Credentialing Plan

ucare®

Product Lines Affected:

	UCARE MEDICARE PLANS
X	UCare Essentials Rx, UCare Standard, UCare Complete, UCare Classic, UCare Aware,
X	UCare Value, UCare Value Plus
X	UCare Group
X	UCare Your Choice, UCare Your Choice Plus
X	EssentiaCare : Grand / Secure / Access
X	UCare Medicare with M Health Fairview & North Memorial: Care Core / / Care Wise
	UCARE STATE PROGRAMS
X	Prepaid Medical Assistance Program (Families and Children)
X	Minnesota Senior Care Plus (MSC+)
X	UCare Connect (SNBC)
X	MinnesotaCare
	UCARE MEDICARE SUPPLEMENT
X	UCare Basic, Extended Basic, 20/50 Copay

	UCARE SPECIAL NEEDS PLANS FOR DUAL ELIGIBLES
X	UCare Connect + Medicare (SNBC)
X	UCare's Minnesota Senior Health Options (MSHO)
	UCARE INSTITUTIONAL SPECIAL NEEDS PLANS
X	UCare Advocate Choice, UCare Advocate Plus
	UCARE INDIVIDUAL AND FAMILY PLANS
X	UCare Individual & Family Plans
X	UCare Individual & Family Plans with M Health Fairview
	UCARE OTHER
X	TPA/ASO
	ASPIRUS HEALTH PLAN MEDICARE ADVANTAGE PLANS
X	Aspirus Essential Rx
X	Aspirus Elite

Policy Title: Credentialing Plan

Department: Health Services Quality & Operations

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Position Responsible for Policy: Credentialing Audit Specialist (CAS)

This Credentialing Plan applies to all providers defined by UCare subject to credentialing. All providers subject to credentialing must be fully credentialed prior to rendering any services to UCare members. Continued participation by the provider under this Credentialing Plan is dependent upon the provider or facility meeting the participation criteria set for in Credentialing Procedure *QCR-0030- Criteria for Acceptance.*

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I. Introduction

{CMS 60.3| MDH 4685.1110, subp. 11| MDH 4685.1110, subp. 6}

The UCare Credentialing Department provides a plan on (re)credentialing of providers consistent with the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS) regulations, State law, and the Health Care Quality Improvement Act of 1986, and supports the organization by monitoring the competency of providers using a fair, thorough application process, thereby promoting the safety and quality of care given to members.

On an annual basis, the appropriate staff will review the Credentialing Plan and present to the Credentialing Committee for approval.

The Credentialing Plan may be changed at any time upon approval by the Credentialing Committee. Any changes that occur in regulatory or accreditation requirements shall automatically be incorporated into the Credentialing Plan as of the regulators and/or accreditation effective date and may supersede the updating of this Credentialing Plan. Changes shall be effective for all new and existing providers. These regulatory changes would be brought to the Credentialing Committee as a notification only.

UCare claims setup is separate from the credentialing process.
Providers should not provide service to UCare members until their credentialing process has been completed. UCare has no obligation to reimburse claims submitted for a practitioner's services until the practitioner has successfully completed the credentialing process.

II. Definitions

{NCQA CR 4-Element A}

Practitioner or Provider

Any health care professional that provides health care under contract with UCare and is a licensed individual health care professional permitted by law to independently provide health care services and direct treatment to patients.

Organizational Provider (Facility)

A specific location or group of locations at which providers provide services to UCare enrollees.

Credentialing Staff

UCare' s Credentialing Staff are those individuals who conduct the credentialing functions in accordance with this Credentialing Plan. Credentialing Staff develop and implement the credentialing policies and procedures.

Credentialing

The review of qualifications and other relevant information pertaining to a provider subject to credentialing who seeks to participate in UCare' s network under a contract with UCare.

Recredentialing

Recredentialing of providers is performed at least every thirty-six months or earlier, for any recredentialing files with variations from credentialing in accordance with the processes and criteria described herein.

Clean Credentialing Files

Credentialing files that have been evaluated per the Credentialing Plan and do not vary from any credentialing criteria as outlined in *QCR-0030-Criteria for Acceptance* or has variations from criteria within *QCR-0030-Criteria for Acceptance* that have been deemed by the Medical Director as having no current significant issues.

Criteria

Eligibility is determined by meeting Pre-Application, Administrative, and Professional Criteria as outlined in procedure *QCR-0030-Criteria for Acceptance.*

Pre-Application Criteria

Pre-Application Criteria are those criteria that all providers requiring credentialing must meet to be eligible to apply for participation status or existing participation status.

Administrative Criteria
Administrative Criteria are those criteria that does not directly relate to providers' professional performance, judgment, and clinical competence.

Professional Criteria
Professional Criteria are those criteria that relate to providers' professional performance, judgment, and clinical competence. In determining whether there is a variation from Professional Criteria, the Credentialing Staff and/or Medical Director apply specific guidelines approved by the Credentialing Committee.

Medical Directors
The Medical Director chairs the Credentialing Committee and works collaboratively with the Credentialing Staff as a clinical resource to ensure implementation of the Credentialing Plan.

Credentialing Committee
The Credentialing Committee is responsible for approving and administering the Credentialing Plan.

Quality of Care Issues
Quality of Care issues, as understood from a regulatory context, and referred to within this Credentialing Plan, describes situations in which the quality of clinical care or service did or potentially could have, adversely affected a member's health or well-being per Quality-of-Care procedures found in policy *QAG011 Potential Deficiency in Clinical Quality of Care.*

Quality Improvement Council (QIC)
The Quality Improvement Council provides direction regarding the planning, design, implementation, and review of improvement activities. The QIC also ensures that quality activities align with the strategic objectives of the organization.

Delegate
Any organization or company to which UCare has contractually given the authority to carry out a particular function on behalf of UCare. For the purposes of this document, a Delegate may perform all, or part of the credentialing activities required for review, meeting all standards as set forth contractually. Delegates are audited annually.

National Practitioner Data Bank (NPDB)
The National Practitioner Data Bank (NPDB) is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. Federal regulations authorize eligible entities to report and/or to query the NPDB. The reports are confidential, and not available to the public.

III. Roles & Committee Structures

{NCQA CR 1-Element A-4| NCQA CR 1-Element A-5|NCQA CR 1-Element A-9| NCQA CR 2-Element A-1| NCQA CR 2-Element A-2| NCQA CR 2-Element A-3}

Credentialing Committee

The Credentialing Committee has the responsibility for the administration of the Credentialing Plan. The Credentialing Committee is responsible for credentialing decisions, standards of care, effectiveness of the credentialing program, and review and approval of the credentialing policies and procedures. The Committee reviews and makes credentialing decisions regarding files that vary from Administrative and Professional Criteria that requires review under the Credentialing Plan. The Credentialing Committee reviews all credentialing files with variation electronically ahead of the Credentialing Committee meetings. They may recommend to approve, deny or terminate a provider's status with UCare.

The Credentialing Committee has delegated review and approval of Clean Credentialing Files to the Medical Director in Section IV of this Credentialing Plan. In cases where the Medical Director approves a provider with variation from Administrative or Professional Criteria in accordance with QIC guidelines for delegated review, the Credentialing Committee shall be notified through the Clean File & Delegated Report at its earliest subsequent meeting.

At times, it may be necessary for the Credentialing Staff to research specialty certification boards that are not recognized by the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA), or other boards recognized by NCQA, to determine if UCare should incorporate the specialty certification boards as part of the primary source verification process at the time of (re)credentialing. The Credentialing Staff will research and prepare the information to be presented at the Credentialing Committee. The Credentialing Committee will then make a determination to accept or deny the specialty certification board.

The Credentialing Committee shall meet monthly virtually/telephonically. Voting membership shall be limited to participating practitioners and UCare Medical Directors. Credentialing Staff will not have voting rights regarding any (re)credentialing decisions but may serve to provide information from the credentialing file and/or provide guidance on UCare' s credentialing policies and procedures. The Committee Chair may temporarily, in writing, add a practitioner, as necessary, to hear professional credentialing matters that require peer expertise not available from existing committee members. In the role of a peer review entity, the practitioner members of the Credentialing Committee are responsible for the review of providers and facilities who vary from Professional Criteria as describe herein.

Quality Improvement Council (QIC)

The QIC has the responsibility and authority for the acceptance, discipline and the activities that may lead to final termination of providers. The QIC has delegated this responsibility to the Credentialing Committee which provides a monthly summary report to the QIC.

Quality Improvement Advisory and Credentialing Committee (QIACC)

The QIACC oversees and directs UCare's Quality Improvement Program for the organization and promotes the provision of optimal, achievable patient care and service, and identifies and addresses health equity by providing guidance to UCare on the quality of care provided to its members.

Board of Directors (BOD)

The UCare BOD has formally delegated the responsibility and authority for acceptance, discipline and activities that may lead to the denial or termination of providers subject to credentialing, to UCare' s Quality Improvement Advisory and Credentialing Committee (QIACC).

Credentialing Appeals Committee

The Credentialing Appeals Committee shall be appointed on an ad hoc basis by UCare's Medical Director, acting on behalf of UCare. Members of the Appeals Committee shall be made up of actively practicing practitioners and may also include one consumer member of the BOD. Three people will make up the Appeals Committee. At least one of the practitioners shall be from the same or similar specialty as the appealing provider. Appeals Committee members shall not be appointed if they are in direct economic competition or have any other conflict of interest with the provider who is the subject of the hearing. Credentialing Committee members generally should not serve on the Appeals Committee. The Appeals Committee's purpose is to hear appeals from providers after the Credentialing Committee has recommended denial or termination of a provider's status or has recommended or imposed disciplinary action, based on professional conduct or competence. Appeals Committee members will excuse themselves from any Credentialing Committee and/or QIACC deliberations if they are present during their meeting.

Medical Directors/Designated Physician's Credentialing Program Responsibilities

The Medical Director reviews and makes the following decisions:

- Weekly reviews and, if appropriate, approves files that have been deemed as clean (re)credentialing files
- Reviews (re)credentialing files that vary from Administrative Criteria
- Reviews (re)credentialing files that vary from Professional Criteria and/or indicated a potential professional competency or performance issue

The Medical Director will review and act on provider (re)credentialing files that Credentialing Staff has identified with possible significant issues. The Medical Director(s) may decide one of the following:

- Approve as a clean file with no significant issues
- Request further information from a provider prior to presenting to the Credentialing Committee
- Make recommendations that the provider's (re)credentialing file be reviewed by the Credentialing Committee

- Approve the provider on the basis that the Professional Criteria variation does not indicate a potential professional competency or performance issues pursuant to the Variation Application File Review grid
- Significant issue that warrants Restriction or Suspension of a provider

The Medical Director also provides guidance and counsel to the Credentialing Staff regarding UCare's professional standards, policies, and procedures.

Credentialing Staff

Credentialing Staff shall perform administrative review functions and prepare cases for the Medical Director, legal, workgroups, or committee reviews per credentialing policies and procedures. Credentialing Staff shall review each (re)credentialing application to determine whether the provider meets Pre-Application Criteria as defined in *QCR-0030 – Criteria for Acceptance*. Credentialing Staff shall ensure that files have been verified and each file has been reviewed to identify clean credentialing files and those files with variation(s) from either Administrative and/or Professional Criteria per the Variation Application File Review grid. If any file varies from review criteria, Credentialing Staff shall route the case to the Medical Director per this Credentialing Plan.

IV. Routing and Review

{NCQA CR 1-Element A-3| NCQA CR 1-Element A-4| NCQA CR 1-Element A-5| NCQA CR 1-Element A-10| NCQA CR 2-Element A-3}

Once the provider has been determined to meet all Pre-Application, Administrative and Professional Criteria per the Variation Application File Review grid, the credentialing record is designated as clean. Clean credentialing files are routed electronically to the Medical Director for review in the Credentialing database for determination of acceptance into the UCare network. Each Medical Director has their unique electronic identifier for the database. Should the credentialing systems fail, we may potentially send via email for approval.

For any providers who do not meet Professional Criteria, per the Variation Application File Review grid, the credentialing file is classified as "with variation" and is routed to the Medical Director for review as described below:

Clean Credentialing Files

UCare's Medical Director can accept all providers with Clean Credentialing Files for participation in the UCare network. The weekly clean-file lists will be presented to the next scheduled monthly Credentialing Committee on the Clean File and Delegated Report.

Administrative Criteria Variation

Applications for providers who do not satisfy administrative criteria are returned to the provider with the administrative denial letter. The Medical Director may delegate in writing the authority to review and approve certain types of variation from Administrative Criteria to the Credentialing Staff and such delegation shall be approved by the Credentialing Committee. After internal coordination, the Credentialing Committee and/or Medical Director may accept or continue the participation status of a provider with Administrative Criteria variations, in accordance with QIC guidelines for delegated review. Administrative terminations and denials are final and are not subject to an appeal hearing unless otherwise required by law or regulation. UCare at its discretion may reconsider the determination if the provider submits additional information for review.

Professional Criteria Variation

Applications for providers, who do not satisfy Professional Criteria as outlined in the Variation Application File Review grid, are submitted to the Medical Director for review. The Medical Director may recommend review by the Credentialing Committee if s/he confirms there is a professional criteria variation that indicates a potential professional competency issue pursuant to QIC guidelines for delegated review. If the Credentialing Committee cannot make a decision, the provider's application will be presented at the next monthly QIC. If the Medical Director determines that the variation does not indicate a potential professional competency issue, the Medical Director may approve the provider and shall notify the QIC at

its earliest subsequent meeting of the approval. The Medical Director may impose monitoring and corrective actions per Sections XI-XIV of this Credentialing Plan.

Credentialing Committee Review and Acceptance

The Credentialing Committee reviews all providers with a Professional Criteria variation that the Medical Director has confirmed indicates a potential professional competency issue. The Credentialing Committee receives notification of Clean Files and files that Credentialing Staff and/or the Medical Director have reviewed with variations from Administrative or Professional Criteria according to Credentialing Committee guidelines for delegated review. Any acceptance by the Credentialing Committee is conditioned upon the execution of a relevant participation agreement with UCare. The Credentialing Committee may request further information from the provider, table an application pending the outcome of an investigation of the provider by any organization or institution or take any other action it deems appropriate including recommending denial of the provider. The Credentialing Committee may base its determination on facts and circumstances regarding professional conduct or competence that it deems appropriate and relevant. In cases with a Professional Criteria variation, the Credentialing Committee shall determine whether the variation indicates a potential or existing professional performance issue. In the event that the Credentialing Committee denies or terminates participation in the network for failure to meet Professional Criteria, appeal provisions will apply as outlined in Section XV of this Credentialing Plan. Determinations made by the Credentialing Committee based on professional performance issues are not considered final until after a provider has waived his or her right to an appeal, has failed to request an appeal in a timely manner or has completed the appeal process. Facilities have no right to appear before the Credentialing Committee.

V. Delegation

{NCQA CR 8-Element A-5| NCQA CR 8-Element A-6}

UCare may delegate a part or all of the (re)credentialing functions to specific participating organizations or newly contracted delegated entities ("Delegate") for provider credentialed types and facilities. This may include primary source verification and ongoing monitoring. The credentialing activities of the Delegate shall comply with UCare credentialing policies, NCQA and state and federal regulations unless otherwise specified in the delegation agreement. UCare shall retain full and final authority for all delegated credentialing activities and shall retain the ultimate right to accept or reject providers into the UCare network.
The delegation evaluation findings and recommendations (includes pre-assessment and annual audits) shall be presented to the Credentialing Committee for review and determination.

The Committees may decide to:

- Approve new and existing delegation
- Approve continued delegation with restrictions or conditions
- Terminate delegation

UCare' s policy regarding delegation is described in UCare policy *CCD021 Delegation Management* and procedure *QCR-0029 Oversight of Credentialing Delegates.*

Revocation or Termination of Delegation

All Delegation Agreements between UCare and entities to which UCare has delegated credentialing will contain appropriate provisions describing the remedies available to UCare, including termination, in the event that the delegate does not properly preform the delegated functions. More specifically, in the event that a delegate fails to meet any of the requirements in the signed Contract Amendment, Credentialing Delegation Agreement, CAP and/or demonstrates a lack of commitment to improve the deficiencies noted in the CAP, UCare, at is discretion, may revoke/rescind a credentialing delegation at any time. UCare will provide the appropriate written notice to the delegate of such revocation or termination. The delegate may also terminate the delegation agreement upon appropriate written notice to UCare as permitted under the agreement. If delegation is revoked or terminated, UCare shall resume responsibility of all credentialing functions.

VI. Discrimination

{NCQA CR 1-Element A-6}

To prevent discrimination, UCare does not make (re)credentialing decisions based on an applicant's race, ethnic or national identity, religion, disability, gender, age, sexual orientation, marital status, or patient type (e.g. Medicaid in which the practitioner specializes.)

To affirm compliance with discrimination provision, the Credentialing Committee members sign a non-discrimination statement annually. Additionally, UCare creates a detailed report of the statistics in our credentialing process called the Non-Discrimination Annual Summary. This summary is a detailed review of age, gender, and specialty type. This is presented to the Credentialing Committee annually.

VII. Practitioner Rights to Credentialing Information

{NCQA CR 1-Element A-7| NCQA CR 1-Element B-1| NCQA CR 1-Element B-2| NCQA CR 1-Element B-3}

Practitioners applying for network participation or continued participation have the following rights:

- The right to review the information submitted in support of their credentialing application. The credentialing record contains documents obtained for the review of the credentialing application. The practitioner does not have the rights to review peer review protected information, references, recommendations and/or information obtained from the National Practitioner Data Bank (NPDB). Practitioners may contact UCare's Credentialing Department at credentialinginfo@ucare.org with questions.

- The right to correct erroneous and/or discrepancy information that was submitted by the practitioner that varies substantially from the information that UCare primary sourced verified during the credentialing process. UCare's Credentialing Staff will notify the credentialing contact and/or practitioner that there is a discrepancy and provide the opportunity to correct any erroneous information, which must be submitted within 14 days from the receipt request for correction either by email (credentialinginfo@ucare.org), fax (612-884-2184), or mail (UCare-500 NE Stinson Blvd, Minneapolis, MN 55413).

- The right to be informed, upon request, of the status of the practitioner's (re)credentialing application. Practitioners may contact UCare's Credentialing Department via email at credentialinginfo@ucare.org and ask for the status of their (re)credentialing application.

In the event that Credentialing Staff discover a discrepancy between their findings and the information submitted by the provider, notice will be promptly made to the Credentialing Contact and/or provider. The letter, which may be sent via email or mail, will indicate that there is a discrepancy and request that the provider (re)submit the information needed to complete the credentialing file within fourteen (14) days from the receipt of the letter.

No Response Received

If the response is not submitted in the time allowed, UCare will assume that the provider does not want to dispute any of the information provided and the provider will be administratively terminated as an UCare participating provider. The provider may not re-apply for participation for six (6) months from the termination date. If the provider has not responded and is not currently an UCare participating provider, the provider will be administratively denied. Additionally, the provider may not be eligible to re-apply for participation for six (6) months from the denial date.

Response Received

If the response is received in the time allowed, the Credentialing Staff will include information obtained for review of the provider's credentialing application. If a provider believes, upon review of the credentialing file, that any information contained therein is misleading or erroneous, the provider has the right to correct erroneous information obtained during the credentialing process within 30 calendar days of receipt by submitting, in writing, any corrections or any explanations of discrepancies in writing (via email or fax) to the appropriate Credentialing Staff. The Credentialing Staff will annotate the credentialing record with the information received. The updated information will be scanned to the individual provider's credentialing record in the credentialing database.

Each provider shall be entitled, upon written request, to be informed of the status of their application. In addition, each provider shall be entitled to review his or her credentialing information per this Credentialing Plan and per the Uniform Credentialing Application and the Uniform Re-Credentialing Application as noted in the Notice of Applicants Rights section, with the exception of information such as letters of reference or recommendations that are peer privileged and/or protected from disclosure or information from the National Practitioner Data Bank (NPDB). UCare may, at its discretion, provide redacted copies or summaries of information provided by individuals if required to maintain confidentiality of protected information. Once a written request has been made to UCare in writing (via email or fax), the Credentialing Staff will respond to such inquiry within two business days of receipt via secure email, fax, or mail. The Credentialing Staff will provide applicable information and/or documentation to the provider and annotate the credentialing database of the request and the information provided.

Providers are notified of the right to correct erroneous information via this Credentialing Plan and the notification letter sent to the provider when erroneous information/discrepancies are identified. The Credentialing Plan is located on the UCare Provider Page. The foregoing does not require UCare to alter or delete any information contained in the file.

VIII. Notification

{NCQA CR 1-Element A-8}

The provider shall be notified via email or mail when an email is not available, within 60 calendar days from final decision for initial credentialing. For any files with adverse decisions, the provider shall be notified within 20 calendar days via email or mail when an email is not available. In the event of an adverse (re)credentialing decision that is subject to appeal, notice to the provider shall meet the requirements of Section XV.

IX. Confidentiality

{NCQA CR 1-Element A-10}

All committees described above, the BOD, and Credentialing Staff supporting credentialing actions operate as a review of organizations pursuant to Minn. Stat. § 145.61 et seq. and professional review bodies pursuant to the Health Care Quality Improvement Act of 1986, 42 U.S.C § 11101 et seq. Non-public information collected for credentialing purposes shall be considered confidential. Access to credentialing files will be limited to authorized individuals. Credentialing documents will be stored in a secure electronic environment and is limited to designated individuals and password protected. Credentialing information will not be released except to another review organization under Minn. Stat. § 145.61 or as otherwise permitted by law. Release of credentialing information to any other organization or individual that is not a review organization per Minn. Stat. § 145.61 may only occur upon approval from UCare' s General Counsel.

Prior to serving on the Credentialing Committee, each committee member must sign a confidentiality agreement and thereafter on an annual basis.

X. Provider Directories

{NCQA CR 1-Element A-11}

Information provided in provider directories, which includes the online provider directory, is consistent with the information obtained during the credentialing process. Specifically, any provider information regarding qualifications given to members should match the information regarding a provider's education, training, certification, and designated specialty gathered during the credentialing process. Specialty refers to an area of practice, including primary care disciplines.

At the time of (re)credentialing; Credentialing Staff enters into the credentialing database each provider's verified information to include education, training, board certification and specialty. This information is then available to be utilized by other areas within UCare, such as directories and other materials for members.

On a daily basis, UCare' s Information Technology Department pulls data from Cactus to the online provider directory using the most current information.

XI. Monitoring

NCQA CR 5-Element A-1| NCQA CR 5-Element A-2| NCQA CR 5 -Element A-3| NCQA CR 5-Element A-4| NCQA CR 5-Element A-5}

Routine Performance Monitoring

Credentialed providers are routinely monitored for adverse events in-between credentialing cycles and at least every six months by the following:

UCare or the delegate will conduct site surveys and assessments of medical/treatment records keeping for all Primary Care Clinics, Ob/Gyn Clinics or other high-volume providers as defined by UCare at the time of initial contracting per Provider Relations and Contracting Procedure *PRC-0107 Site Surveys* prior to UCare contracting with a clinic. In addition, UCare will also visit provider sites that reach its member-complaint threshold or as part of a corrective action as described in this Credentialing Plan as well as procedure *PRC-0180 Provider Network Analysis.*

The Medicare Opt-Out list is reviewed during the (re)credentialing process and ongoing by the Provider Data Audit & Compliance team within 30 calendar days of release with notification to the Credentialing Department.

The Medicare/Medicaid Exclusion & Preclusion Reports (Streamline) are reviewed within 30 calendar days of release by the Provider Data Audit & Compliance team with notification to the Credentialing Department.

Licensing board disciplinary actions are monitored within 30 calendar days of release or alert notification. If there is no release date or alert notification date, the applicable state licensing boards are still reviewed every 30 calendar days.

UCare's credentialing system has a license expiration monitoring/DEA module (LEMM) that runs monthly on any active practitioner against the state licensing boards. The CAS reviews this weekly and looks for any outcome that is flagged as "attention" and will go directly to the state licensing board to review the license action.

Complaints, Appeals and Grievances are reviewed upon receipt and the practitioner's history of complaints is evaluated if applicable. Quality of Care Grievances that qualify as adverse events are reported to the Credentialing Committee monthly as documented in the Credentialing Committee meeting minutes. Additionally, every three months UCare will determine if providers meet a threshold that signifies heightened concern per UCare Procedure QAG011 *Potential Deficiencies in Clinical Quality of Care*. In the event that the provider meets this threshold the provider will be referred to the Medical Director for Professional Criteria review as appropriate.

Information is reviewed from focus studies or other data that indicates sub-standard professional performance related to quality, member satisfaction, utilization management or any other matter related to professional performance or competence as determined by UCare.

Other matters may arise which call into question the continued participation of a provider to treat UCare members. Quality Management, Credentialing Staff and the Medical Directors will be alert and diligent in referring such matters to the Credentialing Committee as appropriate.

XII. Termination of a Provider

{NCQA CR 6-Element A-1}

Providers may be denied or terminated from the UCare network based upon the following reasons:

Pre-Application and/or Administrative Criteria

Terminations due to Pre-Application and/or Administrative Criteria are administrative in nature and not subject to appeal unless otherwise required per regulation law. License surrender or revocation and Medicare/Medicaid exclusions are grounds for immediate termination without committee action. UCare's Credentialing Staff will provide written notice of the denial, suspension, or termination to the provider. The notification will include the effective date of the action and the reason(s) for such action.

Professional Criteria

Termination for failure to meet Professional Criteria is subject to appeal. The Medical Director may refer to the Credentialing Committee termination for failure to meet Professional Criteria. The Credentialing Committee may also, independent of a Medical Director referral; recommend termination for failure to meet Professional Criteria. The Credentialing Committee can consider any information regarding professional conduct or competence that its members they deem relevant and appropriate. Terminations determined by the Credentialing Committee based on Professional Criteria are not considered final until after a provider has waived the right to a hearing, has failed to request a hearing in a timely manner, or has completed the appeal process. The effective date of any professional termination action is the date notice is provided to the provider of the final action.

Provider Contract Compliance

UCare Policy *PRC006 Administrative Provider Contract Termination* governs the procedures to follow to effect contract termination. Credentialing Staff shall coordinate with Provider Relations and Contracting (PRC) regarding actions that may require contract termination.

In any termination, Credentialing Staff shall notify Provider Enrollment staff to deny all claims one day after the effective date of notification of the suspension or restriction.

XIII. Corrective Actions

{NCQA CR 6-Element A-1}

Need for Corrective Action

If a pattern of substandard professional performance or failure to comply with Administrative or Professional Criteria is identified through UCare' s monitoring process or at the time of recredentialing, UCare may, in its own discretion, attempt to remedy the situation through any means it deems appropriate, including educational interventions and Corrective Action Plans (CAPs). CAPs shall be in writing to the provider and outline the specific goals and outcomes required. A timeline for accomplishing the education or the corrective actions will also be specified. UCare is not required to offer a CAP prior to denying, termination or taking any other action related to participation that is permitted under this Credentialing Plan.

Imposition of Corrective Action

Implementation of educational interventions and CAPs vary depending on whether non-compliance is related to Administrative or Professional Criteria. The Medical Director in collaboration with other UCare departments may direct educational interventions or a CAP. Failure to comply with Professional Criteria is reported to the Medical Director. The Medical Director may in his/her own discretion direct education interventions or a CAP. Credentialing Staff will monitor completion of direction action(s) and report periodically on the provider's status to the Credentialing Committee. For facilities who do not meet UCare' s office standards, UCare will impose a CAP and will monitor the CAP until the facility provider has demonstrated that it meets UCare' s office standards.

XIV. Restriction or Suspension of a Provider

{NCQA CR 6-Element A-1}

Restriction is an action that UCare may take to limit the scope of practice of a provider. Suspension is a temporary action pending resolution of a medical board or credentialing action.

Restriction and Suspension

UCare in its discretion may restrict the scope of practice of a provider or suspend participation as a result of failure to continuously meet Administrative or Professional Criteria. If the Medical Director determines that a restriction or suspension for an issue may be warranted, the case shall be referred to the Credentialing Committee. The Medical Director shall review any cases that meet file class 2 or 3 per the Variation Application File Review Grid regarding Professional Criteria and may recommend restriction or suspension to the Credentialing Committee.

- Administrative issues: The provider shall receive written notice and have the right to submit information in response to the notice.
- Professional issues: The provider shall receive written notice and a right to an appeal hearing prior to the imposition of the restriction or suspension unless UCare imposes a summary restriction or suspension.

Summary Restriction or Suspension

UCare may impose a summary restriction or suspension if the provider's license is restricted or suspended, or if a Medical Director determines that the health of any UCare member is in imminent danger because of actions or inactions of the provider. A summary restriction or suspension should generally not exceed sixty (60) calendar days, during which time UCare shall investigate to determine if further action is warranted. The Medical Director shall inform the provider of the summary restriction or suspension by telephone and shall send written notice as soon as practicable.

- Administrative issues: UCare may consider information submitted by the provider.
- Professional issues: The provider has a right to an appeal a hearing for summary restrictions or suspensions. The appeal hearing may occur after the suspension or restriction period.

Claims Denial

Credentialing Staff shall notify Provider Relations and Contracting and Provider Enrollment staff to deny all claims within five (5) business days after the effective date of notification of the suspension or restriction.

XV. Credentialing Appeal Process

{NCQA CR 6-Element A-1 | NCQA CR 6-Element A-2}

Right and Request to Appeal

Appeals are offered to providers after the Credentialing Committee recommends denial or termination of participation status or other disciplinary action based on Professional Criteria. The Credentialing Committee will also offer an appeal in any case where the action is reportable to the National Practitioner Data Bank (NPDB).

If the provider is offered the opportunity to appeal, UCare shall follow this Credentialing Plan as set forth below. Hearings are not offered to facilities. If a delegate of UCare has made the adverse decision, the provider generally shall have access to the delegate's appeal process, although UCare will retain the authority to make a final decision. Appeals regarding provider contracts are governed by UCare Policy *PRC006 Administrative Provider Contract Termination.*

The provider shall be given written notice of proposed action and notice of the right to appeal via certified letter or secure email. The notice shall inform the provider that an adverse action has been proposed against them and the reasons for the proposed action. The provider is informed of their right to review the credentialing file, with the exception of information which is protected under peer review. The provider shall be given 30 calendar days from receipt of such notice to exercise this right. The notice will also inform the provider of his or her right to request a hearing on the proposed action, of the 30 calendar day requirement for requesting such a hearing and of his or her rights in the hearing including, as described below, the right to counsel, to present relevant evidence, and to receive written notice from UCare stating the basis of its decision.

Upon timely receipt of a provider's written request, UCare shall notify the provider that an appeal hearing will be scheduled and UCare will provide further information when a hearing date is set. A restriction or suspension may be extended beyond 60 days to complete the hearing process. If the provider fails to request a hearing in writing within 30 calendar days of receipt of the notice, the provider waives any appeal rights under this Credentialing Plan.

The hearing date will not be less than 30 calendar days from the date the provider receives the hearing notice, unless a shorter period is mutually agreed to by both parties.

Failure of the provider to attend the appeal hearing either in person or by telephone conference call will result in forfeiture of appeal rights, unless the provider is able to demonstrate reasonable circumstances that prevented such attendance.

Pre-Hearing Matters

When a hearing is scheduled, UCare' s Credentialing Staff will provide written notice to the provider stating the time, place and date of the hearing, and the composition of the Appeals Committee. UCare will provide any documents expected to be presented at the appeal to support its decision. The letter should contain copies of the information that is unprotected under peer review statues upon which UCare based its decision. The provider must provide UCare with the name of any representing counsel, and any documents to be presented at the appeal hearing.

UCare's Credentialing Committee Chairperson, acting on behalf of UCare will select the Appeals Committee members. The Appeals Committee and the Provider will be provided information regarding UCare's credentialing determination prior to the hearing. This information shall include, but not limited to, the reason for UCare' s determination including any supporting documentation, any additional documents to support UCare' s determination, and any documents to be used by the provider to contest UCare' s decision. This information shall be provided within the timeframe designated in the appeal hearing date notice sent to the provider.

Documents not disclosed consistent with this Section shall only be presented with good cause for failure to disclose previously and with the consent of both parties in the appeal. The Appeals Committee may, in its sole discretion, postpone further action and final decision, if necessary, to review new information presented.

The Hearing

The provider and UCare may be represented by counsel. UCare shall arrange for a record to be made of the hearing with the format of record at UCare's discretion. A Hearing Officer will be selected prior to the hearing.

Prior to the presentation of evidence or testimony by either party, the Hearing Officer residing over the Appeal hearing shall announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence, including any time limits or other rules or constraints on the proceedings.

UCare may present a summary of the case to the Appeals Committee for consideration. The provider or provider counsel may also present their case.
The provider may be questioned by UCare and/or by the Appeals Committee.

Upon the completion of UCare's and the provider's submission of testimony and evidence, the provider shall have the opportunity to make a brief closing statement. Following the hearing, the Appeals Committee members will meet after the hearing and make a recommendation.

Evidentiary Standards

The oral testimony and documentary evidence provided by UCare and the provider shall be reasonably related to the specific issues or matters involved in the recommended action. The Appeals Committee has the right to refuse to consider testimony or evidence that it does not deem useful in making a decision. The rules of evidence applicable in a court of law do not apply. If a party objects to the presentation of any testimony or evidence, the grounds shall be stated for the objection and the Appeals Committee has the sole discretion to determine whether this evidence will be considered. The Appeals Committee has the ability to determine the relative weight to be given to various items of testimony or evidence submitted.

Appeals Committee's Decision

The Appeals Committee shall make its determination based on the information and evidence produced at the hearing, including the oral testimony, summary oral and written statements, and all documentary evidence submitted to UCare and at the hearing.

After the hearing, the Appeals Committee shall convene and privately discuss the evidence presented at the hearing and the determination of the Credentialing Committee. The Appeals Committee may uphold, overturn, or modify the action. The Appeals Committee's decision shall be by the affirmative vote of the majority of the members of the Appeals Committee.

QIACC Determination

The Appeals Committee recommendation is presented to the QIACC, who in its own discretion may make a determination whether the Appeals Committee acted arbitrarily and capriciously. The QIACC may approve, overturn, or modify the Appeals Committee's recommendation. The provider shall have no right to appear before the QIACC or appointed committee of the QIACC.

When the QIACC has ratified the action, the Credentialing Staff will send a certified letter with return receipt to the provider and legal counsel, as applicable, if the provider is to be terminated, the letter will include notification of the termination date.

Notice and Effective Date of Action

If the QIACC affirms a recommendation to deny or terminate the provider's participation status, the decision shall be the date of the original decision, unless otherwise directed by the QIACC. Notification or "notice" means depositing the correspondence in the United States mail, using certified mail with return receipt addressed to the other party at the office address given in the application, or personal delivery of written notice to the other party. UCare shall provide the provider with written notice of the decision within 5 business days of the decision. Such notice shall include a statement of the basis for the QIACC's decision.

Any final action following an appeal shall be reported by UCare in accordance with the reporting requirements defined in Section XVIII of this Credentialing Plan.

XVI. Break in Service

{NCQA CR 4-Element A}

Break in Service includes, but is not limited to health, military, maternity/paternity or sabbatical leave.

If a credentialed provider that was on Leave of Absence and is past due for recredentialing, the recredentialing application needs to be completed within 60 calendar days of their return from Leave of Absence.

XVII. Expedited Credentialing

UCare recognizes that it can be beneficial for members to make providers available before the completion of the entire credentialing process for emergency situations only (i.e. disaster, network inadequacy). A provider may not be expedited for contracting purposes. A provider may only be expedited once when applying to UCare for the first time. Providers who had been credentialed and are in good status under a delegated credentialing arrangement do not require expedited credentialing.

The provider must submit a completed application, signed and dated release, and signed and dated attestation. An application must be considered clean or it does not qualify for expedited credentialing. UCare will verify all credentialing requirements as set forth in this Credentialing Plan and related procedures. The Medical Director may approve the provider prior to the next scheduled Credentialing Committee if the file is clean.

XVIII. Reporting Requirements

{NCQA CR 6-Element A-1}

UCare shall determine, based upon the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 401 et seq., Minn. Stat. § 147.111; Minn Stat, section 147.00; the Health Insurance Portability and Accountability Act of 1996 and any other relevant federal and state statutes and regulations, whether a denial, termination or other action taken pursuant to this Credentialing Plan shall be reported to the NPDB, the relevant state licensing board, or any other appropriate agency. UCare shall be entitled to make its determination in its sole discretion, in accordance with such policies and procedures as the Credentialing Committee shall adopt provided, however, that the determination shall be made in good faith. UCare will make all required reports described above. UCare shall notify the affected provider, in writing, in the event such report is made.

XIX. References

This Credentialing Plan supports UCare policies:
QCR021 – Providers Non-Response to Requests for Credentialing Documentation
QAG011– Potential Deficiency in Clinical Quality of Care
PRC006 – Administrative Provider Contract Termination

This Credentialing Plan supports UCare procedures:
QCR-0015 – Organizational Assessment Reassessment Requirements
QCR-0019 – Complaint Review and DHS Adverse Actions Reporting
QCR-0021 – Practitioner Credentialing
QCR-0023 – Provider on Review
QCR-0029 – Oversight of Credentialing Delegates
QCR-0030 - Criteria for Acceptance
PRC-0027 – Delegation Management
PRC-0107 – Site Surveys
PRC-0180 – Provider Network Analysis
PRC-0188 – Provider Directory Updates

OTHER REFERENCES
National Committee for Quality Assurance (NCQA)
Centers for Medicare & Medicaid Services (CMS)
Minnesota Department of Health (MDH)
CRWI01 – Acceptable Application and Verification Criteria
CRWI02 – Annual Non-Discrimination Report
CRWI13 – Issue File Review (Variation Application File Review Grid)
CRWI16 – State Board Ongoing Monitoring and DHS Adverse Actions Reporting
CRWI19 – Streamline Monthly Query, DHS Adverse Actions, SIU Reporting, Opt Out Notifications and NPI Deactivations

APPROVALS

DIRECTOR: Wendy Hanson
Date: 2 / 2 2 / 2 0 2 4

COMMITTEE (as appropriate): Credentialing Committee
Date: 3 / 1 2 / 2 0 2 4

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Key Words: *Credentialing, QIACC, QIC, Medical Director, and Credentialing Committee*