider Complaints and Grievances
 - 2. A provider or practitioner must exhaust the remedies afforded by CenCal Health's Complaints and Grievances policy before resorting to formal legal action which.
 - a. Challenge any decision made pursuant to this credentialing policy or the procedures used to arrive at such a decision.
 - b. Asserts any claim against CenCal Health or any participants in the decision process.
 - 3. If the PCC terminates a provider's or practitioner's participation in CenCal Health's provider network and the provider/practitioner does not request a hearing or appeal and the decision of the PCC is upheld, Provider Services

shall immediately proceed, pursuant to the terms of the provider's agreement with CenCal Health, to terminate the agreement.

O. Medical Board of California and National Practitioner Data Bank (NPDB) Reporting

1. Pursuant to Business and Professions Code, Section 805, CenCal Health shall report any reportable actions related to a "medical disciplinary cause or reason" to the Medical Board of California and/or the National Practitioner Data Bank following relevant reporting guidelines.
2. A provider or practitioner who is the subject of a proposed adverse action reportable to the Medical Board of California or the NPDB may request an informal meeting with the Director of Provider Services to dispute the text of the report filed regarding verification issues, and/or with the Chief Medical Officer or appointed Medical Director regarding any Quality of Care dispute. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report to be filed is consistent with the final action.

P. Delegation of Credentialing and Recredentialing

CenCal Health has the discretion to delegate credentialing and recredentialing activities to subcontractors and downstream subcontractors such as to a professional credentialing verification organization or to entities such as medical groups or independent physician organizations. CenCal Health shall enter into a formal and detailed written agreement with the delegated entity. Such agreement shall be revised when the parties change the agreement's terms and conditions. CenCal Health shall remain ultimately responsible for the completeness and accuracy of the delegated activities.

Q. CenCal Health shall establish a delegation system that:

1. Evaluates the delegated entity's ability to perform delegated activities that includes an initial review to assure that the delegated entity has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
2. Assures its members that the same standards of participation as required by DHCS and CenCal Health are maintained throughout its provider network;
3. Retains the right to approve, suspend, or terminate all providers, practitioners, and sites of care;
4. Continuously monitors, evaluates, and approves the delegated functions through the receipt and review of reports no less than semiannually;
5. Ensures that a consistent and equitable process is used throughout its network by requiring:
 - a. The delegated entity adheres to at least the same criteria outlined in this policy. CenCal Health will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation.
 - b. A mutually agreed upon document, which may be a contract, letter, memorandum of understanding, or other document, which clearly defines the performance expectations for CenCal Health and the

delegated entity. This document will define CenCal Health's and the delegate's specific duties, responsibilities, activities, reporting requirements, and identifies how CenCal Health will monitor and evaluate the delegate's performance. This mutually agreed upon document will also specify the remedies available to CenCal Health, including (but not limited to) revocation of the delegation if the delegate does not fulfill its obligations.

- c. CenCal Health's staff to audit the delegate's policies and procedures and a sample of credentialing files on an annual basis to evaluate whether the delegated entity's activities are being conducted in accordance with CenCal Health's expectations and NCQA standards. The only exception to the oversight requirements is when CenCal Health delegates to an entity that is NCQA Certified for Credentialing or accredited by NCQA. CenCal Health may waive the annual audit and may assume that the delegate is carrying out responsibilities in accordance with NCQA standards.
- d. At least annually, CenCal Health's staff monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures.
- e. At least annually, CenCal Health acts on all findings that result from each delegate's monitoring of its credentialing system security controls. CenCal Health implements a quarterly monitoring process until each delegate demonstrates improvement for a finding over three consecutive quarters.
- f. If monitoring reveals deficiencies in the delegate's credentialing and recredentialing processes, CenCal Health will work with the delegate to set priorities and correct the problems. If serious problems cannot be corrected, CenCal Health will revoke the delegation arrangement that CenCal Health retains the right, based on quality issues, to approve, suspend or terminate providers and practitioners.
- g. Functions performed by vendors that do not involve decision-making (i.e., data collection as may be performed by a Credentials Verification Organization (CVO)) are not delegated functions, as defined in this section.

IV. Definitions:

American Board of Medical Specialties (ABMS): An NCQA-approved source for verification of board certification.

American Medical Association (AMA) Physician Master File: An NCQA-approved source for verification of various MD credentials, including, but not limited to medical license, DEA certificate, education and training, board certification, sanction activity.

American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report/Physician Master File: An NCQA-approved source for verification of various

DO credentials, including, but not limited to medical license, DEA certificate, education and training, board certification, sanction activity.

Chiropractic Information Network-Board Action Databank (CIN-BAD): Official Actions Database which is a comprehensive repository of information on actions taken by official bodies with regard to individual chiropractors. It is maintained by the Federation of Chiropractic Licensing Boards as a service to its member boards, to the health care community, and to the general public.

Complete Application: An application with 1) All blanks filled in and necessary additional explanations provided; 2) all requested attachments submitted; 3) verification of the information is complete; and 4) all information necessary to properly evaluate the applicant's qualifications received and is consistent with the information provided in the application.

Council for Affordable Quality Healthcare (CAQH): CAQH is a non-profit alliance of health plans and related associations working together to achieve the shared goal of streamlining the business of healthcare. CAQH is an NCQA-certified Credentials Verification Organization (CVO) and serves as a central repository for credentialing applications that member organizations can access.

Credentialing: means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure, and professional association membership in order to ensure that Network Providers are properly licensed and certified as required by state and federal law. A part of CenCal Health's Quality Assessment and Improvement Program which verifies credentials with the issuer of the credential or other recognized monitoring organization, in order to evaluate a provider's qualifications, affiliations, competence, and to monitor the quality of medical services provided.

Credentials Verification Organization (CVO): An organization that provides primary source verification services to health care organizations to improve and expedite the credentialing process.

Educational Commission for Foreign Medical Graduates (ECFMG): An organization that certifies providers who have graduated from a medical school in another country. ECFMG verifies each provider's diploma with the medical school prior to issuing certification.

Facility-based Provider: A provider who sees CenCal Health's members only as a result of the member being directed to a hospital, freestanding facility, or other inpatient setting. Examples of this type of provider are hospitalists, pathologists, radiologists, anesthesiologists, neonatologists, and emergency room physicians. The facility is responsible for credentialing these providers.

Freestanding Facilities: A health care facility that is physically, organizationally, and financially separate from a hospital and whose primary purpose is to provide immediate or short-term medical care on an outpatient basis. Examples of this type of facility include, but are not limited to, mammography centers, urgent care centers, surgical centers, and ambulatory behavioral health care facilities. CenCal Health assesses these facilities as Organizational Providers.

Healthcare Integrity and Protection Data Bank (HIPDB): A nationwide flagging system established by the Health Insurance Portability and Accountability Act of 1996, Section 221(a), Public Law 104 191, to create a databank of healthcare related adverse actions, including civil judgments, criminal convictions, and actions taken by federal and state agencies responsible for licensing and certification of healthcare practitioners, providers, and suppliers.

Independent Relationship: An independent relationship exists between CenCal Health and a provider when CenCal Health directs its members to see a specific provider or group of providers. An independent relationship is not synonymous with an independent contract.

Medical Disciplinary Cause or Reason: Refers to an aspect of a provider's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Member: a Medi-Cal recipient who resides in the Plan's Service Area and who has enrolled with the Plan.

National Practitioners Data Bank (NPDB): An information clearinghouse established by Title IV of Public Law 99-660 (the Health Care Quality Improvement Act of 1986), to collect and release certain information related to the professional competence and conduct of physicians, dentists, and other health care providers. The U.S. Government established the Data Bank to enhance professional review efforts by making certain information concerning medical malpractice payments and adverse actions available to eligible entities and individuals.

Network Provider: any provider or entity that has a network provider agreement with CenCal Health, CenCal Health's subcontractor, or CenCal Health's downstream subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render covered services. A Network Provider is not a subcontractor or downstream subcontractor by virtue of the network provider agreement.

Office of Inspector General (OIG): In response to legislation preventing certain individuals and businesses from participating in federally funded health care programs (e.g., Medicare), the OIG developed a program to exclude these individuals and entities and maintains a list of all currently excluded parties. Querying the OIG identifies parties excluded due to sanctions imposed by federally funded health care programs.

Provider: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Provider Credentials Committee: A committee of credentialed Network Providers who are made responsible by the QIHEC to review and render decisions regarding provider credentialing and recredentialing.

Primary Source Verification: Refers to contacting the entity, agency, or institution that issues a provider's credential for verification of the document's authenticity. Also refers to an entity, such as a state licensing agency with legal responsibility for originating a document and ensuring the accuracy of the document's information. For some credentials, the primary source does not need to be contacted directly if they make verification available through another source. For the purposes of this

policy, primary source verification means contacting either the actual issuer or another recognized monitoring source approved for verification by the National Committee for Quality Assurance (NCQA). For example, board certification may be verified by contacting the appropriate specialty board (the issuer) or the NCQA approved source of the American Board of Medical Specialties (ABMS) directory.

Quality Improvement and Health Equity Committee (QIHEC): the committee facilitated by CenCal Health's Chief Medical Officer (CMO), or the CMO's designee, in collaboration with the Chief Health Equity Officer, to meet at least quarterly to direct all QIHETP findings and required actions.

Quality Improvement and Health Equity Transformation Program (QIHETP): the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the DHCS Medi-Cal Managed Care Agreement.

Subcontractor: means an individual or entity that has a contract with a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), or Primary Care Case Management (PCCM) entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A Network Provider is not a subcontractor by virtue of the Network Provider agreement with the MCO, PIHP, or PAHP

Verification File: A provider's complete credentialing application with all verifications and documentation gathered during the credentialing verification process, including quality improvement data furnished by the Health Services Department and member complaint data furnished by the Member Services Department.

180-Day Timeframe: To ensure that the PCC does not consider an applicant whose credentials may have changed since verification, CenCal Health and its staff will adhere to strict timeframes for the credentialing process. All verifications, attestations, and information releases will be less than 180 days old at the time of the credentialing decision as per NCQA standards, with the exception of those designated by NCQA as 365 (360) daytime limit. For written verifications, the 180-day time limit begins with the date on the written verification from the entity that verified that particular credential. Unless otherwise stated, all verification timeframes in this policy are 180 days prior to the decision.

V. References:

- A. 42 CFR section 438.2
- B. 42 CFR section 438.214
- C. DHCS 2024 Medi-Cal Managed Care Contract, Exhibit A, Attachment III, section 2.2.12
- D. DHCS APL 22-013, dated July 19, 2022, supersedes APL 19-004
- E. DHCS APL 19-004, dated June 12, 2019, supersedes APL 17-019
- F. Business and Professions Code, Section 805

VI. Cross References:

A. Policy and Procedures (P&Ps):

1. PS-CR01 Provider Enrollment and Screening
2. PS-CR21 Facility Site Review and Medical Record Review Overview
3. PS-CR22 Facility Site Review and Medical Record Review Process
4. PS-CR23 Medical Record Standards
5. PS-PS101 Provider Directory Creation and Maintenance
6. QU-20 Quality of Care Investigations

VII. Attachments: N/A

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date	DHCS P&P Approval Date
05/2024	Luis Somoza, Director of Provider Services; Jordan Turetsky, Chief Operations Officer	NCQA Updates; 2024 Contract Review	01/2024	N/A
11/2023	Jordan Turetsky, Chief Operating Officer	2024 Template Migration	01/2024	N/A
09/2023	Sheila Thompson	NCQA Revision		12/2023
12/2022	Jordan Turetsky	2024 Contract Amendment Update (R.0092)		2023
08/2022	Jordan Turetsky	2024 Contract Amendment Update		2022
01/2021	Terry Howell	Removed references to obsolete policy, update staff titles and committee names		N/A
05/2019	Terry Howell	Added NPMPs, CAQH, Medical Director sign off of all clean files. Changed reference of policy number from 500-2010-J to PS-CR03		N/A