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 facilities seeking initial and continued participation in Canopy Health's network..

III. DEFINITIONS

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 credentialing program to verify the professional qualifications of all participating providers prior to said providers rendering services to members.

B. Providers of medical services are categorized as either requiring credentialing through Canopy Health, e.g. joining network via direct contract, or not requiring credentialing through Canopy Health, e.g. delegated network or hospitalists.

C. In instances where a provider is determined to require credentialing, Canopy Health ensures that providers are thoroughly and appropriately credentialed per standards of

the National Committee for Quality Assurance ("NCQA") and all other state and federal regulations, as applicable, prior to rendering services to members.

D. Facilities that require credentialing include:

1. Hospital
2. Clinical Laboratory
3. Outpatient Physical Therapy Provider
4. Portable X-ray Supplier
5. Skilled Nursing Facility
6. DMEPOS
7. Hospice
8. Ambulatory Surgery Center or Free-Standing Surgical Center
9. Home Health Agency
10. Speech Pathology Provider
11. Outpatient diabetics self-management training provider
12. Federally Qualified Health Center and Rural Health Clinics
13. Comprehensive Outpatient Rehabilitation Facility
14. Behavioral Health – including inpatient, residential, and ambulatory settings

E. In instances where an organizational provider is not accredited, Canopy Health will conduct an onsite quality assessment.

F. 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. Canopy Health's credentialing department will determine if a provider must be credentialed by evaluating the initial request document and/or credentialing application.

B. Within three days of receipt of an initial request from a facility provider, CD will populate the credentialing database to indicate that the request for credentialing has been received and credentialing is now in process.

C. Facility providers are required to submit a Facility/Ancillary Credentialing Application. The credentialing process begins upon receipt of an initial request document as detailed above, completed and signed application and supporting documents, including the following information:

1. Copy of valid state license
2. Copy of state or federal survey, if applicable
3. Copy of Medicare certification, if applicable
4. Accreditation certificates, as applicable
   (i) The Joint Commission (JC)
   (ii) Accreditation Association for Ambulatory Health Care (AAAHC)
   (iii) Community Health Accreditation Program (CHAP)
   (iv) Commission on Accreditation of Rehabilitation Facilities (CARF)
5. Copy of current liability insurance certificate cover sheet
6. Liability Claims History
7. Current W-9
8. Attestation to any actions or sanctions against the organization by state licensure board or federal/state regulatory agency

9. Signed attestation by the appropriate organization representative as to the correctness and completeness of the application
10. A signed release from the provider authorizing the disclosure, inspection, and copying of information and documents pertaining to credentialing qualifications between authorized Healthcare Organizations
11. Signed and dated statement authorizing collection of any information necessary to verify the information in the application
    (i) Pertaining to signatures, in instances where a provider is physically impaired, a stamp signature is acceptable.

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

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

F. Within 15 days from receipt of application the CD will review the documents to ensure they are 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 provider that their application is no longer in process of credentialing and will issue an administrative termination until such items are received. If there are any corrections to the application, the provider must initial, re-sign and re-date the attestation questionnaire.

G. Upon receipt of a complete application, data entry will be done in the credentialing database.

H. Once the submitted application and supporting documentation is 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, copy of current license as provided above is sufficient
   (i) Verification Time Limit: 180 calendar days prior to CPRC committee decision
   (ii) A current valid state license must be obtained from the appropriate issuing State Board, i.e. CDPH; if applicable, must indicate whether

there are State sanctions, restrictions on licensure/limitations on scope of practice

(iii) 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. History of Professional Liability Claims
   (i) Verification Time Limit: 180 calendar days prior to CPRC committee decision
   (ii) Verification is conducted through the National Practitioner Databank (NPDB)
      a) 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".
   (iii) The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the query was conducted

3. Professional Liability Insurance, copy of PLI as provided above is sufficient
   (i) Verification Time Limit: 180 calendar days prior to CPRC committee decision
   (ii) 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.
   (iii) Insurance coverage limits: 1M-3M
   (iv) The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the verification was conducted

4. Sanctions or Limitations on Licensure
   (i) Verification Time Limit: 180 calendar days prior to CPRC committee decision
   (ii) Verification is conducted through the National Practitioner Databank (NPDB)
      a) 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".

(iii) The verification includes the following: initials/identifying signature and date stamp indicating when and by whom the query was conducted

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

6. Medicare Opt-Out Report
   (i) Verification Time Limit: 180 calendar days prior to CPRC committee decision
   (ii) This organization prohibits contracting/employing practitioners who are identified on the Medicare Opt-Out Report
   (iii) Noridian, the California Medicare Administrative Contractor, is queried for Medicare Opt Out status of practitioners
   (iv) The verification is evidenced on the checklist and includes the date the report was run, date it was verified, and staff initials.

I. At any time throughout the credentialing process, a provider has the right to be informed of the status of the credentialing application. Canopy Health will provide status within 10 days of receipt of request.

J. At any time throughout the credentialing process, the provider has the right to review information obtained by Canopy Health for the purpose of evaluating the provider's credentialing 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.

K. A provider 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 provider's malpractice claims history, actions taken against a provider's license/certificate. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law. The provider 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 provider that their application is no longer in process of credentialing 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 provider's file. The provider 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 provider. The provider 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 provider will be subject to administrative action.

L. The provider'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 credentialing standards is saved in electronic format in the provider's record in the credentialing database.

M. 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 credentialing information.
3. If the auditor identifies any deficiencies in the file, it is returned to the Credentialing Specialist for completion.

4. Any identified trends will be brought to the Manager's attention who will then ensure that proper training is complete.

N. 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 credentialing file, is presented to the CPRC for review and decision. Providers will be notified in writing within 60 days from receipt of initial request/application and within 30 days of CPRC decision of their participation status with the network.

O. Facility providers are re-credentialed at least every three years. The reassessment must include a recredentialing application with updated information, supporting documentation, and primary source verification of all information subject to change that was previously verified per the above guidelines. The following must also be verified:

1. Performance monitoring:
   (i) Member concerns which include grievances (complaints), if applicable
   (ii) Utilization management information, if applicable
   (iii) Performance improvement and monitoring, if applicable
   (iv) Quality of Care issues and trends, if applicable
   (v) Onsite assessment, if applicable

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

A. NCQA – CR1 Element A

B. NCQA—CR 7

Revision History:

Version Date	Edited By	Reason for Change
01/01/2017	**M. Durbin**	**Created policy**
05/22/2018	**R. Scott**	**Updated for NCQA requirements**
01/01/2019	**R. Scott**	**Updated for WHA CAP including references for Behavioral Health settings, reference to NCQA CR 7 standard, refined Organizational Facilities to reflect both NCQA and CMS requirements**