Yamhill Community Care
POLICY AND PROCEDURE

POLICY NUMBER: QA-002	**TITLE:** Credentialing Process
DEPARTMENT: Quality Assurance	**APPROVED BY:** President/CEO
EFFECTIVE DATE: 11/18/2016	**REVISION DATE:** 04/19/2023
REVIEW DATES: 10/19/2017, 07/30/2019, 08/01/2020,	
APPLIES TO: Yamhill Community Care, Providers and Subcontractors	

DEFINITIONS:

Practitioner/Provider	A person who is licensed pursuant to Oregon state law to engage in the provision of health care services within the scope of their license or certification. An individual, facility, institution, corporate entity, or other organization which supplies or provides for the supply of services, goods or supplies to covered individuals pursuant to a contract, including but not limited to a provider enrollment agreement. A provider does not include billing providers as used in the Division of Medical Assistance (DMAP) general rules. DMAP billing providers are defined in these rules as agents, except for DMAP billing providers that are clinics
Practitioner/Provider Types	Healthcare Professionals, Allied Health Professionals, Behavioral Health Professionals, Dental Health Professionals, Peer Support Professionals, Traditional Health Worker & Non-Emergent Medical Transportation Professionals
Credentialing/ Recredentialing	A standardized process of inquiry undertaken to validate specific information that confirms a health care practitioner's identity, background, education, competency, and qualifications related to a specific set of established standards or criteria for providers who have requested participation or re-participation with Yamhill Community Care.
Credentialing Period	The period beginning on the date a health insurer receives a complete application and ending on the date the health insurer approves or rejects the complete application or 90 days after the health insurer receives the complete application, whichever is earlier.
Licensed Independent Practitioner	Licensed Independent Practitioner's, who are certified, registered, and/or licensed by a recognized Federal, Oregon State, Washington State, or Idaho State Board to operate independent of supervision in the delivery of services to enrolled members.

National Practitioner Data Bank	A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance.-
National Committee for Quality Assurance (NCQA)	An independent non-profit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)	Office of Inspector General (OIG) has the authority to exclude individuals and entities from Federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties.
Primary Source Verification	The process by which the organization verifies credentialing information directly from the entity that originally conferred or issued the credentialing element to the provider.
Specialist Providers	Any Provider not acting as a primary care provider who has clinical training in a specified area. Medical specialist are doctors who have completed advanced education and clinical training in a specific area of medicine.
Subcontractor	An individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A Participating Provider is not a Subcontractor solely by virtue of having entered into a Participating Provider agreement with an MCE.
System For Award Management (SAM)	A dataset of individuals and entities that are sanctioned or excluded from doing business under a federal contract.
Telemedicine	Use of medical information, exchanged from one site to another, via telephonic or electronic communications, to improve a patient's health status.
Traditional Health Worker (THW)	Umbrella term for frontline public health workers who work in a community or clinic under the direction of a licensed health provider. The five types of Traditional Health Workers: Birth Doula, Personal Health Navigator, Peer Support Specialists, Peer Wellness Specialist and Community Health Workers.

POLICY:

Yamhill Community Care (YCCO) and subcontractors comply with all applicable federal, state, contractual rules and regulations.

This policy establishes guidelines for all aspects of the credentialing process for acute, primary, behavioral, substance use disorders, traditional health workers (THW), and long-term service and supports (LTSS) providers including the delegation of any of the credentialing process activities including provider selection and retention. YCCO ensures that all practitioners/providers have the legal authority and appropriate training, certification, license, and experience to provide care to members prior to participation with the coordinated care organization and that the process will be followed for all licensures and by any entities that perform the process on YCCO's request or behalf.

PROCESS:

Credential Verification:

All new provider applicants should complete the Oregon Practitioner Credentialing Application (OPCA) including Attachment A and Release of Information Form. For licensed independent practitioners, YCCO ensures that a standard process is followed for verifying credentials (primary source verification) and is done in accordance to recognized standards with approved organizations, educational institutions, and licensing boards. At minimum:

- Current/Valid State License
- Education & Training including Board Certification; to verify current standing or if provider has become board certified (as applicable)
- Work History; minimum of 5 years, gaps not to exceed 2 months and date span must be in the month/year format
- Malpractice History; covers most recent 5-year period
- Criminal Background Check
- National Practitioner Databank (NPDB)
- Current/Valid DEA if applicable
- Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) specific to healthcare programs
- U.S. Government Services Administration System for Award Management (SAM) specific to parties excluded from federal contracts
- Information on sanctions, restrictions on licensure and limitations on scope of practice for the most recent 5-year period, available through data source, in all states in which applicant was licensed; or any reports filed with the NPDB
- Active clinical privileges at a participating hospital, or an arrangement with another participating provider who has privileges
- Current, adequate malpractice insurance ($1,000,000 per claim and $3,000,000 aggregate) and history of any liability claims paid on behalf of the provider must be present at the time of committee approval
- Current attestation must be signed and dated by applicant and include reasons for any inability to perform essential functions of the position; lack of present illegal drug use; history of loss of license and/or felony convictions; history of loss or limitation of privileges or disciplinary activity; signed and dated consent for impairment history records as applicable
- Consultation of OHA's Provider Enrollment file for Providers designated as high-risk or moderate providers required to undergo fingerprint-based background checks and site visit within the previous 5 years
- Background checks and OIG exclusion verification for Traditional Health Workers Education, experience, competence, and adequate supervision for providers not required to be licensed or certified by a State of Oregon board or licensing agency per OAR 410-180-0326.
- Accreditation by nationally recognized organizations if a program or facility is not required to be licensed or certified by a State of Oregon board or licensing agency, e.g., Council on Accredited Rehabilitation Facilities or The Joint Commission

Please note that if participating providers are not required to be licensed or certified by a State of Oregon board or licensing agency, then such participating providers must either (1) Meet the definitions for qualified mental health associate (QMHA) or qualified mental health professional (QMHP) and must not be permitted to provide services without the supervision of a licensed medical practitioner or (2) If not meeting either the definitions of a QMHP or QMHA, have the education, experience, and competence necessary to perform the specified assigned duties as per 42 CFR § 438.214(e)

Primary Source Verification

Credential	Verification Time Limit	Credentialing Services Verification Source(s)	Initial	Recred	Methods of Receipt
Current valid license to practice where the provider sees members, to meet CMS and NCQA requirements	180 Days	Documented verbal contact with the appropriate state licensing or certification agency. Electronic verification to state boards where active license is held.	X within the last 5 years	X within the last 3 years	Verbal Electronic
Clinical privileges in good standing at primary admitting facility (must be active admitting privileges at a participating hospital or a written admit plan)	180 days	Documented verbal contact with the facility, Copy of the practitioner directory/roster including name of the hospital, practitioner name, status of provider at hospital Verification letter from the hospital noting admitting privilege status	X	X	Verbal Mail Fax Electronic
Current valid DEA or CDS DEA = Drug Enforcement Agency CDS = Controlled Dangerous Substance	180 days Must be in effect at time of decision	Copy of DEA certificate showing expiration date U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control National Technical Information Service (NTIS) database American Medical Association (AMA) Physician Masterfile or American Osteopathic Association Official Osteopathic Physician Profile Report (DEA only) Address listed on the DEA is within the same state the practitioner is treating the member. Exceptions for DEA include specialties in which prescribing drugs are not the usual practice (AuD, CRNFA, DC, CNS, LPC, LAc, LMT, OT, OD, RPh, PT, RD, SLP and certified first assists.	X	X	Mail Fax Electronic
Education & training including graduation from medical school & completion of a residency program	Prior to the credentialing decision	Letter from school or facility Telephone verification to school/facility American Medical Association (AMA) Physician Masterfile Letter from Medical Board stating all education will be verified prior to licensing and it performs primary source verification Nurse Practitioner that are certified – confirmation letter from certifying board (i.e., ANCC) stating all education and training is primary source verified	X		Verbal Mail Fax Electronic

		Physician Assistants that are certified – confirmation letter from certifying board (i.e., NCCPA) stating all education and training is primary source verified Pharmacists – PGY1 ASHP accredited residency certificate of completion			
Board Certification (all board certifications must be verified)	180 days	ABMS or its member boards, or an official ABMS Display Agent, (Certifax) ABMS = American Board of Medical Specialties AMA Physician Master File. AOA Official Osteopathic Physician Profile Report or AOA Physician Master File. Recognized specialty board	(highest level of ed must be verified when not board certified)	X	Verbal Mail Fax Electronic
Work history within the most recent 5-year period. Gaps not to exceed 2 months.	180 days	Completed practitioner application, Curriculum Vitae showing last five years of work history (includes the beginning and ending month and year for each position of employment experience). If a gap greater than 2 months is discovered, an explanation of the gap will be required.	X Within the last 5 years	X Within the last 3 years	Verbal Mail Fax Electronic
Current adequate malpractice insurance within $1,000,000 for each occurrence and $3,000,000 aggregate.	180 days	Copy of insurance face sheet with practitioner's name, Attestation, letter of intent from malpractice carrier. Providers with federal tort coverage can include a copy of the federal tort letter or attestation from the practitioner of federal tort coverage.	X	X	Mail Fax Electronic
History of professional liability claims that resulted in settlements or judgments within the most recent 5-year period.	180 days	Query to and report from NPDB NPDB = National Provider Data Bank	X	X	Electronic
NPDB Query	180 days	Query to and report from NPDB	X	X	Electronic
State sanctions, restrictions on licensure and/or limitations on scope of practice. Covers most recent 5-year period in all states where the practitioner has practiced.	180 days	Documentation from appropriate state agencies NPDB	X	X	Electronic
Medicare/Medicaid Sanctions History, OIG	180 days	List of Excluded Individuals and Entities (maintained by OIG), available over the Internet State Medicaid agency NPDB	X	X	Electronic

		Per CMS NPDB is not an acceptable source. CMS requires documentation of providers who have been sanctioned by Federal Medicare/Medicaid programs. Preclusion List			
Opt Out Note: Opt Out applies to MD, DO, DDS, DMD, DPM, OD, PA, NP, CNS, CRNA, CNM, Psychologist, LCSW, RD, Nutrition professional	180 days	CMS website: data.cms.gov	X	X	Electronic
GSA/System Awards Management	180 days	SAM.gov	X	X	Electronic
Preclusion	180 days	CMS website: data.cms.gov	X	X	Electronic
NPI	180 days	NPPES NPI Registry: npiregistry.cms.hhs.gov	X	X	Electronic
Death Master File	180 days	ssdmf.com	X	X	Electronic
THW Registry	Must be in effect at time of decision and at least quarterly ongoing	THW Registry https://traditionalhealthworkerregistry.oregon.gov/Search	X	X	Electronic
THW Background Check	Must be passed at time of decision	Verification completed via the OHA THW Registry* Noting of background check completed through the OHA Registry noted in the provider file.	X	X	Electronic

Telemedicine Credentialing
Referring and evaluating providers must be licensed to practice medicine with the state of Oregon or within contiguous are of Oregon and must be enrolled as a Division of Medical Assistance Programs (Division) provider.

Recredentialing Verification
All recredentialing applicants should complete the Oregon Practitioner Recredentialing Application (OPRA) including Attachment A and Release of Information Form. The process is consistent with initial credentialing requirements.

General Service Administration's System for Award Management (SAM) & Office of Inspector General's List of Excluded Individuals and Entities (OIG LEIE) Screening
YCCO screens all providers against SAM and OIG LEIE during the credentialing process Additionally, providers are screened at least monthly to ensure they have not been excluded from participating in federal health care programs. Additional information on this process is located in QA-001 Exclusion Screening Policy and Procedure.

National Practitioner Data Bank (NPDB)
YCCO screens all providers against the NPDB. The NPDB is a web-based repository of reports containing information on medical malpractice payment and certain adverse actions related to health care practitioners, providers, and suppliers. The providers report information

is used in the credentialing and contracting determination process for participation in the YCCO network.

Non-Discrimination
YCCO will not make credentialing or recredentialing decision based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, the types of procedures or types of patients the provider specializes in. YCCO will monitor the provider complaints to ensure that no concerns regarding discrimination exist. The process in the selection and retention of network provider does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

YCCO will not discriminate in the participation, indemnification or reimbursement of any provider who is acting within their license or certification under applicable state law, solely of the basis of the license or certification.

- The above may not be interpreted to:
  - Require YCCO to contract with providers beyond the number necessary to meet the needs of the enrollees;
  - Prevent YCCO from using different reimbursement amounts for different specialties or for different providers of the same specialty; or
  - Prevent YCCO from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to its members.

Credentialing Decisions and Notification:
Decisions
All files satisfactorily passing the primary source verification will be forwarded to the credentialing committee which includes the medical director for determination of plan participation. Should the provider not meet the established thresholds the Chief Medical Officer will seek advice and expertise from participating providers on the determination. In the event that YCCO assumes the credentialing and recredentialing functions a Credentialing Committee with be formed or the functions absorbed by the appropriate committee. Currently YCCO utilizes subcontractors for credentialing and recredentialing with use of the partner Credentialing Committee with YCCO Chief Medical Officer input when applicable.

Process Timeframes & Notifications
- Processing will be completed in accordance with ORS 743.918 (within 90 days upon receipt of a completed application).
- Application and Attestation date must be within 180 days of credentialing committee decision.
- Evidence of SAM & OIG LEIE query within 180 days of decision date.
- Provider notification within 60 calendar days of the credentialing committee decision date.
- Recredentialing will take place no less frequently than every 3 years.

Actionable Issues
1. Credentialing or Contract Issues
   a. All participating practitioners and organizational providers are required to meet and maintain compliance with credentialing criteria.
   b. Credentialing or contract issues include without limitation, the following:
      i. Failure to maintain required professional liability insurance coverage
      ii. Leaving active practice in contracted service area
      iii. Failing otherwise to comply with the contract or with the YCCO's rules and regulations
      iv. Failure to meet credentialing criteria

v. Failure to comply with billing or coding standards generally accepted by the profession
vi. Submission of inaccurate information

2. A participating practitioner or organizational provider has no right to appeal the YCCO's decision to terminate credentialing based on failure to comply with the following credentialing or contracting requirements:
    a. Failure to maintain professional licensure
    b. Failure to maintain board certification
    c. Failure to maintain professional liability insurance coverage
    d. Change in practice location when credentialing approval is based on network need
    e. Failure to a respond to a request for credentialing information within 30 calendar days of the request
    f. Failure to comply with conditional credentialing requirements, including without limitation obtaining and maintaining any required board certification
3. Upon discovery of noncompliance with credentialing or contracting requirements, the Credentialing Department will notify the Chief Medical Officer (CMO) or physician designee of the non-compliance and Provider Relations to initiate appropriate action.
4. When a credentialing action is taken based on credentialing or contracting requirements, a report may be required to the National Practitioners Data Bank (NPDB) as required by law.

Quality of Patient Care Issues

1. "Quality of patient care" refers to standards of practice that, in The YCCO's judgment, are related to ensuring an appropriate medical outcome of treatment, including without limitation practitioner competency, rather than to patient convenience or to other concerns. In general, whenever a credentialing action is taken based on quality of patient care, a report will be required to the National Practitioners Data Bank (NPDB) as prescribed by law.
2. Quality of Patient Care Issues include, without limitation the following:
    a. Incompetence
    b. Unethical practice
    c. Felony Conviction
    d. Abuse of drugs and alcohol
    e. Loss or reduction of hospital privileges
    f. Licensing board actions related to patient care
    g. Misrepresentations to Members regarding the provision of medical services or payment
    h. Other conduct reasonably deemed to be detrimental to quality of patient care or a failure to observe quality assurance and utilization protocols

Chief Medical Officer and Credentialing Committee Review

1. Any information that may result in a credentialing action will be immediately referred to the CMO or physician designee for review.
2. The CMO or designee shall conduct a preliminary investigation and review the case with the YCCO, as appropriate
3. Unless the CMO or designee exonerates the practitioner, the CMO or designee shall refer the matter with recommendation to the Credentialing Committee for decision.
4. If the Credentialing Committee recommends exoneration, the Credentialing Committee's decision to exonerate will stand. In the event the Credentialing Committee determines that any action other than exoneration is appropriate, the participating practitioner or organizational provider will be given written notice of the decision and the opportunity to request a hearing, if applicable.

Appeal Process

1. A participating practitioner or organizational provider subject to an adverse decision of the Credentialing Committee on a credentialing or contracting matter may request a hearing as provided in this Section III. No appeal is available to initial credentialing applicants or when credentialing or contract is terminated for one of the reasons set out this policy.
2. Written notice of the opportunity to request a hearing shall include:
    a. That a credentialing action is proposed;
    b. The reasons for the proposed action;
    c. Appeal rights to request a hearing on the proposed action;
    d. The practitioner or organizational provider has 30 calendar days after the notification was sent to request a hearing. The request much be in writing.
    e. A summary of hearing rights, including the right to:
        i. Representation by an attorney or other person of the practitioner or organizational provider's choice;
        ii. Select one of the 3 Hearing Panel members if the termination is related to quality of patient care or otherwise "with cause", provided that the nominee mush be qualified by training to evaluate the issues involved, not have previously participated in the matter and not be in direct economic competition with the practitioner or organizational provider;
        iii. Have a record made of the proceeding, copies of which may be obtained by the practitioner or organizational provider upon payment of a reasonable charge;
        iv. Call, examine, cross-examine witnesses;
        v. Present evidence determined to be relevant by the Hearing Panel regardless of its admissibility in any court of law; and
        vi. Submit a written statement at the hearing.
3. A statement of the practitioner or organizational provider's status pending the hearing, particularly including whether members may or may not be serviced without limitation or restriction pending the hearing.
4. Within 15 days of a request for hearing, or such longer time as may be required based on delay in appointment of panel member by the practitioner or organizational provider, a Hearing Panel will be appointed. The Panel is composed of 3 persons professionally qualified to evaluate the standards applicable to the practitioner or organizational provider. Whenever reasonably possible, the majority of the hearing panel members will be clinical peers. A clinical peer is defined as a medical practitioner with the same professional degree or higher,
5. In the event that the termination was based on credentialing or contract issues other than quality of patient care, YCCO will appoint the three members of the panel.
6. YCCO will not be held responsible for any expenses incurred by the practitioner or organizational provider, including, but not limited to, panel representation, expert witnesses, preparatory work, work-day interruption, and/or case reviewers. In particular, panel members chosen by the practitioner or organizational provider to participate on the panel are not compensated by YCCO for service on the panel.
7. Within 10 days after panel members have been appointment, the hearing will be scheduled, and notification will be sent to the Hearing Panel members and the practitioner or organizational provider. Notification will include date, time, and place of the hearing (hereafter "Fair Hearing"). The Fair Hearing date should not be less than 30 days after the notice without consent of the practitioner and should be scheduled in any event within 60 days of the notice. YCCO will make all reasonable efforts to meet these timelines but will coordinate hearing dates with the practitioner or organizational provider.
8. The Fair Hearing will be scheduled and completed within 180 days from the date of the request for hearing. Absent waiver of the requirement by YCCO, failure of the practitioner requesting a hearing to accept a hearing date within 180 days constitutes a waiver of rights to a Fair Hearing and a voluntary acceptance of the final proposed or

adverse action, which will become effective on the date specified in the notice informing the practitioner that the right to a Fair Hearing has been waived.

9. Failure to appeal at a scheduled Fair Hearing, without good cause, constitutes a waiver of the right to a Fair Hearing.
10. The process for Fair Hearings will be as follows:
    a. A record of the hearing will be made by electronic recording if all participants agree and/or by staff minutes;
    b. The YCCO will be represented by staff or by counsel, and will begin with an opening statement, followed by such testimony or other evidence as it wishes to present;
    c. At the discretion of the Hearing Panel, the practitioner or organizational provider may offer an opening statement either after The YCCO's opening statement or after completion of The YCCO's evidence;
    d. After completion of The YCCO's evidence, the practitioner or organizational provider shall offer such testimony or other evidence as they wish to present;
    e. The Hearing Panel in its discretion may ask any questions it wishes to ask, may permit such rebuttal as it deems useful, and may invite verbal or written closing arguments from the parties;
    f. The practitioner or organizational provider will be excused so the Hearing Panel may deliberate, with or without participation by The YCCO at the Panel's discretion.
11. The record will be considered closed at the end of the Fair Hearing unless the practitioner or organizational provider requests and the Hearing Panel grants additional time to submit supplementary materials or briefing, in which case the record will be considered closed upon receipt of those materials by the Hearing Panel. The Hearing Panel shall issue a written notice of the appeal decision to the YCCO, copy to the practitioner or organizational provider, within ten (10) days after the record is closed. The decision shall be in writing, including a statement of the specific reason(s) for the decision.
12. In the event the Hearings Panel upholds a practitioner's appeal requesting continuation of full credentialing, the practitioner will be recredentialed without further action. In the event the Hearing Panel determines to impose conditions under which the credentialing will be upheld or denied, those conditions will be given effect without any additional hearing. In the event the Hearings Panel denies the practitioner's appeal, no further administrative appeal is provided and any required report regarding credentialing, participation, or quality of patient care will be made to the NPDB as prescribed by law.
13. Reporting to Authorities - The decision of the Hearing Panel is final unless overturned by an order of a court of competent jurisdiction. If the final determination is a reportable event.

Summary Suspension

The Chief Medical Officer or designee, or the Chief Executive Officer, each have authority to summarily suspend a participating practitioner or organizational provider's credentialing status whenever any of them determines that failure to do so may result in an imminent danger to the health and/or safety of any individual or to the reputation of YCCO.

Any such action will be reported to each of the individuals listed above and referred to the Credentialing Committee at its next regularly scheduled meeting for a determination on whether the practitioner or organizational provider's credentialing will be terminated or otherwise subjected to further action. Any decision of the Credentialing Committee will be subject to appeal as provided in this policy. The Credentialing Committee may decide to continue a summary suspension during the appeal process.

A summary suspension is effective immediately upon notification. The notice of suspension shall include the following:

- An explanation of the cause of the suspension to the affected practitioner or organizational provider; and
- Notice that the matter will be referred to the Credentialing Committee at its next regularly scheduled meeting for final determination

Member Notification
In the event of termination, Provider Relations will be notified in order to assist Members in the transition care.

YCCO will not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

YCCO will decline to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.

Providers that are declined a contract will receive information on the dispute resolution process, including the use of an independent third-party arbitrator, for a provider's termination, declination, or non-renewal of a provider contract per OAR 410-141-3560.

YCCO will terminate a provider contract immediately upon receipt of Legal Notice from the State that a provider is precluded from being enrolled as a Medicaid provider.

Provisional Contracts:
YCCO may execute provisional provider contracts pending the outcome of screening and enrollment with OHA, this contract may be for no longer than 120 days. The contract will terminate immediately if notified by OHA that the provider is precluded from being enrolled as a Medicaid provider. Notwithstanding the forgoing YCCO may not execute provisional provider contracts with moderate or high-risk providers who are required to undergo fingerprint-based background checks until the provider has been approved for enrollment by OHA. If provider has undergone a fingerprint-based background check as part of Medicare enrollment, this will be deemed to satisfy the requirement for OHA provider enrollment.

Provider Rights:
Providers have rights during the credentialing and recredentialing process including having a right to be informed (upon request) of the status of their application, a right to review non-protected information obtained during the credentialing or recredentialing process and the right to correct erroneous information. Providers will be informed of their provider rights, privacy and appeal rights and credentialing and recredentialing activities will be conducted in a non-discriminatory manner. Payment will be made to the provider during the credentialing period according to ORS 743.918.

Record Keeping:
Documents, drafts, records, and paperwork will be retained in accordance with the Record Retention Policy and Procedure, OAR 410-141-3520, and 42 CFR 455.410 through 42 CFR 455.470).

Additional Provider Requirements:
Seclusion and Restraint:
All contracted providers and facilities have policies and procedures or other documentation pertaining to use of seclusion and restraint. Review will take place of the use of seclusion and restraint in facilities licensed for its use and assess during the credentialing and recredentialing process if the organizations use is appropriate in accordance with 42 CFR Ch.E. Subpart C 438.100 (b) (2) (v)

Enrollee Rights to Clinical Records:
Providers and facilities are informed of and have an enrollee right to clinical records policy/procedure pertaining to the member's right to receive and request clinical records and the right to request amendment or correction in accordance with 42 CFR 438.100 (b) (2) (3); (d)

Provider Retention and Training:
YCCO provides training for CCO staff and participating providers and their staff regarding the delivery of covered services, applicable administrative rules, and the CCO's administrative policies.

YCCO provides Cultural Responsiveness and Implicit Bias training for CCO staff and the provider network which, at a minimum, includes:

a. Implicit bias/addressing structural barriers and systemic oppression;
b. Language access and use of health care interpreters;
c. Culturally and Linguistically Appropriate Services (CLAS) Standards;
d. Adverse childhood experiences/trauma informed care;
e. Uses of data to advance health equity; and
f. Universal access or accessibility in addition to ADA.

YCCO staff, participating providers and their staff will be trained in applicable contracting and credentialing State and Federal rules and regulations, as well as the YCCO Credentialing Process policy.

YCCO staff, participating providers and their staff will be trained in the following:

- The credentialing of providers;
- Delivery of covered services; and
- Sub-contracting with third parties

Training must include material relating to, as set forth in 42 CFR §§438.608(b) and 438.214(d):(i) the credentialing and enrollment of providers and subcontractors and (ii) the prohibition of employing, contracting, or otherwise being affiliated with (or any combination or all of the foregoing) with sanctioned individuals.

YCCO provides access to the YCCO Credentialing Process policy on the YCCO website and in Community Integration Management (CIM) system.

Sub-Contracting:

1. If a subcontractor chooses to contract any or all of the credentialing or recredentialing functions the subcontractor provides YCCO with the following upon request:
    a. Written description of the subcontracted activities
    b. Documented audit prior to contracting
    c. Documented annual audits of contracted activities as well as subcontracted activities.

OVERSIGHT & COMPLIANCE:

YCCO will ensure processes to monitor credentialing by performing a review (audit) of the subcontractor. The audit process is based on the contractual agreement to which both organizations have agreed to which will include the following:

- Description of the contracted activities and responsibilities of the organization and the subcontractor.

- Requirement of semiannual reporting to the organization (at a minimum must include progress in conducting credentialing and recredentialing activities and on activities to improve performance.)
- Process by which the organization evaluates the subcontractor performance.
- Specifies that the organization retains the right to approve, suspend and terminate individual practitioner, providers, and sites, even if the organization contracts decision making.
- Describes the remedies available to the organization if the subcontractor does not fulfill its obligations, including revocation of the contractual agreement.
- Provisions for protected health information.

YCCO THW Liaison will complete a quarterly THW registry check of all contracted THWs to ensure providers are still active and registry has not terminated. This information will be documented and saved in the YCCO contract file.

YCCO will utilize a credentialing audit tool based on the Oregon Credentialing Audit Tool and the Oregon Credentialing File Review Tool and will include the following:

- Review of policies and procedures
- Monitoring of Restraints and Seclusion during initial credentialing and again during recredentialing
- File review of initial credentialed practitioners and facilities
- File review of recredentialed practitioners and facilities
- Initial and ongoing monitoring of SAM and OIG LEIE, THW registry, limitations of licensure, complaints, adverse events, and poor quality. This will include the initial report of individuals and organizations as well as a process for ongoing monitoring. Interventions for findings indicating complaints, adverse events, or poor quality.
- All audit findings will be reviewed by the appropriate YCCO committees and if applicable a corrective action plan will be constructed and monitored.

REFERENCES:

ORS 743B.454 1(b)
OAR 410-141-3510; 410-141-3560
42 CFR 438.12, 438.214, 438.230, 438.100; 455.400-470 (excluding 460), 42 CFR 455.3
CCO Contract, Exhibit B, Part 4, Section 5Section 1128 or 1128A of the Social Security Act
OHA's Provider Enrollment File and CMS Provider Types and Risk Categories document, available at www.oregon.gov/oha/hsd/ohp/pages/plan-tools.aspx

RELATED POLICIES & DOCUMENTS:

QA-001 Exclusion Screening
CMPL-014 Record Retention
QA-007 Subcontractor Oversight
ENR-003 Restraints and Seclusions
YCCO Credentialing Audit Tool
Oregon Credentialing File Review Tool

Log of Review/Revision

Date	Review/Revision	By Whom
11/18/2016	Credentialing requirements of various health care professionals added- Process A.	Ebenjamin, Quality Oversight Coordinator
11/18/2016	Approved	SMcCarthy, Director of Operations and Integration
04/06/2017	Policy Revised and Updated	JRoe, Quality Assurance Specialist
04/14/2017	Approved	BRajani, Medical Director

04/21/2017	Approved	SMcCarthy Interim Chief Executive Officer
10/19/2017	Policy revised, updated, and put into new format	Jroe, Quality Assurance Specialist
11/01/2017	Approved	BRajani, MD Medical Director SMcCarthy, PhD President/CEO
07/30/2019	Branding and reformatting to current policy template with additions and/or clarifications of current OAR, CFR, and OHA CCO Contract language.	JRoe, Quality Assurance Specialist
10/29/2019	Definition updates	JRoe, Quality Assurance Specialist
08/01/2020	Update to formatting bullets for policy clarification, OAR update and typo fix.	JRoe, Quality Assurance Specialist
5/6/2021	Update to include required language for external quality review	ALee, Sr. Contract/Compliance Analyst
5/12/2021	Approved	SMcCarthy, President/CEO
11/23/2021	Clarified screening requirements for providers identified by CMS as moderate or high risk	JHowell, FWA Program & Oversight Specialist
03/29/2022	Clarification of provider training to create clarity.	JRoe, Benefit Administration Supervisor
04/09/2022	Formatting and subcontractor clarification updates only, no content change	JRoe, Benefit Administration Supervisor
06/24/2022	Policy updated with Fair Hearing Clarification, table added to indicate additional primary source verification processes and additional formatting to enhance readability.	JRoe, Benefit Administration Supervisor
10/26/2022	Fixed process timeframes and notifications deleted in error by entering as present in the previous version.	JRoe, Benefit Administration Supervisor
04/19/2023	THW additions and credentialing requirements.	JRoe, Health Plan Operations Manager