

**EVOLENT HEALTH LLC  
POLICY AND PROCEDURE**



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 REVISION DATE: 05/30/2019  
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**POLICY TITLE:** Organizational Provider Credentialing and  
 Recredentialing  
**DEPARTMENT:** Provider Credentialing  
**ORIGINAL DATE:** February 2016

**Approver(s):** Sharlee LeBleu, Director, Credentialing Operations

**Policy Review Committee Approval Date:** May 30, 2019

**Product Applicability:** mark all applicable products below:

<b>COMMERCIAL</b>	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <i>Products:</i> <input type="checkbox"/> Small <i>Exchange:</i> <input type="checkbox"/> Shop <input type="checkbox"/> All <input type="checkbox"/> Indiv. <input type="checkbox"/> Indiv. <input type="checkbox"/> Large States: <input type="checkbox"/> GA <input type="checkbox"/> MD <input type="checkbox"/> OH <input type="checkbox"/> TX <input type="checkbox"/> _____
<b>GOVERNMENT PROGRAMS</b>	<input type="checkbox"/> MA HMO <input type="checkbox"/> MA C-SNP <input checked="" type="checkbox"/> MA D-SNP <input type="checkbox"/> MSSP <input type="checkbox"/> Next Gen ACO <input type="checkbox"/> MA All <input checked="" type="checkbox"/> Medicaid <i>States:</i> <input type="checkbox"/> DC <input checked="" type="checkbox"/> KY <input type="checkbox"/> MD <input type="checkbox"/> _____
<b>OTHER</b>	<input type="checkbox"/> Self-funded/ASO

**Regulatory Requirements:** National Committee for Quality Assurance (NCQA) and Kentucky Department of Medicaid Services Contract Section 28.2.

**Related Documents:** NVR.013 Ongoing Monitoring of Sanctions and NVR.014.E Provider Sanctioning and Reporting Policy, NVR.010.E.KY Practitioner Credentialing and Recredentialing. NVR.019.E Aperture Credentialing LLC Primary Source Verification and Provider Enrollment, and NVR.021.E Responsibilities of the Chief Medical Officer and the Credentialing Committee.

**PURPOSE**

A highly qualified Provider Network is a cornerstone to assuring that the most cost-effective and evidence base care is available to members. This policy provides guidance for validating a provider’s credentials.

**DEFINITIONS**

**Credentialing:** The process by which the Evolent Health reviews and evaluates the qualifications of providers to provide services to members. Network approval is determined by the extent to which applicants meet defined requirements for state licensure, good standing with state and federal regulatory bodies., service availability, and accessibility, as well as, for conformity to the Evolent’s utilization and quality improvement

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requirements.

**Medicare Opt-Out:** A physician, other provider or organization, who has opted out of Medicare, may not accept Federal reimbursement during the Opt-Out period. Opt-Out providers are not eligible to participate in the Health Plan Medicare provider network.

**The National Committee for Quality Assurance (NCQA)** is a private, not-for-profit organization dedicated to improving health care quality. NCQA is a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

**Type I Organizational Providers:** Providers meeting all credentials verification guidelines.

**Type II Organizational Providers:** Providers not meeting all credentials verification guidelines.

**Organizational Provider:** Includes, but is not limited to, a hospital (including acute care, critical access, rehabilitation, and psychiatric hospitals), ambulatory surgery center, behavioral health service organization, community mental health center, psychiatric residential treatment facility, Chemical Dependency Treatment Center, single specialty or multispecialty center, rural health clinics, federally qualified health centers, primary care centers, local health departments, free-standing birthing centers, durable medical equipment supplier, home health agency, private duty nursing agency, home infusion, hearing aid vendors, renal dialysis clinics, emergency medical transportation provider, non-emergency medical transportation providers and laboratory and x-ray providers.

**Practitioner:** Includes, but is not limited to, Medical Doctor (MD), Doctor of Osteopath Medicine (DO), Doctor of Dental Science (DDS), Doctor of Dental Medicine (DMD), Doctor of Podiatry Medicine (DPM), Doctor of Chiropractic (DC), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Advanced Practice Register Nurse (APRN), Certified Register Nurse Anesthetist (CRNA), Family Nurse Practitioner (FNP), and, Physician Assistant (PA), Certified Nurse Midwife (CNM), Audiologist (AUD), Optometrist (OPT), Family Planning Providers, Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Psychological Practitioner (LPP), Licensed Psychologist (LP), Licensed Art Therapist (LPAT), Licensed Certified Behavior Analyst (LBCBA). Practitioners who do not require credentialing are not considered practitioners for the purpose of this policy.

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- A. Evolent Health (Evolent) has developed a systematic method for assessing organizational providers against credentialing standards. The Health Plan enrolls providers in their respective networks in accordance with Center for Medicare & Medicaid Services (CMS) provider eligibility requirements. A provider cannot enroll, re-enroll, or otherwise remain active in the provider network if the provider has active sanctions imposed by Medicare or Medicaid, if required licenses and certifications are not current, if money is owed to the Medicare or Medicaid Program, if the provider has opted out of Medicare program, or if the Office of the Attorney General has an active fraud investigation involving the provider or the provider otherwise fails to satisfactorily complete the credentialing process.

***Requirements for Verification of Credentials include:***

1. Provider is in good standing with state and federal regulatory bodies.
  2. Completed facility/ancillary service application including the credentials verification release statement.
  3. A copy of valid, current state license.
  4. A current malpractice insurance face sheet showing active malpractice coverage up to the minimum amount in accordance with existing state laws at the time of the credentialing decision.
  5. A copy of any certification or accreditation held by the provider, if applicable.
  6. If not certified or accredited, a copy of a letter from CMS or the applicable state agency that shows the facility was reviewed and indicates that it passed inspection or a copy of the most recent CMS or state review. The issue date of the review or CMS letter cannot be more than three years prior to the submission date of an application.
  7. The provider has attested on the facility application to having a process in place to monitor patient safety.
  8. The provider has attested on the facility application to having a transfer policy.
- B. Health plan does not perform an onsite survey if not accredited as all inpatient and residential treatment facilities are required to be certified, accredited or have passed CMS/State survey to become a participating provider in Health Plan's provider network.
- C. Providers such as behavioral health service organization, community mental health center, psychiatric residential treatment facility, single specialty or multispecialty center, rural health clinics, federally qualified health centers, primary care centers who are not certified, accredited or have not passed CMS/state survey, are enrollment in Health Plan's provider network as a "group" provider type. Individual practitioners employed by these "group" provider types are required to be credentialed in accordance with policy NVR.010.E.KY Practitioner Credentialing & Recredentialing until such time that the organization becomes certified, accredited or receives its CMS/state survey. At that time, the organizational provider is credentialed according to the process described in this policy.

- D. Providers and Practitioners will be recredentialed at least every 36 months. A 36-month cycle is to the month, not to the day. Providers may be reviewed for recredentialed prior to the passage of 36 months if other quality or service data identifies the need for an earlier review.

## PROCEDURE

- I. Confidentiality of credentialing information
  - A. Information received through the credentialing process is considered confidential and utilized only for reviewing prospective provider applicants for participation in the network.
  - B. All written documentation received is placed in the applicant's file and stored in a locked cabinet or is scanned in secure electronic folders.
- II. Identification/Notification to the Provider Credentialing Department of prospective providers
  - A. Upon receipt of a provider's application packet from enrollment, contracting or a provider's office, for those who require credentialing, within two business days, the Provider will be logged to begin the credentialing process.
  - B. Aperture Credentialing, Inc. picks up the start work file on the Secure FTP site and begins PSV services in accordance with Evolent policies.
  - C. Upon completion of credentialing process, the Evolent provider credentialing coordinator forwards all Type I and Type II profiles to the Health Plan's CMO, or designated MD for provider to review.
  - D. Prior to inclusion in the Health Plan's next Credentialing/Peer Review Committee agenda, the Health Plan's CMO or designated MD reviews Type II provider profiles and identifies any in which additional information is needed for the committee's review.
  - E. CMO can make an independent decision, on any Type II provider profile, deemed by CMO, as a Type I provider profile. The provider credentialing coordinator develops the Health Plan's Credentialing/Peer Review Committee's packet and includes, at a minimum, an agenda and listing of all Type I organizational providers. To ensure a nondiscriminatory review, all Type II provider files are de-identified prior to inclusion in the committee packet. The packet is distributed at least five business days prior to the committee meeting.
- III. Recredentialing
  - A. All providers and practitioners who required credentialing will be recredentialed at a least every 36 months. The 36-month cycle is to the

month, not to the day. Providers and practitioners may be recredentialled prior to the passage of 36 months if other quality or service data identifies a need for an earlier review.

IV. Organizational Provider Reinstatement

- A. If a credentialed provider leaves the provider network for more than 30 days, they must complete the entire credentialing process in order to be reinstated.

V. Decision-Making Process

- A. The Health Plan's Credentialing Committee is composed of participating practitioners in the Health Plan's network and chaired by the Health Plan's CMO or designated MD. The Committee reviews each applicant in accordance with NCQA Standards and Guidelines and votes for acceptance for participation, for denial for participation, or to request additional information or a modified participation status, i.e., recredentialing less than three years in the future.
- B. The Health Plan's Credentialing/Peer Committee will not vote for acceptance or denial based on race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed, or types of patients.
- C. The Health Plan will not discriminate, in terms of participation, reimbursement, or indemnification, against any organizational provider who is acting within the scope of their license or certification under state law, solely on the basis of the license or certification. This prohibition does not preclude any of the following actions by the Health Plan:
  - i. Refusal to grant participation to provider in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis).
  - ii. Use of different reimbursement amounts for different specialties or for different providers in the same specialty.
- D. Implementation of measures designed to maintain quality and control costs consistent with its responsibilities
- E. The Health Plan's Credentialing/Peer Review Committee may request additional information from the provider if there are areas in which further clarification is needed prior to making a decision. Providers being reviewed and in need of additional information are considered non-participating until a final decision is reached by the committee. The committee may not grant temporary privileges for any reason.
- F. The Health Plan's CMO or designated MD may implement immediate administrative restrictions with regard to any participating provider where

the Health Plan’s CMO or designated MD believes such restriction is necessary to protect the health and safety of members. Examples of such circumstances include, but are not limited to, Emergency Orders of Restriction and Licensure Board Disciplinary Orders. For approved practitioners, the effective date commences with the date the application was deemed complete.

**VI. Following Participating Network Approval**

- A. Once a provider is approved for network participation, the provider credentialing coordinator enters the credentialing approval date into Evolent Credentialing Database.
- B. Within 60 days of the credentialing decision date, the provider credentialing coordinator sends a plan decision letter to the provider.
- C. A letter is sent to all providers denied participation with the plan.
- D. The provider credentialing coordinator provides notice to the State Medical Licensure Board of any adverse actions taken based on a determination by the Health Plan’s Credentialing Committee. Reporting is conducted in accordance with the National Practitioner Data Bank (NPDB) requirements.
- E. The provider credentialing coordinator ensures a complete copy of the Health Plan’s Credentialing Committee minutes and listing of organizations reviewed are maintained in a secure committee folder.

**RECORD RETENTION**

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

**REVIEW HISTORY**

DESCRIPTION OF REVIEW / REVISION	DATE REVISED
New Policy	12/2016
Language added to allow CMO/Designated Medical Director to review and downgrade a TYPE II provider to a Type I and make the plan decision without need to present to Credentialing Committee.	09/2017
Language changes to align with new systems and processes. Language that explains why we do not conduct onsite-survey for non-accredited facilities and Change of Ownership	05/2018

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Wording added to the Organizational Provider definition	09/2018
<ul style="list-style-type: none"><li>- Annual Review &amp; Structural Adoption</li><li>- Change of Policy Ownership from Joel Scott to Sharlee LeBleu</li></ul>	05/30/2019