Credentialing and Recredentialing

CareSource credentials and recredentials licensed independent practitioners including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action.

Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners. Our Vice President/Senior Medical Director is responsible for the credentialing and recredentialing program.

Through credentialing, CareSource checks the qualifications and performance of physicians and other health care practitioners.

CareSource offers two easy ways to become credentialed:

1. **The Council on Affordable Quality Healthcare (CAQH), Universal Credentialing Data Source** — This system allows providers to enter data one time, at no cost, to satisfy the credentialing and recredentialing requirements of participating health insurance plans. If you use the CAQH service you only need to select CareSource as an authorized user of your data on the CAQH website for more information, please log on to the CAQH website at **www.caqh.org** or call CAQH at **1-888-599-1771**.
2. **The Michigan Association of Health Plans (MAHP), Standard Practitioner Application** — The Michigan Association of Health Plans offers this standard form for health care organizations in Michigan as an easy way to keep your information. For more information, please visit the MAHP website at **www.mahp.org**.

To be credentialed, CareSource requires that you submit either:

1. The completed CAQH application or the MAHP application ***or***
2. The CAQH Number and National Provider Identifier (NPI) via one of three methods:
   - Email: **Contract.Implement@caresource.com**
   - Fax: 937-396-3632
   - Send by certified mail with return receipt to:
     CareSource
     Attn: Contract Implementation Specialist
     P.O. Box 8738
     Dayton, OH 45401-8738

If your organization is seeking credentialing, please submit either the Standardized Credentialing Form Part B Agency/Program/Organization Providers application or the Organizational Provider Credentialing Application via one of the above three methods.

Please also include copies of the following documents:

- Malpractice Insurance Face Sheet
- DEA Certificate (current)
- CLIA Certificate (if applicable)
- Standard Care Arrangement (if an Advanced Practice Nurse)

It is essential that all documents are complete and current. Otherwise, CareSource will discontinue the contracting and credentialing process.

Michigan Debarred Provider Attestation

As required by its contract with the State of Michigan, CareSource must verify that its Providers and the Providers' employees have not been debarred or suspended by any state or federal agency. CareSource must also require that its Providers and the Providers' employees disclose any criminal convictions related to federal health care programs. "Provider employee" is defined as **directors, officers, partners, managing employees or persons with beneficial ownership of more than 5% of the entity's equity**.

Providers must provide a list that identifies all Provider employees, as defined above, along with the employee's tax identification or social security numbers. Providers and Provider employees must execute the attestation titled, **"CareSource Debarment/Criminal Conviction Attestation"** (in addition to being subject to and cooperating with CareSource verification activities) as a part of the credentialing and recredentialing process.

CareSource conducts credentialing and recredentialing activities utilizing the Michigan Department of Community Health (MDCH), the Centers for Medicare and Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) and URAC guidelines. All providers are listed in the provider directory and the following are credentialed:

- Practitioners who have an independent relationship with CareSource. This independent relationship is defined through contracting agreements between CareSource and a practitioner or group of practitioners and is defined when CareSource selects and directs its enrollees to a specific practitioner or group of practitioners
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities
- Practitioners who are hospital-based, but see the organization's members as a result of their independent relationship with the organization
- Non-physician practitioners who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits
- Covering practitioners (locum tenens)

The Following Providers do not Need to be Credentialed

- Practitioners who practice exclusively within the inpatient setting and who provide care for organization members only as a result of the members being directed to the hospital or other inpatient setting
- Practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility and who are not listed separately in the CareSource provider directory
- Pharmacists who work for a Pharmacy Benefits Management (PBM) organization to which the organization delegates' utilization management functions
- Practitioners who do not provide care for members in a treatment setting (e.g. board-certified consultants)

Provider Selection Criteria

CareSource is committed to providing the highest level of quality of care and service to our members. Our providers are critical business partners with us in that endeavor. As a result, we have developed the following provider selection criteria to facilitate this optimal level of care and service, as well as promoting mutually rewarding business partnerships with our providers.

CareSource is committed to providing the highest level of quality of care and service to our members. Our providers are critical business partners with us in that endeavor.

Quality of care delivery, as defined by the Institute of Medicine, states: "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

CareSource has developed comprehensive care management and quality improvement programs to facilitate this level of quality-of-care delivery, as well as a comprehensive credentialing program to ensure that our providers have the appropriate training and expertise to serve our members from a care delivery and service perspective. CareSource bases selection on quality of care and service aspects in addition to business and geographic needs for specific provider types in a nondiscriminatory manner.

The following selection criteria have been put in place and are assessed during the credentialing and recredentialing process in addition to day-to-day monitoring via internal mechanisms and interactions with our members. They include and are not limited to:

1. Active and unrestricted license in the State issued by the appropriate licensing board
2. Current DEA certificate (if applicable)
3. Successful completion of all required education
4. Successful completion of all training programs pertinent to one's practice
   - For MDs and DOs, successful completion of residency training
   - For other providers where special training is required or expected for services being requested, successful completion of training
5. Board Certification in specialty is required for all physicians. Physicians will be listed in the provider directory as specialists only if certified by a specialty board, which is a member of the American Board of Medical Specialties or other Credentialing Committee recognized Board.

6. Liability insurance coverage at specified limits established for all practitioners by the credentialing policy
7. Good standing with Medicaid and Medicare
8. Medicaid Number or state-specific Provider Reporting Number (Medicare number if applicable)
9. Quality of care and practice history as judged by:
   - Medical malpractice history
   - Hospital medical staff performance
   - Licensure or specialty board actions or other disciplinary actions, medical or civil
   - Lack of member grievances or complaints related to access and service, adverse outcomes, office environment, office staff or other adverse indicators of overall member satisfaction
   - Other quality of care measurements/activities
   - Business needs that may dictate policy exceptions require careful scrutiny of above factors to ensure quality credentialing
   - Lack of issues on HHG-OIG or MDCH site (fraud and abuse), EPLS, NPDB, HIPDB
10. Signed, accurate and current Credentialing Application and contractual documents
11. Participation with Care Management, Quality Improvement and Credentialing programs
12. Compliance with standards of care and evidence of active initiatives to engage members in preventive care
13. Agreement to comply with plan formulary requirements or acceptance of Plan Preferred Drug List(s) as administered through Pharmacy Benefit Manager
14. Agreement to access and availability standards established by the health plan
15. Compliance with service requirements outlined in the Provider Agreement and Provider Manual

Practitioner Rights

- Practitioners have the right to review information submitted to support their credentialing application upon request to the CareSource Credentialing Department. CareSource keeps all submitted information locked and confidential.
- Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing Department prior to presentation to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner will be notified and given the opportunity to correct this information prior to presentation to the credentialing committee.
- Practitioners have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing Department.

Practitioners have the right to review information submitted to support their credentialing application upon request to the CareSource Credentialing Department.

Organizational Credentialing and Recredentialing — The following organizational providers are credentialed and recredentialed:

- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting
- Hospitals
- Home health agencies
- Skilled nursing facilities
- Ambulatory surgical centers, free-standing
- Urgent care centers, free-standing
- Dialysis centers
- Hospice care organizations
- PT/OT/SLP (Physical, occupational therapy and speech language pathology) facilities

The Following Elements are Assessed for Organizational Providers

- Provider is in good standing with state and federal regulatory bodies
- Provider has been reviewed and approved by an accrediting body
- Every three years is still in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body
- Liability insurance coverage is maintained
- Completion of a signed and dated application

Provider Responsibilities — Providers are monitored on an on-going basis to ensure continuing compliance with participation criteria. CareSource will initiate immediate action in the event that participation criteria are no longer met. Providers are required to inform CareSource of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification, or any event reportable to the National Practitioner Data Bank (NPDB) /Healthcare Integrity and Protection Data Bank (HIPDB).

Recredentialing — Providers are recredentialed a minimum of every three years. As part of the recredentialing process, CareSource considers information regarding performance to include complaints and safety and quality issues collected through the quality improvement program, in addition to information regarding sanctions collected from the NPDB, Medicare and Medicaid Sanctions and Reinstatement Report, Medicare Opt-Out, and the HHS/OIG. Providers will be considered recredentialed unless otherwise notified.

Providers are recredentialed a minimum of every three years.

Board Certification Requirements

All physicians applying to become participating providers with CareSource must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board. Physicians who are pursuing certification must be certified within the timeframe specified by their respective board. Failure to become certified may result in termination as a participating provider. Physicians whose boards require periodic re-certification will be expected, but not required, to be recertified. However, failed attempts at re-certification may be reason for termination. This board certification requirement does not apply to physicians already participating with CareSource before January 1, 2003. Certain business needs may allow variances to the board certification requirement as long as other measures of quality and performance support a physician's application to be credentialed.

All physicians applying to become participating providers with CareSource must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board.

Delegation of Credentialing/Recredentialing

CareSource will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is NCQA or URAC-accredited for these functions, utilizes an NCQA or URAC-accredited Credentials Verification Organization (CVO), and successfully passes a pre-delegation audit demonstrating compliance with NCQA, URAC, federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA, URAC and regulatory requirements.

The following will be included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes for the previous year
- Credentialing file review

Delegates must be in good standing with Medicaid or CMS.

Monthly reporting will be required from the delegated entity. This will be defined in an agreement between both parties.

CareSource may also choose to outsource the credentialing and recredentialing function at any time to an NCQA or URAC-accredited CVO. Providers will be notified of this and must adhere to the requests from the chosen CVO.

Appeals of Credentialing/Recredentialing Decisions
CareSource may decide that an applying or participating provider may pose undue risk to our members and should be denied participation or be removed from CareSource's network. If this happens, the applying or the participating provider will be notified in writing. Appeal opportunities are available to a participating provider if he/she has been affected by an adverse determination. To submit an appeal request, please follow these steps:

Step 1. Submit to the Vice President/Senior Medical Director an appeal request in writing, along with any other supporting documentation. Send it to:

CareSource
Attn: Vice President/Senior Medical Director
P.O. Box 8738
Dayton, OH 45401-8738

All appeal requests must be received by CareSource within 30 days of the date you are notified of the decision. The request, along with any supporting information, will be presented to the credentialing committee for review at the next meeting. The committee will respond within 30 days of that meeting. You will be notified in writing of the committee's decision.

Step 2. If the committee maintains the original decision, an appeal may be made consistent with provisions of the CareSource Fair Hearing Policy. Any appeal request must be submitted in writing and received by CareSource within 30 days of the date you are notified of the first appeal decision. The CareSource Fair Hearing Policy is available at **www.caresource.com**. Search "Fair Hearing Policy."

CareSource
Attn: Vice President/Senior Medical Director
P.O. Box 8738
Dayton, OH 45401-8738

Applying providers do not have appeal rights. However, they may submit additional documents for reconsideration by the Credentialing Committee to the address above.

Provider Disputes
Provider disputes for issues related to quality, professional competency or conduct should be sent to:

CareSource
Attn: Quality Improvement
P.O. Box 23037
Lansing, MI 48909-3037

Provider disputes for issues that are contractual or non-clinical should be sent to:

CareSource
Attn: Provider Relations
P.O. Box 23037
Lansing, MI 48909-3037

Summary Suspension

CareSource reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a participating provider, who, in the opinion of the CareSource Vice President/Senior Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of our members. Any participating provider who is subject to a suspension or termination may dispute the action and request a hearing through the CareSource Fair Hearing Plan.