
Overview

Credentialing is the process by which the appropriate peer-review bodies of 'Ohana Health Plan (the Plan) evaluate the credentials and qualifications of providers, i.e., physicians, allied health professionals, hospitals and ancillary facilities/health care delivery organizations. This includes – as applicable to provider type – background, education, postgraduate training, experience, work history, demonstrated ability, patient-admitting capabilities, licensure, regulatory compliance, health status that may affect a practitioner's ability to provide health care and, as applicable to non-individuals, accreditation status. Providers are required to be credentialed prior to being listed as participating network providers of care or services to Plan members.

The Credentialing department or its designee is responsible for gathering all relevant information and documentation through a formal application process. The practitioner credentialing application must be attested to by the applicant as being correct and complete. The application captures professional credentials and contains a questionnaire section that asks for professional liability claims history and suspension or restriction of hospital privileges, licensure, DEA certification or Medicare/Medicaid sanctions.

Primary source verifications are obtained in accordance with state regulatory agency requirements and Plan policy and procedure and include a query to the National Practitioner Data Bank. Physicians, allied health professionals and ancillary facilities/health care delivery organizations are required to be credentialed in order to be network providers of services to Plan members. Satisfactory site inspection evaluations are required to be made at the office locations of all primary care physicians (PCP) and obstetrics and gynecology specialist physician offices. Some facilities also need a site inspection evaluation to be completed, relative to accreditation status.

After the credentialing process has been completed, notification of the credentialing decision is forwarded to the provider within 60 calendar days of the committee's decision.

Credentialing may be done directly by the Plan or by an entity approved by the Plan for delegated credentialing. In the event that credentialing is delegated to an outside agency, the Plan is required to establish that the credentialing capabilities of the delegated agency clearly meet state regulatory and Plan requirements. All participating providers or agencies delegated for credentialing are to use the same standards as defined in this section. Compliance is monitored on a regular basis, and formal audits are conducted annually. Ongoing oversight includes regular exchanges of network information and the annual review of policies and procedures and credentialing forms and files.

Practitioner's Right to Be Informed of Credentialing/ Re-Credentialing Application Status

Upon receipt of a written request, the Plan will provide written information to the practitioner of the status of the credentialing/re-credentialing application, generally within 15 business days. The information provided will advise of any items still needing to be verified, any non-response in obtaining verifications and any discrepancies in verification information received compared with information provided by the practitioner.

Practitioner's Right to Review Information Submitted in Support of Credentialing/ Re-Credentialing Application and Right to Correct Erroneous Credentialing/ Re-Credentialing Information

In the event the credentials verification process reveals information submitted by the practitioner that differs from the verification information obtained by the Plan, the practitioner has the right to review the information that was submitted in support of his/her application, and has the right to correct the erroneous information. The Plan will provide written notification to the practitioner of the discrepant information.

The Plan's written notification to the practitioner includes:

- The nature of the discrepant information;
- The process for correcting the erroneous information submitted by another source;
- The format for submitting corrections;
- The time frame for submitting the corrections;

- The addressee in Credentialing to whom corrections must be sent;
- The Plan's documentation process for receiving the correction information from the practitioner; and
- The Plan's review process.

The practitioner may review documentation submitted by him/her in support of the application/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies and certification boards, subject to any restrictions of the Plan. The Plan or its designee will review the corrected information and explanation at the time of considering the practitioner's credentials for provider network participation or re-credentialing. The practitioner may not review peer review information obtained by the Plan.

**Baseline
Criteria**

Baseline criteria for provider network participation:

License to Practice

Practitioners must have a current valid license to practice;

DEA Certificate

Physicians (M.D., D.O., D.P.M.), as applicable to specialty, must have a current DEA Certificate;

Board Certification

Physicians (M.D., D.O., D.P.M.) maintain board certification in the specialty being practiced as a provider for the Plan or accredited training that renders a physician eligible to sit for the board certification examination;

Hospital Admitting Privileges

Specialist Practitioners shall have hospital admitting



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privileges at a Plan-participating hospital (as applicable to specialty). PCP's shall have admission and treatment privileges in a minimum of one (1) general acute care hospital within the Plan network and on the island of service. For the island of Hawai'i, this means one (1) general acute care hospital in East Hawai'i and one (1) in West Hawai'i. If a PCP (including specialists acting as PCPs) with an ambulatory practice does not have admission and treatment privileges, the practitioner shall have written arrangements with at least one (1) other practitioner with admitting and treatment privileges with an acute care hospital within the Plan network..

Liability Insurance

Plan providers (all disciplines) shall be required to carry and continue to maintain professional liability insurance in the following required limits:

Individual Practitioners

\$1 million per occurrence; \$3 million aggregate;

Facilities

\$2,000,000 per occurrence \$2,000,000 aggregate.

Covering Physicians

PCPs in solo practice must have a Plan-participating covering physician willing to care for their members in their absence.

Allied Health Practitioners

Allied health professionals (AHPs), both dependent and independent, are credentialed by the Plan.

Dependent AHPs include the following, and are required to provide collaborative practice information to the Plan:

- Advanced practice registered nurse (APRN)
- Certified nurse midwife (CNM)
- Physician assistant (PA)
- Osteopathic assistant (OA)

Independent AHPs include, but are not limited to the following:

- Licensed clinical social worker
- Licensed mental health counselor
- Licensed marriage and family therapist
- Physical therapist
- Occupational therapist
- Audiologist
- Speech/language therapist/pathologist

**Ancillary
Health Care
Delivery
Organizations**

Ancillary facilities or health care delivery organizations must complete a credentialing application and provide information on accreditation, licensure, regulatory status, claims history, liability insurance coverage and rating. In addition, depending on accreditation and/or Medicaid status, a site inspection evaluation may be required as part of the credentialing process.

**Long-Term Care
and Community
Based Services**

Terms of Plan participation for long-term care agencies and community-based services providers are in accordance with the Hawai'i Department of Human Services – Social Services Division requirements. Credentialing is performed to ensure only appropriately qualified providers are providing services to members.

Re-Credentialing

In accordance with state requirements and Plan policy and procedure, re-credentialing of all provider types is conducted at least once every three years.

**Updated
Documentation**

Providers must furnish copies of current professional or general liability insurance, license, DEA certificate, and accreditation information (as applicable to provider type) to the Plan, prior to or concurrent with expiration.

**Office of Inspector
General Medicaid
Sanctions Report**

On a regular and ongoing basis, the Plan accesses the listings from the Department of Health and Human Services Office of Inspector General Medicaid Sanctions (exclusions and reinstatements) Report and the State's list of excluded providers for the most current available information. This information is cross-checked against the network of Plan providers. If providers are identified

as being currently sanctioned, such providers are subject to immediate suspension. Notifications of termination of contract are given in accordance with Plan Policies and Procedures.

**Sanction Reports
Pertaining to
Licensure, Hospital
Privileges or Other
Professional
Credential**

On a regular and ongoing basis, the Plan contacts State licensure agencies to obtain the most current available information on sanctioned providers. This information is cross-checked against the network of Plan providers. If a network provider is identified as being currently under sanction, appropriate action is taken in accordance with Plan policy and procedure. If the sanction imposed is revocation of license, the provider is subject to immediate termination. Notifications of termination are given in accordance with contract and Plan policies and procedures.

In the event a sanction imposes a reprimand or probation, written communication is made to the provider requesting a full explanation, which is then reviewed by the Credentialing/Peer Review Committee. The committee makes a determination as to whether the provider should continue participation or whether termination should be initiated.

**Hearing and
Appellate Review**

The Plan has a clearly defined Hearing and Appellate Review policy and procedure that it applies whenever the Plan chooses to alter the conditions of participation of a practitioner based on issues of quality of care, conduct or service, which are reportable to regulatory agencies.

The Plan makes available the Hearing and Appellate Review process to practitioners whenever the plan chooses to alter a practitioner's conditions of participation based on issues of quality of care, conduct or service provided.

The following recommendations or actions entitle the practitioner affected thereby to a Hearing and Appellate Review:

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- Non-renewal of participating practitioner status at time of re-credentialing for reasons associated with clinical care, conduct or service, or for such reasons that may require a report to be made to the National Practitioner Data Bank;
- Suspension of participating practitioner status for reasons associated with clinical care, conduct or service, or for such reasons that may require a report to be made to the National Practitioner Data Bank;
- Revocation of participating practitioner status for reasons associated with clinical care, conduct or service or for such reasons that may require a report to be made to the National Practitioner Data Bank.

Notification of the adverse recommendation, together with reasons for the action, hearing and appellate review rights and the process for obtaining a hearing and appellate review, shall be provided to the practitioner within 30 days of the date of the termination recommendation. Notification to the practitioner shall be mailed by certified return-receipt mail.

The practitioner shall have a period of 30 days in which to file a written request for a hearing and appellate review. The request shall be mailed via certified return receipt mail.

Upon timely receipt of the request, the Chief Executive Officer or his designee shall notify the practitioner of the date, time and place of the hearing. Such hearing shall not take place less than 30 days from the date of the notice of the hearing.

The practitioner and the Plan shall be entitled to legal representation at the hearing. The practitioner has the burden of proving by clear and convincing evidence that the reason for the termination recommendation lacks any factual basis or that such basis or the conclusion(s) drawn there from, are arbitrary, unreasonable or capricious.

The Hearing and Appellate Review Committee shall consider and decide the case objectively and in good faith. Within 30 days after final adjournment of the hearing and appellate review, the committee shall make a written report and forward its decision to the Quality Improvement Committee. Notification of the Plan's final decision will be provided to the practitioner within 30 days.

In addition to the hearing and appellate review process through a Peer Review Committee as outlined above, Plan providers may also avail themselves of the complaint, appeals and grievances processes identified in Section 6 - Appeals and Grievances. Section 6 outlines the complaint resolution process for providers who wish to file a complaint or appeal an administrative decision made by the Plan. Section 6 also includes the provider's right to and process for appealing a Plan decision to administratively terminate a provider's contract for reasons **other** than for quality of care or conduct, i.e., network re-engineering, etc. Appeals and grievances and provider termination appeal requests are reviewed through a Plan Administrative Review Committee process, not the "peer review" process as identified in this section.