I. SCOPE

This policy applies to (1) Canopy Health, LLC ("Canopy Health") and its subsidiaries and affiliates (each, an "Affiliate"); and (2) any other entity or organization with which Canopy Health contracts for such entity or organization to perform provider credentialing on Canopy Health's behalf (each a "Contractor") To the extent that any Contractors perform functions set forth herein, references to "Canopy Health" or the "Credentialing Department" shall be interpreted to refer to such Contractors.

II. PURPOSE

The purpose of this policy is to implement a fair and reasonable process to evaluate the qualifications of practitioners seeking continued participation in Canopy Health's network.

III. DEFINITIONS

Attestation: The statement which attests to the validity of information contained in the application and releases the network, or its designee Canopy Health, to obtain primary source verifications.

Credentialing Peer Review Committee: A group of providers selected by Canopy Health that evaluate the qualifications and make the final determination regarding the status of providers applying for participation in Canopy Health's network, and evaluate the necessity, quality or utilization of care rendered by providers in the network. Peer review is conducted by other health care providers from the same discipline or with similar or essentially equal qualifications who are not in direct economic competition with the health care professional under review.

Participating Provider: Any practitioner or organization that is contracted or employed by Canopy Health to render services to members.

Primary Source: An organization or entity with legal responsibility for originating a document and ensuring the accuracy of the information it conveys.

IV. POLICY

A. It is the policy of Canopy Health to implement a recredentialing program to verify the professional qualifications of all providers seeking continued participation in each network within the required state recredentialing cycle length, but no more than 36 months after the date of the previous credentialing decision.

B. Canopy Health ensures that providers are thoroughly and appropriately recredentialed per standards of the National Committee for Quality Assurance ("NCQA") and all other state and federal regulations, as applicable.

C. Providers who do not meet the criteria set forth in this policy are either not eligible for continued participation or must be presented to the CPRC for review and determination.

D. The CPRC retains the final authority to make the determination about which practitioners participate within its network.

E. All documents and information obtained during the credentialing process are confidential and access is limited to committee members and Canopy employees who are directly involved in the process.
   1. Electronic information is stored on secure servers.
   2. Hard copy information is housed in locked file cabinets and/or other locked area(s) with access limited to Canopy Credentialing Department employees.
   3. The credentialing application, its contents and the information obtained during the credentialing process are protected from discovery under Section 1157 of the California Evidence Code.
   4. Contents of the credential file may not reproduced or distributed, except for purposes of confidential peer review and credentialing consistent with §1157 or for the express purpose of contracted health plan/National Committee for Quality Assurance (NCQA) delegation oversight processes.

V. PROCEDURE

A. The Canopy Health credentialing department ("CD") will determine whether or not a practitioner is eligible for recredentialing six months prior to their recredentialing due date.
   1. A validation of the provider's contract will be completed immediately upon generating Recredentialing Report

   Providers identified as missing contracts will be subject to additional review:
   - a. In instances where providers are not contracted:
     - (i) CPRC will decide whether provider should be contracted.
       - a) Should decision be within the 36 month timeframe then the provider will be recredentialed.
       - b) If outside of the 36 month timeframe provider will be initially credentialed.
   - b. If CPRC decides not to contract the provider, the provider will no longer be identified in Canopy Health materials as part of Canopy Health's network and the provider's record in the credentialing database will be deactivated.

B. Once contracts are validated, outreach for a recredentialing application will be conducted.
   1. 1st Request for Recredentialing: this is completed five months prior to the recredentialing due date.
      a. A letter is generated and sent to the provider's office indicating that they are due for recredentialing and an application is needed to ensure they remain compliant.
   2. 2nd Request for Recredentialing: this is completed four months prior to the recredentialing due date.
      a. A letter is generated and sent to the provider's office indicating that they are due for recredentialing and an application is needed to ensure they remain compliant.
      b. A memo is faxed to the office.
      c. A phone call is made to the office.
   3. 3rd Request for Recredentialing: this is completed three months prior to the recredentialing due date.
      a. A letter is generated and sent to the provider's office indicating that they are due for recredentialing and an application is needed to ensure they remain compliant.
      b. A phone call is placed to the office along with a fax.
      c. A memo is faxed to the office.
      d. A phone call is made to the office.
      e.
   4. Non-responsive providers who do not respond to the 1st, 2nd, or 3rd requests will be included in the CPRC meeting as non-compliant to policy with a recommendation to terminate; the CPRC must decide how to proceed.
   5. If the network terminates a practitioner that it later decides to reinstate, the practitioner must be initially credentialed if the break in network participation is more than 30 calendar days or exceeds the recredentialing cycle length of 36 months.

C. Practitioners are required to submit a recredentialing application and all necessary supporting documentation.

D. The recredentialing process begins upon receipt of a completed and signed application and supporting documents, including the following information:
   1. State licensure information of current and previously held licensure in all jurisdictions

2. Evidence of current Drug Enforcement Agency ("DEA") certificate or state controlled dangerous substance certificate, or covering provider information, if applicable
3. Current hospital affiliations or privileges, or covering information, if applicable
4. History of loss or limitation of privileges or disciplinary action
5. Current professional liability coverage clearly identifying the provider, expiration date, and coverage type
6. Professional liability claims history
7. Reasons for inability to perform the essential functions of the position, with or without accommodation
8. Lack of present illegal drug use
9. History of loss of license, felony convictions, or sanctions
10. A signed attestation from the provider as to the correctness and completeness of the application
11. A signed release from the provider authorizing the disclosure, inspection, and copying of information and documents pertaining to credentialing qualifications between authorized Healthcare Organizations
12. Signed and dated statement authorizing collection of any information necessary to verify the information in the application; CAQH electronic attestation date is sufficient for this element as long as a copy of a signed attestation, regardless of date, is present in the application
    a. Pertaining to signatures, in instances where a provider is physically impaired, a stamp signature is acceptable.

E. Application and documentation must be attested to within 180 days of CPRC committee decision.

F. Where applicable, explanations must be provided for responses to disclosure questions.

G. Within 15 days from receipt of application the CD will review the documents to ensure it is complete. If upon initial assessment, one of the above items is missing, or the information contained in the application is inconsistent, the CD will notify the applicant by phone or in writing, of all missing or incomplete information. The notification will include the name, address and telephone number of the CD. If the information is not provided within 60 days, the CD will notify the practitioner that their application is no longer in process of recredentialing and will issue an administrative termination until such items are received. If there are any corrections

to the application, the practitioner must initial, re-sign and re-date the attestation questionnaire.

H. Upon receipt of a complete application, CD will update the practitioner's record in the credentialing database.

I. Once complete, primary source verification is conducted for the following items as detailed below (in some instances, a copy of the original document meets this standard):

1. State License
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. A current valid state license must be obtained from the appropriate issuing State Board; if applicable, must indicate whether there are State sanctions, restrictions on licensure/limitations on scope of practice
   c. The verification includes the following: name, expiration date of the license and any actions against the license, initials/identifying signature and date stamp indicating when and by whom the verification was conducted

2. Drug Enforcement Agency License
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. Verification must be obtained through issuing agency, e.g. DEA or official NTIS website
   c. All DEA certificates must be issued in state of provider's practice
   d. This organization allows participation of a provider who does not have an active DEA registration provided there is a practitioner with a valid state specific DEA certificate who will provide DEA coverage until the provider secures his/her own.
      (i) Provider must explain why he or she does not have an active DEA registration and whether or not one is in process
      (ii) Provide coverage letter with covering provider's DEA certificate and agreement for coverage
      (iii) The covering provider's DEA certificate must be primary source verified with schedule 2-5 dispensing capacity

3. Board Certification, if applicable

a. Verification Time Limit: 180 calendar days prior to CPRC committee decision

b. This organization recognizes the following certifying boards:

(i) MDs/DOs
- a) American Board of Medical Specialties (ABMS)
- b) American Osteopathic Association (AOA)
- c) American Medical Association (AMA)
- d) American Board of Podiatric Medicine (ABPM)

(ii) DDS/DMD
- a) American Board of Oral Maxillofacial Surgery (ABOMS)

(iii) DPM
- a) American Board of Podiatric Medicine (ABPM)
- b) American Board of Podiatric Surgery (ABPS)

(iv) Anesthesia Assistant (AA)
- a) National Commission for Certification of Anesthesiologist Assistants (NCCAA)

(v) APN/ARNP/CNP
- a) American Nurses Credentialing Center (ANCC)
- b) American Academy of Nurse Practitioners Certification Program (AANPCP) AACN Certification Corporation
- c) Pediatric Nursing Certification Board (PNCB)
- d) National Certification Corporation (NCC) for Women's Health (OB/GYN) Nurse Practitioners (WHNP) or Neonatal Nurse Practitioner (NNP)
- e) Accreditation Board for Specialty Nursing Certification (ABSNC)

(vi) CNM/LMW
- a) American College of Nurse Midwives (ACNM)
- b) American Midwifery Certification Board (AMCBE)

(vii) CNS
- a) American Nurses Credentialing Center (ANCC)
- b) AACN Certification Corporation
- c) Oncology Nursing Certification Corporation (ONCC)

(viii) CRNA
- a) American Association of Nurse Anesthetists (AANA)
- b) American Nurses Credentialing Center (ANCC)
- c) National Board on Certification/Recertification of Nurse Anesthetists (NBCRNA)
- d) Council on Certification of Nurse Anesthetists (CCNA)

e) American Nurses Credentialing Center (ANCC)

(ix) PA

a) National Commission on Certification of Physician Assistants (NCCPA)

c. The verification includes the following: expiration date of the certificate, initials/identifying signature and date stamp indicating when and by whom the verification was conducted

4. History of Professional Liability Claims
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. Verification is conducted through the National Practitioner Databank (NPDB)
      (i) This organization requires a review of all past claims to make the appropriate determination of whether or not the practitioner meets the criteria set forth in policy CD 1006 "Criteria for Clean or Case File Review".
   c. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the query was conducted

5. Hospital Privileges, if applicable
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. Verification of privileges must be conducted directly from the hospital
      (i) Confirmation can be documented via telephone, written confirmation or through the hospital's website.
      (ii) Provider's privileges must be in "Good Standing"
   c. If the practitioner does not have admitting privileges, the practitioner must have a formal inpatient coverage arrangement with another provider or with a Hospitalist Network; in such instances a memo to file is acceptable detailing the arrangement.
   d. The verification includes the following: end date/reappointment date of privileges, initials/identifying signature and date stamp indicating when and by whom the verification was conducted

6. Professional Liability Insurance
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision

b. Current copy of liability insurance cover sheet with legible name, expiration date, and liability covered or a copy of the federal tort letter for providers with tort coverage.
c. Insurance coverage limits: 1M-3M; Provider Extenders: .2M-.6M
d. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the verification was conducted

7. Sanctions or Limitations on Licensure
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. Verification is conducted through the National Practitioner Databank (NPDB)
      (i) This organization requires a review of all past sanctions or limitations to make the appropriate determination of whether or not the practitioner meets the criteria set forth in policy CD 1006 "Criteria for Clean or Case File Review".
   c. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the query was conducted

8. Medicaid/Medicare Sanctions
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. This organization prohibits contracting/employing practitioners who are identified as having Medicaid/Medicare sanctions
   c. Verification is conducted through the following sources:
      (i) Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE)
      (ii) System for Award Management (SAM) which verifies General Services Administration (GSA)
      (iii) California: Suspended and Ineligible Practitioner List
   d. The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the verification was conducted

9. Medicare Opt-Out Report
   a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
   b. This organization prohibits contracting/employing practitioners who are identified on the Medicare Opt-Out Report
   c. Practitioners will be queried for all names, current and previous

d. Noridian, the California Medicare Administrative Contractor, is queried for Medicare Opt Out status of practitioners.
e. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.

10. Social Security Death Master File as applicable (based on product line)
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.

11. Office of Foreign Assets Control
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. The Office of Foreign Assets Control (OFAC) administers and enforces economic sanction programs primarily against countries and groups of individuals who are debarred from doing business in this country.
    c. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.
    d. It is the policy of Canopy Health not to contract providers in any government line of business that are identified on the OFAC sanctions report.

12. Medi-Cal NPI Type I Enrollment Verification
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.
    c. Providers who will be contracting to provide services to Medi-Cal members must be enrolled in the Medi-Cal Program under their Type I individual NPI. If a provider is not registered or cannot show proof of enrollment with Medi-cal, it will depend on the IPA/Medical Group's decision on whether to continue to discontinue the credentialing process.

13. Medicare Enrollment Verification
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.

14. NPI Registry Verification
    a. Verification Time Limit: 180 calendar days prior to CPRC committee decision
    b. The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.

15. Preclusion List - The Preclusion List is a list generated by CMS that contains the names of prescribers, individuals, and/or entities that are unable to receive payment for Medicare Advantage (MA) items and service and or Part D drugs prescribed or provided to Medicare beneficiaries.
    a. Preclusion list is sent by the health plans
    b. List is checked for any precluded provider
    c. Canopy Health is notified if provider is on the list. Members will be supported in finding a new provider by the health plan or the delegated medical group as appropriate.

16. Facility Site Review: *PCP Category Physicians and Provider Extenders, if applicable*
    a. Verification Time Limit: must be within the last three years
    b. It is the policy of Canopy Health in compliance to state specific regulations that any practitioner, i.e. physician or provider extender, contracting as a PCP have a complete and current facility site review.
        (i) FSR evidence will be gathered via:
            a) *PCP Physicians in Orange County*
                (i) CalOptima Report
                (ii) If not on report, email sent to CalOptima requesting confirmation of FSR
            b) *PCP Physicians and Provider Extenders in LA County*
                (i) LA Care Website
                (ii) Confirm that practice address and Supervising Physician have a current FSR
    c. In instances where a PCP (physician or provider extender) does not have a current FSR, the Credentialing Specialist must submit a request to the appropriate health plan for processing.

17. Performance Monitoring

a. Information from quality improvement activities, member complaints, utilization management activities, enrollee satisfaction surveys and/or other related activities will be gathered.
   (i) Quality of Care Issue Log will be assessed for each provider.

J. At any time throughout the recredentialing process, a practitioner has the right to review information obtained by Canopy Health for the purpose of evaluating the practitioner's recredentialing application. This includes non-privileged information obtained from any outside source (e.g. malpractice insurance carriers, state licensing boards, National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure. Practitioners are notified of these rights prior to the start of the recredentialing process. Canopy Health will provide documentation as allowable by this policy and law within three days of receipt of request.
   1. Addendum A to the California Participating Practitioner Application notifies practitioners of their rights during and after the recredentialing process

K. At any time throughout the recredentialing process, a practitioner has the right to be informed of the status of the recredentialing application. Canopy Health will provide status within 10 days of receipt of request.
   1. Addendum A to the California Participating Practitioner Application notifies practitioners of their rights during and after the recredentialing process

L. A practitioner is notified by the CD if information obtained from another source varies substantially from information provided in the application. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law. The practitioner also has the right to revise information that they may feel was submitted erroneously from another source. CD will notify the applicant by phone or in writing. The notification will include the name, email, address and telephone number of the CD. If a response is not received within two days of Notification of Discrepancy, CD will notify the practitioner that their application is no longer in process of recredentialing and will issue an administrative termination until such items are received. If a timely response is received, Canopy Health will reverify the primary source information in dispute. If the primary source information has changed,

correction will be made immediately to the practitioner's file. The practitioner will be notified in writing, via letter or fax, that the correction has been made. If upon reverficiation, primary source information remains inconsistent, the CD will notify the practitioner. The practitioner may then provide proof of correction by the primary source body to Canopy Health CD within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided. If after 10 days, primary source information remains in dispute, the practitioner will be subject to administrative action.

M. The practitioner's complete application, supporting documentation, and attestation information, primary source verifications, and any other pertinent information used in determining if the provider has/has not met recredentialing standards is saved in electronic format in the practitioner's record in the credentialing database.

N. Prior to CPRC review or Clean File submission to Medical Director, 10% of completed files are audited by a CD staff member who did not previously work the file to ensure completeness and consistency in information.
   1. Audit Time Limit: 180 calendar days prior to CPRC committee decision
   2. The credentialing application is signed and dated by the auditor to evidence review of recredentialing information.
   3. If the auditor identifies any deficiencies in the file, it is returned to initial reviewer for completion.
   4. Any identified trends will be brought to the Manager's attention who will then ensure that proper training is complete.

O. Based on the criteria set forth in this policy and detailed further in CD1006, if the file meets the criteria for a "clean" file, a clean file list is sent to the Medical Director for signed approval. If the file does not meet the criteria for a "clean" file, a committee packet that includes all issue summaries is prepared. This packet, along with the complete recredentialing file, is presented to the CPRC for review and decision. Practitioners will be notified in writing within 30 days of CPRC decision if there has been a change in their participation status with the network.

P. All of the procedures set forth in this Policy will be complete in adherence to the strict confidentiality and security standards set forth by Canopy Health's security and privacy policies and procedures.

VI. ENFORCEMENT

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VII. REFERENCES

1. NCQA: CR 1 Element A, B