POLICY AND PROCEDURE	
TITLE: Credentialing for Organizational Providers	
DEPARTMENT: Network Operations	**POLICY #:** CR-002
EFFECTIVE DATE: 01/27/2011	**REVIEW/REVISION DATE:** 08/08/2024
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PRODUCT TYPE: Medi-Cal	**REPLACES:** v.1 Credentialing for Organizational Providers

I. Purpose

A. Gold Coast Health Plan (GCHP)'s Credentialing Program ensures that GCHP Providers meet required and professionally appropriate standards for the delivery of quality care. GCHP's Credentialing Program maintains a network of Providers who deliver its members safe, consistent, equitable, and high-quality care. The Credentialing Program involves assessment, evaluation, and monitoring of a provider's ability to deliver quality care to GCHP Members. It requires that all providers maintain compliance with the GCHP credentialing requirements, which include requirements established by the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS) or designee, the National Committee for Quality Assurance (NCQA), and other applicable regulatory agency requirements and/or standards. The GCHP Credentialing and Recredentialing standards are reviewed by the GCHP Credentials/Peer Review Committee (C/PRC).

II. Policy

A. This Organizational Provider Credentialing Policy is one aspect of GCHP's Quality Improvement Program. Through this policy, GCHP ensures that organizational providers who seek to participate in GCHP's Network undergo a credentialing process prior to providing care to GCHP Members, except as set forth in Section VII.E., Exemption from Credentialing Process. This Credentialing Policy requires that Organizational Providers meet all regulatory accreditation, and quality requirements before delivering care to Members and that the qualifications of said providers are verified on an ongoing basis. In addition, this policy assures a consistent, rigorous, and fair process for evaluating and credentialing Organizational Providers.

III. Definitions

A. **Attestation:** A signed statement by a provider confirming the validity, correctness and completeness of a credentialing application and the representations therein.

B. **Clean File:** A provider who fully meets the standards, guidelines, and criteria for credentialing. Also referred to as a Type I Provider.

C. **Commission:** The Ventura County Medi-Cal Managed Care Commission, the governing body for Gold Coast Health Plan.

D. **Credentials/Peer Review Committee (C/PRC):** A subcommittee of the Quality Improvement Committee (QIC) that is responsible for decision-making related to the credentialing and recredentialing of healthcare practitioners and organizational providers.

E. **Credentialing Process:** Includes both the credentialing and recredentialing of providers to evaluate and verify the provider's licensure, certification, or other qualifications and to monitor the competency and quality of medical services provided. Initial credentialing is conducted prior to a provider providing care to GCHP members; recredentialing is conducted within three (3) years of the initial credentialing process.

F. **Delegated Credentialing:** Occurs when the credentialing functions of a managed care organization have been outsourced or contracted to be performed by another capable organization. The delegating organization is responsible for ensuring that the delegate performs the activities in accordance with regulatory and accreditation requirements including the delegating organization's approved policy for credentialing.

G. **Free-Standing 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, and surgical centers. GCHP assesses these facilities as Organizational Providers.

H. **Gold Coast Health Plan (GCHP):** An independent public entity governed by the Ventura County Medi-Cal Managed Care Commission (the Commission).

I. **Member:** Any Eligible Beneficiary who is enrolled with Contractor/GCHP. For the purposes of this policy, the terms "Enrollee," "Beneficiary," and "Member" shall be interchangeable.

J. **Network Provider:** Credentialed provider who has entered into a contractual agreement with GCHP to provide healthcare services to GCHP's Members and follow all established plan policies and procedures.

K. **Organizational Provider:** An institution or organization that provides services, such as a hospital, residential treatment center, home health agency, or rehabilitation facility.

L. **Peer Review:** Evaluation or review of provider performance by professionals with similar types and degrees of expertise (e.g., evaluation of a physician's credentials and practice by another physician).

M. **Provisional Credentialing:** A process that provides a managed care organization with the ability to add providers to its network prior to completing the full credentialing process.

N. **Quality Improvement (QI) Committee (QIC):** The committee responsible for the monitoring and evaluation of the overall effectiveness of quality improvement activities at GCHP. *Credentialing decisions are not made by this committee, the C/PRC is a subcommittee that reports to the QIC.

O. **Type I Providers:** Organizational Providers whose Verification File fully meets the minimum criteria for credentialing and the quality criteria as set forth in this policy. Also referred to as a "Clean File."

P. **Type II Providers:** Organizational Providers whose Verification File does not meet the GCHP minimum and additional criteria for credentialing as set forth in this policy and whose Verification File requires further review by the C/PRC.

Q. **Verification File:** A provider's complete credentialing application with all documents gathered during the credentialing/recredentialing process, including primary source verification, quality improvement data, and other information furnished to GCHP.

IV. Procedure

A. Authority and Responsibility for Credentialing
   i. Overview:
      1. GCHP has designated the QIC to oversee all Quality Improvement Program Policies and Procedures and make recommendations to the Commission. GCHP's Commission has delegated credentialing functions to GCHP's C/PRC, with leadership of and oversight by the GCHP Chief Medical Officer (CMO) or his/her designee. The C/PRC is responsible for administering and operating the Credentialing Program and for

approving or denying an Organizational Provider's credentials. A summary report of each C/PRC meeting will be made to the QIC and, subsequently, to GCHP's Commission by the CMO or his/her designee. Each Member of the C/PRC is responsible for maintaining objectivity in the credentialing process.

ii. Composition of the Credentials/Peer Review Committee
    1. The CMO is responsible for the oversight and operation of the Credentialing Program and serves as Chairperson or may appoint a Chairperson with equal qualifications. The CMO of GCHP must review, approve, sign and date the GCHP credentialing policies and procedures, as updated from time to time each year.
    2. The Credentials / Peer Review Committee consists of 8 voting members who serve two-year terms which may be renewed (there are no term limits). The Credentials / Peer Review Committee is a peer-review body that includes participating practitioners who span a range of specialties, including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, geriatrics, etc.) and specialty care. Members are nominated by the CMO and approved by the Commission.

iii. Responsibilities/Duties of the CMO
    1. Overseeing the clinical quality of care, i.e., the review of complaints and grievances, the review and assessment of potential quality issues submitted to the Quality Improvement department, compliance with medical records reviews required by DHCS, and all other ongoing performance monitoring.
    2. Recommending new members to be appointed to the C/PRC.
    3. Referring significant quality of care issues to the C/PRC for review.
    4. Assuring the completeness of credentialing files.
    5. Coordinating and following up on clinical quality of care recommendations by the C/PRC and QIC.
    6. Reviewing the list of providers to be presented for review prior to the C/PRC meeting to determine if any of the candidates have clinical quality of care issues that may require review by the C/PRC. Classifying credentialing files as Type I or Type II.
    7. Reviewing and approving files designated as Type I.
    8. Approving a provider who fully meets the established criteria as a provisional provider between Committee meetings.
    9. Presenting candidates for initial credentialing and recredentialing to the C/PRC.
    10. Ensuring that proceedings of the C/PRC are recorded in the minutes of the Committee.

11. Communicating with providers regarding their credentialing status.
12. Assuring the fairness of the credentialing process and facilitating the appeal and fair hearing process.
13. Ensuring the confidentiality of records of peer review proceedings.
14. Reporting to the QIC, Commission, and other appropriate authorities as required by law.

iv. Duties of the Credentials/Peer Review Committee
   1. The C/PRC reviews and evaluates the qualifications of each Organizational Provider applying to become a contracted provider or seeking recredentialing as a contracted Organizational Provider. The C/PRC has authority to:
      a. Review Type I credentialing and recredentialing provider list. Type I files will be presented to the C/PRC on a list of Type I files as one group for informational purposes. The CMO or designee will sign each file, and the list will be documented in the minutes of the C/PRC.
      b. Receive and review Type II providers applying for credentialing or recredentialing.
      c. Review the quality of care findings resulting from GCHP's credentialing and quality monitoring and improvement activities.
      d. Act as the final decision maker regarding the initial and subsequent credentialing of providers based on clinical competency and/or professional conduct.
      e. Review the Credentialing and Recredentialing policies and procedures annually.
      f. Establish, implement, and make recommendations regarding policies and procedures.
      g. Perform other related responsibilities.

v. Quorum of the C/PRC
   1. A quorum (half plus one voting member) shall be satisfactory for the valid assessment of the actionable agenda items of C/PRC, which meets at least quarterly and/or as deemed necessary by the Chairperson. The C/PRC may meet and take action in a forum other than a face-to-face meeting, such as a teleconference or web conference (with audio). Any action taken must be with a quorum present, and all proceedings must be recorded, and minutes presented to the Committee at its next regularly scheduled meeting. Voting members include only the Committee Physicians. The C/PRC Chair votes only when there is a tie vote, in order to break the tie. If during a meeting, a

quorum is no longer met, the voting must cease. All meetings must be conducted in accordance with the Brown Act.

vi. Committee Minutes and Reports
    1. Complete and accurate minutes will be prepared and maintained for each meeting. Minutes will reflect the name of the Committee, the date and duration of the meeting, the members present and absent, and the names of guests or other representatives. The minutes will reflect decisions and recommendations, the status of activities in progress, and the implementation status of recommendations, when appropriate. Applicable reports and substantiating data will be appended for reporting purposes. The C/PRC will be responsible for reviewing minutes for accuracy. A summary report will be submitted to the QIC which in turn reports to the Commission.
        a. For each Organizational Provider discussed, the minutes will identify the type and a summary of the discussion regarding that provider, the C/PRC recommendation, and the rationale for recommendation.
        b. Minutes shall be securely retained electronically and manually in accordance with GCHP Policy and Procedure (P&P) ADM-005 *Records Management Program*.

vii. Confidentiality, Immunity, and Release of Policy
    1. All peer review records and proceedings are included in the quality improvement process of GCHP and are confidential and privileged in accordance with Section 1157 of the California Evidence Code. GCHP classifies all credentialing records that are part of the credentialing peer review process as confidential. The mechanisms in effect to ensure the confidentiality of information collected in this process are as follows:
        a. GCHP shall hold in confidence all data and information that it acquires in the exercise of its duties and functions as a peer review organization recognized under California Statutes Section 1157.
        b. Access to such documents will be restricted to:
            i. The Organizational Provider being credentialed, solely pursuant to the description set forth in this document below titled “Provider’s Rights,”
            ii. C/PRC Members,
            iii. Commissioners, only if presented in closed session of a Commission meeting related to a C/PRC action and presented as confidential and privileged,

iv. GCHP Credentialing Staff and legal counsel, and
v. experts, witnesses, representatives of provider, or other participants in the Fair Hearing Process, as set forth in GCHP P&P QI-028 *Fair Hearing Policy*.

c. All C/PRC members, support staff, and other individuals who attend any Committee meetings will be required to sign a confidentiality of information agreement prior to attendance and annually thereafter in order to protect the peer review function. Any breach of confidentiality may be grounds for corrective action by the C/PRC.
d. Each C/PRC member will be immune, to the fullest extent provided by law, from liability to applicants for damages or other relief for any action taken or statements or recommendations made within the scope of the C/PRC duties exercised.
e. All C/PRC members will comply with GCHP policies for conflicts of interest, Ethics and Conflict of Interest.

viii. Conflict of Interest
1. All voting C/PRC members are required to sign a Conflict of Interest Agreement before becoming a member and on an annual basis. Committee members shall reveal any associations, conflicts of interest or potential conflicts of interest with any credentialing applicant to the Committee Chair prior to the consideration of a candidate. No person may participate in the review and evaluation of any provider with whom he/she has been in a professional corporation, partnership, or similar entity or where judgment may be compromised. The Chair of the C/PRC shall have the authority to excuse a voting member from the C/PRC when a conflict of interest exists.

ix. Non-Discriminatory Practices
1. GCHP conducts each C/PRC meeting in a non-discriminatory manner. A heterogeneous committee will be maintained, and all committee members responsible for credentialing decisions will annually sign a statement affirming that they do not discriminate in credentialing decisions against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. GCHP will not discriminate, with respect to the credentialing/privileging process against a licensed provider solely on the basis of civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state if the judgement, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care

that would be lawful if provided in this state. Practitioners have the right to file grievances/complaints regarding fair and non-discriminatory practices in the credentialing and/or recredentialing process.

2. In order to monitor the credentialing and recredentialing processes for potentially discriminatory practices, quarterly audits of provider grievances/complaints will be conducted to determine if there are grievances/complaints alleging discrimination. The grievance/complaints reports are reported to the C/PRC.

B. The Credentialing Program
   i. Scope of Credentialing
      1. Credentialing requirements apply to all Organizational Providers that provide care to GCHP members including:
         a. Hospitals
         b. Skilled Nursing Facilities/Long Term Care Facilities
         c. Free-Standing Surgical Centers
         d. Home Health Agencies/Hospice Providers
         e. Adult Day Health Care Providers of Community Based Adult Services
         f. Congregate Living Health Facilities
         g. Intermediate Care Facilities
         h. Free-Standing Birthing Centers
         i. Chronic Dialysis (End Stage Renal Disease) Clinics
         j. Laboratories
         k. Behavioral Healthcare Providers, including Ambulatory, Residential, and Inpatient Facilities
         l. Substance Use Disorder Providers, including Ambulatory, Residential, and Inpatient Facilities
         m. Federally Qualified Health Centers (FQHCs), as needed
   ii. File Audit
      1. On an ongoing basis, the staff member responsible for administration and coordination for the C/PRC activities, generally the Credentialing Specialist or designee, will review files at the time of completion, prior to forwarding to the CMO or designee, to ensure accuracy and timeliness. This administrative file review will assess the:
         a. Completeness of verification, method of verification, and source of required documentation
         b. Timeliness of file completion
         c. Compliance with GCHP Credentialing Policy minimum criteria

2. In addition to the administrative file review conducted by the staff member responsible for administration and coordination for the C/PRC activities, generally the Credentialing Specialist, prior to submission of files to the CMO and/or C/PRC, the GCHP Compliance Department will conduct at least one internal annual compliance audit of the GCHP credentialing program and policies using the Industry Collaborative Effort (ICE) Tool or any other appropriate method, to ascertain compliance with GCHP Credentialing Policy criteria. The audit tool is based upon current NCQA, DHCS and GCHP standards and modified on an as-needed basis.
3. Lastly, for those organizations to which GCHP has delegated credentialing responsibilities, the staff member responsible for administration and coordination for the C/PRC activities, generally the Credentialing Specialist, conducts quarterly roster audits and reviews submitted delegate reports. The GCHP Compliance Department conducts pre-delegation audits for newly delegated entities and annual audits for existing delegates as set forth in Section XI. Delegated Credentialing. For the annual compliance audits, the GCHP Compliance Department will audit a subset of files completed during the past 12 months using either a random sampling methodology and/or a Roster Audit.
4. At a minimum, the files audited should result in a 90% rate of completeness, timeliness, and compliance with minimum criteria, regulatory, and contractual requirements. Results of the audits must be documented on a checklist. In the event any deficiencies are identified through the oversight process, corrective action plans are implemented based upon areas of non-compliance. If the delegate is unable to correct or does not comply with the corrective action plan within the required timeframe, GCHP will take action that may include imposing sanctions, de-delegation of the delegated function or termination of the contract or agreement. Focused audits may be performed to verify deficiencies have been corrected or if a quality issue is identified. The results of all audits are reported to the GCHP Compliance Committee, C/PRC, and QIC. The GCHP's Compliance Committee, which supports GCHP's regulatory compliance functions, reports to the Commission.

C. Criteria for Credentialing
    i. Overview

1. GCHP accepts providers into its network at its sole discretion based on the need for providers in certain specialties, geographic areas, or similar considerations.
2. Each Organizational Provider must meet minimum criteria for participation in the GCHP Network. These criteria are intended to comply with standards of GCHP, DHCS, NCQA, or any other applicable regulatory and/or accreditation entities where applicable.

ii. Minimum Criteria for Credentialing
   1. All Organizational Providers within the scope of this Credentialing Policy who apply for credentialing must satisfy the following minimum standards:
      a. Be in good standing with state and federal regulatory bodies, including but not limited to:
      b. Having a current, valid, unrestricted, and unencumbered license, registration, or certification, as appropriate.
      c. Accreditation by an accrediting body recognized by CMS or California Department of Public Health (CDPH), as applicable.
      d. A current Medi-Cal provider number and National Provider Identifier (NPI).
      e. Commercial General Liability Insurance of $1 million per occurrence and $3 million aggregate and Professional Liability Insurance, if applicable, of $1 million per occurrence and $3 million annual aggregate.

iii. Additional Criteria
   1. In addition, providers must meet the additional criteria set forth below. Organizational Providers that do not meet the additional criteria will be identified as Type II files.
      a. Satisfaction of GCHP standards for quality of care, as set forth in the “Quality of Care Criteria” section of this policy.
      b. No open indictments or convictions, or pleadings of guilty or no contest to a felony, and no open indictments or convictions to any offense involving moral turpitude, or fraud, gross misdemeanors reasonably related to the provision of health care and related services, or any other similar offense.
   2. The requirements to show that the Organizational Provider is in good standing with state and federal regulatory bodies are as follows:
      a. Hospitals

i. Copy of current accreditation by an acceptable accrediting organization. Acceptable accrediting organizations for hospitals are:
    1. The Joint Commission (TJC),
    2. Center for Healthcare Quality Improvement (CHIQ),
    3. American Osteopathic Association/Healthcare Facilities Accreditation Program (HFAP)
    4. Det Norske Veritas Healthcare (DNV))
ii. Copy of a current and valid State License
iii. Copy of a current Liability Insurance Coverage face sheet
iv. Verification of current Medi-Cal Provider Number and NPI

b. Skilled Nursing Facilities/Long Term Care Facilities
    i. Copy of current accreditation by an acceptable accrediting organization or a survey report or letter from CMS and/or CDPH that, within the last 3 years, the organization has been reviewed and passed inspection. Acceptable accrediting organizations are:
        1. TJC
        2. Commission on Accreditation of Rehabilitation Facilities (CARF)
    ii. Copy of a current and valid State License
    iii. Copy of a current Liability Insurance Coverage face sheet
    iv. Verification of current Medi-Cal Provider Number and NPI

c. Free-Standing Surgical Centers
    i. Copy of accreditation by an acceptable accrediting organization. Acceptable accrediting organizations are:
        1. TJC
        2. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
        3. Accreditation Association for Ambulatory Health care (AAAHC)
        4. American Osteopathic Association/Healthcare Facilities Accreditation Program (HFAP)
        5. Institute for Medical Quality (IMQ)

ii. Copy of a current and valid State License
iii. Copy of a current Liability Insurance Coverage face sheet
iv. Verification of current Medi-Cal Provider Number and NPI

d. Home Health Agencies/Hospice Providers
   i. Copy of accreditation by an acceptable accrediting organization or a survey report or letter from CMS or the California State Department of Public Health that, within the last 3 years, the organization has been reviewed and passed inspection. Acceptable accrediting organizations are:
      1. TJC
      2. Community Health Accreditation Program (CHAP)
      3. Accreditation Commission for Home Care, Inc. (ACHC)
   ii. Copy of a current and valid State License
   iii. Copy of a current Liability Insurance Coverage face sheet
   iv. Verification of current Medi-Cal Provider Number and NPI
e. Adult Day Health Care Centers for Community Based Adult Services
   i. Accreditation by an acceptable accrediting organization or a survey report or letter from CMS or the California State Department of Public Health that, within the last 3 years, the organization has been reviewed and passed inspection. Acceptable accrediting organizations are:
      1. TJC
      2. CARF
   ii. Copy of a current and valid State
   iii. Copy of a current Liability Insurance Coverage face sheet
   iv. Verification of current Medi-Cal Provider Number and NPI
f. Congregate Care Facilities
   i. Accreditation by an acceptable accrediting organization or a survey report or letter from CMS or the California State Department of Public Health that, within the last 3 years, the organization has

been reviewed and passed inspection. Acceptable accrediting organizations are:
    1. TJC
    2. CHIQ
    3. CARF
ii. Copy of a current and valid State license
iii. Copy of a current Liability Insurance Coverage face sheet
iv. Verification of current Medi-Cal Provider Number and NPI

g. Intermediate Care Facilities
i. Accreditation by an acceptable accrediting organization or a survey report or letter from CMS or the California State Department of Public Health that, within the last 3 years, the organization has been reviewed and passed inspection. Acceptable accrediting organizations are:
    1. TJC
    2. CARF
ii. Copy of a current and valid State License
iii. Copy of a current Liability Insurance Coverage face sheet
iv. Verification of current Medi-Cal Provider Number and NPI
v. Attestation that the ICF/DD meets all requirements outlined in Section XII of APL 23-023 *Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care*
vi. Re-credentialing is to occur every two (2) years through re-submission of an ICF/DD Attestation (see Intermediate Care Facility for Developmentally Disabled (ICF/DD) Credentialing Attestation reference). Through the attestation the following will be reviewed during the two-year recredentialing process:
    1. Completion of the Medi-Cal Managed Care Plan's specific Provider Training within the last two (2) years
    2. Facility Site Audit from State Agency
    3. W-9 Request for Taxpayer Identification Number and Certification

4. MCP Ancillary Facility Network Provider Application
5. Certificates of Insurance (Professional and General Liability)
6. City or County Business License (excludes ICF/DD-H and -N homes with six or less residents)
7. 5% Ownership Disclosure
8. Possess an active CDPH License and CMS Certification
9. In good standing as a Regional Center Vendor

vii. If an ICF/DD has a change to any requirement attested to between the years ICF/DD Homes are to be re-credentialed, the ICF/DD will report the years the ICF/DD are to be re-credentialed. The ICF/DD Home must report that change to GCHP along with required documentation within 90 days of when the change occurred.

h. Free-Standing Birthing Centers
   i. Copy of current and valid accreditation by Commission for the Accreditation of Birth Centers (CABC)
   ii. Copy of a current and valid State certification for Comprehensive Perinatal Services Program
   iii. Copy of a valid and current State license
   iv. Copy of a current Liability Insurance Coverage face sheet
   v. Verification of current Medi-Cal Provider Number and NPI

i. Chronic Dialysis (End Stage Renal Disease) Clinic
   i. Copy of current and valid accreditation by an acceptable accrediting organization (Acceptable organization are: ACHC, National Dialysis Accreditation Commission (NDAC.)
   ii. Copy of a current and valid State License
   iii. Copy of a current Liability Insurance Coverage face sheet
   iv. Verification of current Medi-Cal Provider Number and NPI

j. Laboratories

i. Copy of current and valid CLIA Certificate of Compliance or a Certificate of Accreditation issued by CMS
ii. Letter from CMS or CDPH or an accrediting organization approved by DMS and CDPH that organization has been reviewed and passed its most recent annual inspection
iii. Copy of a current and valid State License or certification of deemed status by an accreditation agency approved by CDPH
iv. Copy of a current Liability Insurance Coverage face sheet
v. Verification of current Medi-Cal Provider Number and NPI

3. For those Organizational Providers where a site survey is required, Gold Coast Health Plan may substitute a CMS or State Survey for compliance with State licensing standards and federal Medicare Conditions of Participation in lieu of the required site visit. The CMS or State Survey may not be greater than three (3) years old at the time of verification. Gold Coast Health Plan will obtain the survey report or letter from CMS or the State, from either the provider or the agency stating that the facility was reviewed and passed. Such substitution is not permissible for Hospitals or Free-Standing Surgical Centers, as they are required to be accredited by an acceptable accrediting organization. If no site survey is available for an applicable organizational provider, Gold Coast Health Plan will conduct a site survey using an identified, standardized site survey tool (see reference item: 12. HICE Site Review Tool_2023). The site survey will include a process to ensure the provider credentials their practitioners and verifies that they are appropriately licensed at all times. Site survey results will be shared with the Organizational Provider and corrective action will be conducted as necessary.

iv. Quality of Care Criteria
1. Organizational Provider practice patterns must reflect a general adherence to established practice standards and protocols as adopted by GCHP. A provider's practice must also align with the scope of practice for the organization's license and/or certification.
2. Organizational Providers must maintain satisfactory performance in the area of practice quality indicators (i.e.,

clinical outcomes, performance measure outcomes, Member satisfaction, etc.) established by GCHP.

3. GCHP retains the right to accept/terminate providers based on quality issues. Termination of individual providers for quality of care considerations shall be supported by documented records of noncompliance with specific expectations and requirements for providers.

v. Business Administrative Criteria

1. Professional specialty provider(s) must fill a network need as determined by GCHP. GCHP reserves the right to deny participation or terminate a contract, on a case-by-case basis if need does not exist for a particular specialty and if such action is deemed in the best interest of the network. GCHP also maintains the right to terminate a provider without cause.
2. If a provider is denied inclusion in the network or his/her contract is terminated for business administrative criteria, it will not be considered a denial of credentialing and will not be considered a denial for a quality reason. The provider will not have access to fair hearing processes.
3. If GCHP terminates a provider for administrative reasons, it may reinstate the provider within 30 calendar days of termination and is not required to perform initial credentialing. GCHP will perform initial credentialing if reinstatement is more than thirty (30) calendar days after termination. In the event that the termination is found to be in error, the credentialing process will be determined on a case-by-case basis.

D. Credentialing Review

i. Process

1. GCHP providers must be enrolled in the Medi-Cal Program to be credentialed by GCHP. In instances where GCHP elects to enroll Organizational Providers, the staff member responsible for administration and coordination for the C/PRC activities, generally the Credentialing Specialist or designee will assist Provider Network Operations and check the sources for Medicaid/Medicare sanctions.
2. Each provider must submit a legible and completed application on a GCHP application form, which includes a signed and dated consent form, a signed attestation, and all other required documentation as outlined herein. The attestations will include the following:
    a. A history of loss of license or felony conviction.
    b. The application's accuracy and completeness.

3. GCHP re-credentials all Organizational Providers at least every three years since their last credentialing or recredentialing date. The intent of the process is to identify any changes that may affect an Organizational Provider's ability to perform the services it is under contract to provide.

ii. Application and Verification
    1. Each provider must complete and sign the GCHP application including appropriate inquiries and an attestation that the information given is correct and gives GCHP the right to verify the information. The following information is obtained and verified:
        a. State license, registration, or certification
        b. Accreditation status, if applicable
        c. Insurance coverage
        d. Sanction information, including Medicare/Medi-Cal sanctions
        e. Documentation showing Medi-Cal enrollment and NPI
    2. A copy of the license, accreditation report or a letter from the regulatory and accrediting bodies regarding the status of the provider is collected.
    3. Documents submitted by providers will be verified, using the sources identified on Attachment A, Credentialing Verification sources used by Gold Coast Health Plan for Organizational Providers.
    4. The recredentialing process will also include performance-monitoring information. Sources of such information may include one or more of the following:
        a. Member grievances/complaints
        b. Member and Practitioner/Provider satisfaction surveys
        c. Utilization Management
        d. Risk Management
        e. Quality improvement activities, performance quality measures, potential quality issues, quality deficiencies, and/or trending patterns
    5. Upon receipt of the application the Credentialing staff will:
        a. Prepare and send a letter to the applicant reviewing the application process. If the application is incomplete, the Credentialing Specialist or designated staff will request that the applicant provide the additional missing information required within thirty (30) calendar days.
        b. If the required information is not received within thirty (30) calendar days, GCHP staff will again inform the applicant

that the application is incomplete and request the needed information within fifteen (15) calendar days.

6. Non-Responsive Organization Providers: For applicants for initial credentialing, if the required information is not received within 45 calendar days of the date of initial receipt of the application, GCHP will consider the application withdrawn. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to GCHP.
7. For applicants for recredentialing, the CMO sends a formal letter to the provider reflecting:
    a. The number of times and specific dates GCHP has reached out to the provider and his/her designee (as applicable).
    b. The provider's contractual requirements regarding recredentialing, if applicable.
    c. That the provider has five business days in which to respond and that failure to respond will result in administrative denial of the application for recredentialing and contract termination.
8. Provider Network Operations will be notified when a provider has failed to respond to the recredentialing efforts.

iii. Verification

1. The GCHP credentialing staff will conduct verification as required by the most current and applicable DHCS, NCQA, and other GCHP adopted guidelines. GCHP accepts letters, telephone calls, emails, scanned documents including faxes, computer printouts, and/or online viewing of information as acceptable sources of verification. The information must be accurate and current.
2. Verbal verifications documented in credentialing files are dated and signed by the credentialing staff who receives the information (noting source and date). Written verifications are received in the form of letters or documented review of latest cumulative reports released by primary sources. Internet verifications may be obtained from any CMS, DHCS, NCQA, and/or GCHP-approved website source.
3. To meet verification standards, all credentials must be valid at the time of the C/PRC's decision and the specific time limits as set forth by DHCS, NCQA, GCHP and any other applicable regulatory and/or accreditation entities. Each provider credentialing file will include copies of all applicable verified credentials documents.

iv. Credentialing Actions
    1. Failure to Meet Minimum Requirements – Administrative Action
        a. If an application for initial or recredentialing does not meet the Minimum Criteria in Section IV.C.ii. above, it will be denied on an administrative basis and will not be submitted to the C/PRC for action. If it fails to satisfy the additional criteria in Section IV.C.iii, it will be submitted to the C/PRC as Type II file for consideration.
    2. Type I Review
        a. Any provider meeting the Minimum Criteria will be noted as "meets all standards" and be assigned a designation of Type I, provided the provider submits a complete application and required attachments. Type I applicants will be reviewed and approved by the CMO and submitted to the C/PRC as a group for informational purposes.
    3. Type II Review
        a. GCHP may identify quality of care issues that require Committee review. All providers with identified quality of care issues will be individually reviewed and considered by the C/PRC.
    4. Suspensions and Pending Organizational Providers' Files
        a. If any one of the following issues are identified, Credentialing staff will forward the credentialing file or active provider file to the CMO or designee for review and, if verified, may be cause for immediate denial of an application or summary suspension as a provider for GCHP:
            i. A restriction, imposition of probation, suspension, or a revocation of the provider's license, certification, or registration;
            ii. A sanction, debarment, or exclusion that disallows participation in the Medicare and Medicaid programs;
            iii. A condition that is identified that would suggest that care by the provider would present a danger to a Member;
            iv. Any verified evidence that the provider lied or made a misstatement on the application;
            v. Loss of NPI or Medi-Cal provider number; or
            vi. No current insurance coverage
        b. If any of the following issues are identified for a provider who is being considered for initial credentialing or

recredentialing the committee may, but is not required to, temporarily extend the provider's credentials until the provider has had due legal process or has had the opportunity to complete a Corrective Action Plan, or the provider may be suspended because of the seriousness of the accusation:

i. A pending felony charge;
ii. A pending criminal charge involving any criminal activity related to the provider's practice; or
iii. Any pending action by the licensing board or accreditation agency of the provider that could result in revocation or limitation of the provider's license to practice or accreditation.

v. Exemption from Credentialing Process
   1. At times, there may be a need for GCHP to enter into a Letter of Agreement (LOA) with a provider for certain out-of-network services for a single patient, because such services are either not available or not accessible within the network. In these cases, a provider will not be formally credentialed, but they must be eligible for credentialing. Full credentialing must take place before GCHP enters into a network participation agreement with any such provider.

vi. Credentialing Actions – Committee Decisions
   1. When a new credentials file or a re-credentials file is complete, it will be presented to the CMO as a Type I file or to the C/PRC as a Type II file. Type I files are approved by the CMO and presented to the C/PRC as a group for informational purposes of the CMO's action. Type II files will be considered and acted on individually by the Committee.
   2. Factors to be considered by the C/PRC:
      a. History of actions taken by a licensing body.
      b. History of suspension or exclusion from federal or state health care programs,
      c. History of criminal charges, if any.
      d. History of grievances and complaints by Plan Members (for recredentialing).
      e. Reviews submitted to the C/PRC by the QIC (for recredentialing).
      f. Peer review issues referred to the C/PRC and verified and rated as significant Potential Quality Issues (for recredentialing);
      g. History of the provider failing to abide by the policies of GCHP, including failing to meet the standard quality

indicators such as HEDIS Metrics and access requirements (for recredentialing).

3. These factors will be considered as a whole for use by the C/PRC in determining if a provider will be credentialed or re-credentialed and to determine the services that the provider may provide to Plan Members.
4. A provider will receive one of the following designations from the Committee:
    a. Approved without reservation
    b. Approved with reservation (follow up within 3, 6, 9, 12 months)
    c. Not approved because of insufficient data
    d. Not approved (final decision)
    e. Decision pending receipt of further information
    f. Suspended

vii. Communications of Credentialing Decisions

1. The staff member responsible for administration and coordination for the C/PRC activities, generally the Credentialing Specialist will send a letter to the Organizational Provider informing it of a decision (for new applicants) or of a denial of the application (for applicants for recredentialing), within 60 days of such decision. The staff member responsible for administration and coordination for the C/PRC activities, generally the Credentialing Specialist, will also notify Provider Network Operations of any denials of recredentialing applications.

E. Ongoing Monitoring

i. GCHP staff monitors provider sanctions, and grievances/complaints and quality issues between credentialing cycles and takes appropriate action(s) against providers when it identifies occurrences of poor quality. GCHP acts on important quality and safety issues in a timely manner by reporting such occurrences at C/PRC meetings or as needed. These providers will be identified as Type II when they are presented to the C/PRC.

ii. If an occurrence requires urgent attention, the CMO or designee will address it immediately, issuing appropriate action(s) to ensure quality and safety for GCHP members. The C/PRC will be engaged, as appropriate. If the CMO determines that there is an immediate danger to the provision of care by a provider, the CMO or designee may summarily suspend the provider.

iii. On an ongoing monitoring basis, GCHP collects and takes appropriate intervention and/or action by:

1. Collecting and reviewing Medicare and Medicaid sanctions. All providers must maintain good standing in the Medicare or Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal programs may not participate in the GCHP provider network.
2. Collecting and reviewing grievances/complaints:
    a. Member Complaints/Grievances:
        i. The CMO or designee will review a report of Member complaints/grievances quarterly and at year end. If an unusually large number of grievances, as defined in the criteria below, are filed against a provider, the CMO or designee will review copies of the actual grievance documentation and will make a determination as to whether the grievance materials should be submitted to the C/PRC at the next regularly scheduled meeting.
3. Collecting and reviewing information from identified adverse events:
    a. GCHP staff monitors for adverse events at least every six months to determine if there is evidence of poor quality that could affect the health and safety of Members. Depending on the nature of the adverse event, GCHP will implement actions and/or interventions based on its policies and procedures when instances of poor quality are identified.
4. Collecting and reviewing information on validity of license and administrative sanctions through CDPH and Licensed Facility Information Systems.
5. Potential Quality Issues (PQIs): Refer to GCHP P&P QI-023 *Potential Quality Issue Investigation*.

F. Disclosure of Confidential Provider Information
    i. Prior to disclosing any confidential provider information via phone, the following must be verified by the credentialing staff and confirmed by the provider or designee listed on the credentialing application (i.e., provider's credentialing staff, office manager or any authorized person designated by provider):
    ii. The Organizational Provider's communication is primarily by email. The Email and contact name must match what is listed on application/file. If a phone call or email is received and the contact information doesn't match that on the application, then a call is placed to the provider/owner to provide authorization and have them send email authorizing the new contact.

G. File Retention
    i. Credentialing files shall be retained for at least seven years, as set forth in GCHP's P&P ADM-005 *Records Management Program*. Credentialing files are considered protected and confidential. Each provider has an electronic file in the Quality Improvement (QI) directory and/or within the Credentialing Verification Organization (CVO). File cabinets containing provider files shall be locked and/or secured at all times. Staff utilizing provider files shall ensure files will be secured, as practical or business appropriate, after normal business hours.

H. Delegated Credentialing
    i. Delegation is the formal process by which a managed care organization (MCO) such as GCHP, gives another entity (e.g., an Independent Practice Association (IPA), hospital, medical group) the authority to perform credentialing functions on its behalf. When functions are delegated, the MCO, e.g., GCHP (i) is responsible and accountable for assuring that the same standards of participation are maintained throughout its provider network; (ii) retains the right to approve, suspend, or terminate all providers and sites of care; and (iii) ensures that a consistent and equitable process is used throughout its network by requiring:
        1. That the delegated entity adheres to at least the same criteria, policies, and procedures. GCHP will evaluate the delegated entity's capacity to perform the delegated activities prior to delegation;
        2. A mutually agreed upon document, which may be a contract, exhibit, letter, memorandum of understanding, or other document, which clearly defines the performance expectations for GCHP and the delegated entity. This document will define GCHP's and the delegate's specific duties, responsibilities, activities, reporting requirements, and identify how GCHP will monitor and evaluate the delegate's performance. This mutually agreed upon document will also specify the remedies available to GCHP, including (but not limited to) revocation of the delegation if the delegate does not fulfill its obligations;
        3. GCHP staff audit the delegate's files on an annual basis to evaluate whether the delegated entity's activities are being conducted in accordance with GCHP expectations and NCQA standards. The only exception to the oversight requirements is when GCHP delegates to an entity that is NCQA Certified for Credentialing or NCQA Accredited. GCHP does not need to conduct an annual file audit or evaluation, however, credentialing policies and procedures will be reviewed as applicable to delegated functions;

4. If monitoring reveals deficiencies in the delegate's credentialing and recredentialing processes, GCHP will work with the delegate to set priorities and correct the problems. If serious problems cannot be corrected, GCHP will take action that may include imposing sanctions, de-delegation of the delegated function or termination of the contract or agreement;
5. That GCHP retains the right, based on quality issues, to approve, to suspend or terminate providers;
6. Functions performed by vendors that do not involve decision-making are not delegated functions, as defined in this section.
7. If GCHP delegates authority to perform credentialing reviews to a professional credentialing verification organization, the delegation will be in a written subcontract or agreement and comply with the requirements set forth in APL 23-006 *Delegation and Subcontractor Network Certification* and any subsequent APL.

V. Attachments

A. National Provider Data Bank and Healthcare Integrity and Portability Data Bank (If applicable): www.npdb-hipdb.com
B. National Plan and Provider Enumeration System (NPPES) https://npiregistry.cms.hhs.gov/
C. Medi-Cal www.medi-cal.ca.gov
D. Direct Link to Suspended and Ineligible Provider List: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
E. Enrolled Medi-Cal https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers
F. The Licensed Facility Information System (LFIS) www.alirts.oshpd.ca.gov/Default.aspx
G. Direct Link to OSHPD: www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx
H. The California Department of Public Health (CDPH) http://www.cdph.ca.gov/Pages/DEFAULT.aspx
I. Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing
J. Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx
K. Department of Health Care Services (DHCS) www.dhcs.ca.gov
L. Sanctioning Bodies
    i. Procurent/Non procurent: www.sam.gov
    ii. Office of Inspector General: www.oig.hhs.gov/fraud/exclusions/database.html

iii. Medicare Opt Out/NHIC: www.med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing

M. Accrediting Bodies
   i. The Joint Commission (TJC): www.jointcommission.org
   ii. Healthcare Facilities Accreditation Program (HFAP): www.hfap.org
   iii. Det Norske Veritas (DNV▪GL): www.dnvglhealthcare.com
   iv. Center for Improvement in Healthcare Quality (CIHQ): www.cihq.org
   v. Accreditation Association for Ambulatory Health Care (AAAHC): www.aaahc.org/Accreditation/AAAHC
   vi. Community Health Accreditation Program (CHAP): www.chapinc.org
   vii. Accreditation Commission for Health Care (ACHC): www.achc.org
   viii. Commission on accreditation of Rehabilitation Facilities (CARF): www.carf.org
   ix. Commission for the Accreditation of Birth Centers (CABC): www.birthcenters.org
   x. Institute for Medical Quality (IMQ): http://www.imq.org/
   xi. Accreditation of Ambulatory Surgical Facilities (AAAASF): https://www.aaaasf.org/general/contact-us
   xii. National Dialysis Accreditation Commission (NDAC): https://ndacommission.com/
   xiii. Clinical Laboratory Improvement Amendments (CLIA): https://wwwn.cdc.gov/clia/Resources/LabSearch.aspx and/or https://www.cms.gov/apps/clia/clia_start.asp
   xiv. Ventura County EMS Agency: http://www.vchca.org/certification-and-licensure

N. Non-Accredited Organizational Providers:
   i. If an Organizational Provider is not accredited, Gold Coast Health Plan will accept a copy of a current CMS or State review (within 3 years). If the Organizational Provider does not have a current CMS or State review Gold Coast Health Plan will conduct an onsite quality assessment.

O. California Alcohol and Drug Program Certification: www.dhcs.ca.gov
P. Professional Liability Coverage – Certificate of Insurance submitted by the provider

VI. References

A. 42 CFR § 438.214
B. APL 18-022 Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services
C. APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment

D. APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
E. California Evidence Code, Section 1157
F. GCHP P&P QI-028: Fair Hearing Policy
G. GCHP P&P QI-023: Potential Quality Issue Investigation
H. GCHP P&P ADM-005: Records Management Program
I. HICE Site Review Tool 2023
J. Intermediate Care Facility for Developmentally Disabled (ICF/DD) Credentialing Attestation
K. MC Policy Letter 02-003, Credentialing & Re-Credentialing: Time Line Change, New Primary Source Verification Requirements and Verification of Credentials of Non-Physician Practitioners
L. Prevailing National Committee for Quality Assurance "Standards and Guidelines for the Accreditation of Health Plans" Credentialing and Recredentialing Standards

VII. Revision History

STATUS	DATE REVISED	REVIEW DATE	REVISION AUTHOR/APPROVER	REVISION SUMMARY
Created	01/27/2011		Charles Cho, MD, CMO	
Reviewed		01/27/2011	Earl Greenia, COO	
Approved		10/29/2014	Policy Review Committee	
Reviewed		01/05/2015	DHCS	
Reviewed		01/05/2015	Ruth Watson, COO, Interim CEO	
Reviewed		01/19/2016	DHCS	
Reviewed		01/20/2016	Dale Villani, CEO	
Approved		03/09/2017	Credentialing/Peer Review Committee (C/PRC)	
Reviewed		03/11/2017	Dale Villani, CEO	
Revised	12/05/2019		Kimberly Timmerman, QI Director	
Approved		12/05/2019	Credentialing/Peer Review Committee (C/PRC)	
Reviewed		12/05/2019	Nancy Wharfield, MD, CMO	
Reviewed		09/11/2020	DHCS	
Reviewed		09/15/2020	Robert Franco, Interim Compliance Officer	
Revised	05/25/2023		Rachel Ponce, Manager Quality Improvement	Included addition of non-responsive organizational

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				provider process, delegation of credentialing to a CVO language, and reference update.
Approved		06/01/2023	Credentialing/Peer Review Committee (C/PRC)	
Reviewed		06/08/2023	Nick Liguori, CEO	
Revised	11/22/2023		Rachel Ponce, Manager Quality Improvement	Inclusion of site review requirements for non-accredited organizational providers as well as a reference to the GCHP approved Site Review Tool to meet NCQA Health Plan Accreditation standard CR-7A.3. Removal of history of sanctions language from Minimum Criteria for Credentialing requirements.
Revised	01/05/2024		Rachel Ponce, Manager Quality Improvement	Removal of requirement to have C/PRC approval for Type I Providers.
Revised	01/23/2024		Jasmine Bailey, Credentialing Specialist III	Removal of Organizational Providers that provide care: Acute Rehabilitation Facilities and Emergency Medical Technicians
Revised	07/08/2024		Rachel Ponce, Manager Quality Improvement	Inclusion of credentialing and recredentialing requirements for ICF/DDS to align with APL 23-023.
Revised	07/23/2024		Jasmine Bailey, Credentialing Specialist III	Inclusion of non-discrimination language to align with State Bill 487: Abortion: Provider Protections.
Revised	08/08/2024		Jasmine Bailey, Credentialing Specialist III	Removed C360 and replaced with new compliance system Policy Tech