Credentialing Program Manual

Policies and Procedures

APPROVED BY

UMPQUA HEALTH NETWORK CREDENTIALING SUB COMMITTEE OF THE QUALITY IMPROVEMENT COMMITTEE

UPDATED APRIL 2025

Table of Contents

Introduction

Umpqua Health, in accordance with OAR 410-141-3510, UHA's CCO Contract, CMS, health plan client standards, requires all healthcare practitioners/providers and non-licensed provider types to complete initial credentialing prior to participation and re-credentialing every 36 months (to the day) pursuant to Patient Protection and Affordable Care Act (PPACA) Section 6402, 42 CFR §§§ 438.214, 455.400 through 455.470 (excluding § 455.460). This process includes completion of the initial OPCA, primary sources verification of specific elements as delineated in this policy, followed by review and decision by the UHA Credentialing Sub-Committee.

UHA has delegated the tasks of credentialing and recredentialing, as well as the development, maintenance and updating of UHA's policies and procedures to Umpqua Health Management (UHM). In turn, UHM has further delegated the tasks of credentialing and recredentialing to Umpqua Health Network (UHN). UHA, UHM and UHN (collectively "Umpqua Health") adopt , the policies and procedures outlined in this Credentialing Program Manual.

UHN's Credentialing Department and the UHA Credentialing Sub-Committee collect evidence of credentials, screen the credentials, report credential information of participating practitioners/providers including acute, primary, dental, behavioral, substance use disorders, long term services and supports (LTSS), telemedicine practitioners/providers and facilities used to deliver covered services. This process helps lead to early detection of incomplete/lack of education or training in applicant's scope of stated practice. In addition, this manual is provided as a guidance document for oversight through UHA's Quality Improvement Committee to assist with routine monitoring of Umpqua Health's provider network.

In addition, UHN serves as a credentialing delegate for ATRIO Health Plans, Inc, established through the delegated credentialing statement of work (SOW) Medicare Advantage Services Agreement. This SOW requires the credentialing and re-credentialing of practitioners/providers who provide services to ATRIO members and must ensure continued compliance with regulations in accordance with CMS standards (Medicare Managed Care Manual, Chapter 6), health plan client standards, 42 Code of Federal Regulation (CFR) 422.204, and Social Security Act, Section 1852.

Umpqua Health's comprehensive Credentialing (CR) Program ensures that its applicants and provider network meet the standards of professional licensure and certification as delineated by State, Federal and accreditation requirements. The process enables Umpqua Health to recruit and retain a quality network to serve health plan members and ensure ongoing access to care. The CR Program consistently and periodically assesses and evaluates the ability of practitioners/providers to deliver quality care between credentialing and re-credentialing cycles, and it emphasizes and supports their ability to successfully manage the health care of members in a cost-effective manner. The CR Program enables Umpqua Health to ensure that all practitioners/providers are following health plan policies and procedures, contractual agreements, and applicable regulatory and/or accreditation requirements and/or standards.

The CR Program Manual is reviewed at least annually to ensure ongoing compliance; however, the CR Program Manual will be reviewed and updated as needed with a State or Federal

regulatory change, contractual change, or internal process change occurs. The CR Program is reviewed by members of the UHA Credentialing Sub-Committee of the Quality Improvement Committee (QIC) and the Compliance Department, as needed. All employed and contracted practitioners/providers are subject to the peer review process. Health plan client or its agent will be provided with a current copy of Umpqua Health's CR Program Manual upon any material change.

Definitions

Ad Hoc: When necessary or needed; created or done for a particular purpose as necessary.

Approved Status or Credentialing Approval: When a practitioner/provider has met Umpqua Health's credentialing criteria based on his or her credentials, background check, education, work history, malpractice claims history (i.e. "clean" history), and peer reviews.

Authority: Oregon Health Authority.

Authority Approved Training Program: An organization that provides an education in the core curriculum that meets Authority standards for one or more types of traditional health workers and is approved by the Authority to train those types of traditional health workers.

Behavioral Health Clinician:

- A licensed psychiatrist;
- A licensed psychologist;
- A licensed nurse practitioner with a specialty in psychiatric mental health;
- Master's level clinical social worker
- A licensed professional counselor or licensed marriage and family therapist;
- A certified clinical social work associate;
- A licensed or certified addiction medicine specialists;
- An intern or resident who is working under a board-approved supervisory contract in a clinical mental health field; or
- Any other clinician whose authorized scope of practice includes mental health diagnosis and treatment.

Birth Doula: Is a birth companion who provides personal, nonmedical support to birthing person and their families throughout a birthing person's pregnancy, childbirth, and post-partum experience (OAR 950-060-0010(3)).

Clean Files: Initial credentialing or re-credentialing of practitioner/provider files where primary source verification is completed by the Credentialing Department. The files meet all requirements to be approved by the UHA Credentialing Sub-Committee. No concerns found.

Clinical Supervision: Oversight by a qualified clinical supervisor of substance use, problem gambling, and mental health services and supports provided according to these rules, including ongoing evaluation and improvement of the effectiveness of those services and supports (309-019-0105(33)).

Clinical Supervisor: An individual qualified to oversee and evaluate substance use, problem gambling, or mental health services and supports (OAR 309-019-0105(34)).

Community Health Worker (CHW):

- Is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.
- Under OAR309-019-0105(42) is an individual who meets qualification criteria adopted by the Authority under ORS 414.665 and who is certified pursuant to the requirements in OAR 410-180-0310.
- Under ORS 414-025(7) is an individual who meets qualification criteria adopted by the authority under ORS 414.665 (Traditional health workers utilized by CCOs) and who:
    - Has expertise or experience in public health;
    - Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;
    - To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community the worker serves;
    - Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;
    - Provides health education and information that is culturally appropriate to the individuals being served;
    - Assists community residents in receiving the care they need;
    - May give peer counseling and guidance on health behaviors; and
    - May provide direct services such as first aid or blood pressure screening.

Competencies: Key skills and applied knowledge necessary for THWs to be effective in the work field and carry out their roles (OAR 950-060-0010(8)).

Coordinated Care Organization (CCO): An organization meeting criterion adopted by the Oregon Health Authority under ORS 414.572 (Coordinated care organizations) (ORS 414.025(8)).

Credentialing: A standardized process of inquiry undertaken by credentialing organizations to validate specific information that confirms a health care practitioner's identity, background, education, competency, and qualifications related to a specific set of established standards or criteria.

Credentialing Information: Information necessary to credential or recredential a health care practitioner/provider.

Credentialing Bodies:

- Oregon Medical Board;
- Oregon Board of Psychologist Examiners;
- Oregon Board of Licensed Social Workers;
- Oregon Board of Licensed Provision Counselors and Therapist; or
- Oregon State Board of Nursing.
- Mental Health & Addiction Certification Board of Oregon (MHACBO)

Credentialing Organization: A health care organization that credentials health care practitioners/providers. This includes, but is not limited to the following:

- Ambulatory surgical centers;
- Coordinated care organizations;
- Self-insured health plans;
- Third-party administrators;
- Worker's compensation health plans;
- Dental plan issuers;
- Health plan issuers;
- Hospitals;
- Independent practice associations as defined in ORS 743B.001;
- Health care practitioner organizations; and
- Other health care facilities or organizations that are required to credential health care practitioners.

Curriculum Vitae (CV): Overview of a practitioner's/provider's education, qualifications, and previous experience.

Deferred Status (i.e. tabled): Action is required on the practitioner's/provider's application. Additional information is requested by the UHA Credentialing Sub-Committee, and the application will be reviewed at the next scheduled UHA Credentialing Sub-Committee meeting.

Delegated Credentialing Agreement: A written agreement between credentialing organizations that delegates the responsibility to perform specific activities related to the credentialing and re-credentialing of health care practitioners/providers. For telemedicine credentialing, delegated credentialing agreement has the meaning given that term in ORS 442.015.

Discrepancies: When information submitted by practitioner/provider differs from information verified by the Credentialing Department during primary source verification.

Division: Every individual organizational unit within the Authority.

Family Support Specialist: Under OAR 950-060-0010(1)) is an individual who meets qualification criteria adopted under ORS 414.665 and may be either a peer support specialist or a peer wellness specialist who, based on similar life experiences, provides support services to and has experience parenting a child who:

- Is a current or former consumer of mental health or addiction treatment; or
- Is facing or has faced difficulties in accessing education, health, and wellness services due to mental health or behavioral health barriers.

Grandfathered Traditional Health Worker: An individual certified before June 30, 2019, by the Oregon Health Authority's (OHA or Authority) as a result of their prior work experience and fulfillment of all additional requirements for grandfathering as set forth in OARs 410-180-0300 through 410-180-0380.

Hearing Committee: Ad hoc committee composed of five (5) practitioners/providers appointed by the UHA Credentialing Sub-Committee Chair from among the Umpqua Health's participating

provider panel, with the UHA Credentialing Sub-Committee Chair to designate the Hearing Committee Chair.

Health Care Practitioner or Practitioner: An individual authorized to practice a profession related to the provision of health care services in this state for which the individual must be credentialed. This may include, but is not limited to individuals licensed as:

- Acupuncturists;
- Addiction Medicine Specialist;
- Advanced Registered Nurse Practitioner;
- Audiologists;
- Certified Nurse Midwife;
- Certified Registered Nurse Anesthetists;
- Chiropractic Physicians;
- Clinical Nurse Specialists;
- Doctors of Dental Medicine;
- Doctors of Dental Surgery;
- Doctors of Medicine;
- Doctors of Osteopathic Medicine;
- Doctors of Podiatric Medicine;
- Licensed Clinical Social Workers;
- Licensed Dietitians;
- Licensed Marriage and Family Therapists;
- Licensed Massage Therapists;
- Licensed Professional Counselors;
- Naturopathic Physicians;
- Nurse Practitioners;
- Occupational Therapists;
- Optometrists;
- Oral and Maxillofacial Surgeons;
- Pharmacists;
- Physical Therapists;
- Physician Assistants;
- Psychologist Associates;
- Psychologists;
- Registered Nurse First Assistants; and
- Speech-Language Pathologists.

Health Plan Client:

- ATRIO Health Plans, Inc

High Risk: Medicare and Medicaid designate a "high" risk category according to section 42 CFR §424.518(c)(l) when a practitioner/provider is newly enrolling. A practitioner/provider designated "high" risk must meet limited and moderate risk screening requirements. Criminal background checks must be conducted, and submission of fingerprint set required based on risk of Fraud, Waste, and Abuse in accordance with 42 CFR §455.434. A practitioner/provider at

high risk is defined by one who has received suspension, sanction, or exclusion from a State or Federal program within the previous 10 years.

Independent Relationship: Exists when Umpqua Health Alliance (UHA) directs those it serves to see a specific practitioner or group of practitioners, including all practitioners whom members can see, a specific practitioner/provider or group of practitioners, including all practitioners whom members may select as primary care physicians.

Licensed Health Care Professional: A practitioner of the healing arts acting within the scope of their practice under state law who is licensed by a recognized governing board in Oregon.

Licensed Medical Practitioner (LMP): A person who is documented by the Local Mental Health Authority (LMHA) or designee as (1) physician, nurse practitioner, or physician's assistant who is licensed to practice in the State of Oregon, and whose training, experience, and competence demonstrate the ability to conduct a mental health assessment and provide medication management; or (2) for Intensive Outpatient Services and Support (IOSS) and Intensive Treatment Services (ITS) providers, a board-certified or board eligible child and adolescent psychiatrist licensed to practice in the State of Oregon.

Licensing Action: Any action that suspended, revokes, limits, or conditions licensure or certification in any way and includes warnings, reprimands, probation, and administrative penalties.

Limited Risk: Medicare and Medicaid designate a "limited" category according to section 42 CFR §424.518(a)(l) to a physician or non-physician. A practitioner/provider designated "limited" risk must meet State or Federal requirements for practitioner/provider scope of practice prior to determination of enrollment. Verification of all state licensing is held in accordance with 42 CFR §455.412. Practitioner/provider meets enrollment criteria for scope of practice in accordance with 42 CFR §455.436.

Local Mental Health Authority (LMHA): One of the following entities (OAR 309-019-0105):

- The board of county commissioners of one or more counties that establishes or operates a CMHP;
- The tribal council in the case of a federally recognized tribe of Native Americans that elects to enter into an agreement to provide mental health services; or
- A regional local mental health authority composed of two or more boards of county commissioners.

Locum Tenens (i.e. substitute physician): A practitioner/provider who substitutes for another practitioner/provider, while he or she is absent for reasons such as illness, vacation, continuing medical education, pregnancy, etc. in accordance with OAR 410-120-1260(15)(a)(A).
Managed Care Entity (MCE): Is a general term that means an entity that enters one or more contracts with the Authority to provide services in a managed care delivery system, including but not limited to the following types of entities defined in and subject to 42 CFR Part 438: managed care organizations (MCOs), primary care case managers (PCCMs), prepaid

ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs). A CCO is an MCE for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state funds or both.

Managed Care Organization (MCO): Is a specific term that means an MCE defined in 42 CFR Part 438. A CCO is an MCO for its managed care contract(s) subject to federal managed care requirements specified in 42 CFR Part 438.

Member: An OHP client enrolled with an MCE.

Mental Health Intern: Program staff who meet qualifications for QMHA and are currently enrolled in a graduate program approved by the Division-approved certification or licensing body but does not have the necessary graduate degree in psychology, social work, or related field of behavioral science, or have an equivalent degree as determined by the Division-approved certification or licensing body (OAR 309-019-0105).

Moderate Risk: Medicare and Medicaid designate a "moderate" risk category to listed practitioner/provider types in section 42 CFR §424.518(b)(1). A practitioner/provider designated "moderate" risk must meet limited risk screening requirements. On-site visits are conducted in accordance with 42 CFR §455.432.

National Committee for Quality Assurance (NCQA): An independent nonprofit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

National Practitioner Data Bank (NPDB): A database of confidential information created by Congress and run by the U.S. Department of Health and Human Services (HHS). The information provided allows qualified organizations to run a query on a practitioner/provider applying for network participation. The query will provide insight into but not limited to the following: adverse action, sanctions, and previous performance issues.

Non-Licensed Provider: Any applicant holding certification(s) as one of the following:

- Certified Alcohol and Drug Counselor (CADC) I, II, & III
- Certified Gambling Addiction Counselor (CGAC) I & II
- Certified Prevention Specialist (CPS)
- Certified Recovery Mentor (CRM) I & II
- Certified Gambling Recovery Mentor (CGRM)
- Qualified Mental Health Associate (QMHA) and QMHA II
- Qualified Mental Health Professional (QMHP)
- Peer Support Specialist (PSS)
- Community Health Worker (CHW)
- Peer Wellness Specialist (PWS)
- Traditional Health Worker (THW)

Non-Summary Termination: Discharge of a practitioner/provider from Umpqua Health based on the aggregate information available to the UHA Credentialing Sub-Committee.

Oregon Health Plan (OHP): Oregon's Medicaid program or related state-funded health programs. Any OHP contract shall identify whether it concerns Oregon's Medicaid program or a related state-funded health program, or both.

Participating Practitioner/Provider or Network Provider: A practitioner/provider that has a contractual relationship with an MCE (e.g., UHA) or a health plan. A participating practitioner/provider is not a subcontractor solely by virtue of a participating practitioner/provider agreement with an MCE.

Peer Delivered Services Supervisor: A qualified individual, with at least one year of experience as a PSS or PWS in behavioral health treatment services, to evaluate and guide PSS and PWS program staff in the delivery of peer delivered services and supports (OAR 309-019-0105(115)).

Personal Health Navigator (PHN): An individual who meets qualification criteria adopted by the Authority under ORS 414.665 (Traditional health workers utilized by coordinated care organizations) and who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes (ORS 414.025(23)).**Peer Support and Peer Wellness Specialist Supervision:** Supervision by a qualified clinical supervisor and a qualified peer delivered services supervisor as resources are available. The supports provided include guidance in the unique discipline of peer delivered services and the roles of peer support specialists and peer wellness specialists (OAR 309-019-0105(117).

Peer Support Specialist:

- A qualified program staff providing peer-delivered services to an individual or family member with similar life experience under the supervision of a qualified clinical supervisor and a qualified peer-delivered services supervisor as resources are made available (OAR 309-019-0105(116)).
    - Under OAR 950-060-0010(13), is an individual providing services to another individual who shares similar experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition. A peer support specialist shall be: A self-identified individual currently or formerly receiving addiction or mental health services;
    - A self-identified individual in recovery from an addiction disorder who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;
    - A self-identified individual in recovery from problem gambling.

Peer Wellness Specialist:

- An individual who meets qualification criteria adopted by the Authority under ORS 414.665 (Traditional health workers utilized by coordinated care organizations) and who is responsible for assessing mental health and substance use disorder service and support

needs of a member of a coordinated care organization through community outreach, assisting members with access to available services and resources, addressing barriers to services and providing education and information about available resources for individuals with mental health or substance use disorders in order to reduce stigma and discrimination toward consumers of mental health and substance use disorder services and to assist the member in creating and maintaining recovery, health and wellness (ORS 414.025(21).

- A program staff who supports an individual in identifying behavioral health service and support needs through community outreach, assisting individuals with access to available services and resources, addressing barriers to services, and providing education and information about available resources and behavioral health issues in order to reduce stigma and discrimination toward consumers of behavioral health services and to provide direct services to assist individuals in creating and maintaining recovery, health, and wellness under the supervision of a qualified clinical supervisor and a qualified peer-delivered services supervisor as resources are made available (OAR 309-019-0105(118)).

Practitioner: Is an individual licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license or certification (OAR 410-140-0000(243).

Primary Source: The entity that originally conferred or issued a credential. Examples are education, training, and licensure used to determine the accuracy of the qualifications of an individual healthcare practitioner/provider.

Primary Source Verification: The verification of a health care practitioner's/provider's reported qualifications from the original source.

Provider: An individual, facility, institution, corporate entity, or other organization that supplies or engages in delivery of health services or items or referring for those services or items. Also termed a rendering provider, or bills, obligates, and receives reimbursement from the Authority's Health Services Division on behalf of a rendering provider of services, also termed a billing provider (BP). The term provider refers to both rendering providers and BP unless otherwise specified (OAR 410-120-0000(216) and OAR410-141-3500(66)).

See definition of Healthcare Practitioner above for specific provider types.

Qualified Mental Health Associate (QMHA): An individual delivering services under the direct supervision of a Qualified Mental Health Professional (QMHP) who meets the minimum qualifications as authorized by the Local Mental Health Authority (LMHA) or designee and specified in OAR 309-019-0125 (OAR 309-019-0105(130)).

Qualified Mental Health Professional (QMHP): A Licensed Medical Practitioner (LMP) or any other individual meeting the minimum qualifications as authorized by the LMHA or designee and specified in OAR 309-019-0125 (OAR 309-019-0105(131)).

Quality Improvement Act 1986: The Health Care Quality Improvement Act of 1986 was enacted to improve the quality of medical care by providing a means whereby the incompetent performance of physicians would be disclosed and remedied through effective professional peer review.

Reciprocal Billing Arrangement: A substitute practitioner/provider retained on an occasional basis.

Re-Credential: The process of reviewing and verifying a practitioner/provider credentials still meets standardized credentialing criteria Frequency to be no more than 36 months.

Re-Credentialed Status: The renewal of a practitioner/provider's network participation whose previous services has met Umpqua Health's credentialing/re-credentialing criteria.

Registry: A list maintained by the Authority of THWs certified under OARs 950-060-0000 through 950-060-0160 (OAR 950-060-0010(16)).

Sanctions: Action taken against a practitioner/provider in cases of fraud, waste, abuse, or violation of contractual requirements.

Subcontract (OAR 410-141-3500(71)):

- A contract between an MCE and a subcontractor pursuant to which such subcontractor is obligated to perform certain work that is otherwise required to be performed by the MCE under its contract with the State; or
- Is the infinitive form of the verb "to Subcontract", i.e. the act of delegating or otherwise assigning to a Subcontractor certain work required to be performed by an MCE under its contract with the State.

Subcontractor: An individual or entity that has a contract with an MCE that relates directly or indirectly to the performance of the MCE's obligations under its contract with the State. A participating provider is not a subcontractor solely by virtue of having entered into a participating provider agreement with an MCE (OAR 410-141-3500(72)).

Subsidiaries of Umpqua Health, LLC:

- Umpqua Health Alliance
- Umpqua Health Management
- Umpqua Health Network

Summary Termination: Discharge of a practitioner/provider without any notice or hearing, employment relationship with Umpqua Health ends immediately.

Suspension: Temporary prevention of a practitioner/provider from continuing to be contracted and or participating with Umpqua Health.

Telemedicine: The provision of health services to patients by physicians and health care practitioners from a distance using electronic communications (ORS 442.015(26)).

Temporary Status: A status granting a practitioner/provider network participation onto Umpqua Health's provider panel in the interim of awaiting approval or denial by UHA's Credentialing Sub-Committee. This status is not to exceed 90 days and will be granted to qualified applicants on a case-by-case basis between UHA Credentialing Sub-Committee meetings.

Termination/Denied Status: A practitioner/provider failed to meet criteria established by Umpqua Health. Action of ending practitioner/provider contract and or participation with Umpqua Health.

Traditional Health Worker (THW): A community health worker, peer wellness specialist, personal health navigator, peer support specialist, or birth doula not otherwise regulated or certified by the State of Oregon (OAR 950-060-0010(19))

Unreturned Credentialing Packet: Oregon Practitioner Credentialing Application (OPCA) or Oregon Practitioner Re-Credentialing Application (OPRA) that is not submitted to the Umpqua Health's Credentialing Department within designated period.

Verification Time Limit: Ensures that the credentialing verification process does not exceed the prescribed time limit of 180 days; and ensures that the practitioner's/provider's recredentialing occurs at least every 36 months to the day in accordance with Oregon Administrative Rule (OAR) 410-141-3510.

Youth Support Specialist: An individual who meets qualification criteria adopted under ORS 414.665 and may be either a peer support specialist or a peer wellness specialist and who, based on a similar life experience, provides supportive services to an individual who:

- Is not older than 30 years old, and
- Is a current or former consumer of mental health or addiction treatment; or
- Is facing or has faced difficulties in accessing education, health, and wellness services due to mental health or behavioral health barriers.

Practitioners/Providers Within Credentialing and Re-Credentialing Scope

Umpqua Health is committed to continuously improving the quality of member/patient care and serving the community in an efficient and cost-effective manner. To do so, Umpqua Health reviews those practitioners/providers who fall within the scope of credentialing under NCQA, CMS, health plan client standards, OARs, CFRs, and/or UHA's CCO Contract prior to the provision of care to members to complete initial credentialing prior to participation and re-credentialing every 36 months (to the day).

UHA's Credentialing Sub-Committee assesses:

Medical Practitioners:

a. Medical doctors (MD).
b. Oral surgeons.
c. Dentists (DDS/DMD).
d. Chiropractors (DC).
e. Doctors of Osteopathy (DO).
f. Podiatrists (DPM).
g. Other medical practitioners.

Oral-health providers:

a. Advanced Dental Hygienist Practitioners (RADHP)

Nonphysician practitioners/providers:

a. Allied Health/Midlevel's such as Nurse Practitioners (NP, PNP, ANP, CRNA etc.).
b. Physician Assistants (PA).
c. Optometrists (OD).
d. Physical therapists (PT, MPT, DPT).
e. Occupational therapists (OTR).
f. Vision Services providers.
g. Speech and language therapists (SLP).
h. Dieticians (RD).
i. Certified Nurse Midwife.
j. Advanced Registered Nurse Practitioner

Behavioral healthcare practitioners:

a. Psychiatrists and other physicians.
b. Addiction medicine specialist.
c. Doctoral or master's-level psychologists.
d. Master's-level clinical social workers.
e. Master's level clinical nurse specialist or psychiatric nurse practitioners.
f. Qualified Mental Health Associate.
g. Qualified Mental Health Professional.

h. Traditional Health Workers.
i. Behavioral Health Clinicians.
j. Licensed Social Worker.
k. Certified Social Worker.
l. Other behavioral healthcare specialists (e.g., Licensed Professional Counselor, Licensed Marriage, and Family Therapist).

Additional Requirements

Credentialing requirements apply to the following:

a. Practitioners/providers who are licensed, certified, or registered by the State to practice independently (i.e., without direction or supervision).
b. Practitioners/providers who have an independent relationship with Umpqua Health or its subsidiaries.
    i. An independent relationship exists when Umpqua Health or its subsidiaries directs members to see a specific practitioner/provider or group of practitioners/providers, including all practitioners/providers members can select as a primary care practitioner/provider.
c. Practitioners/providers who provide care to members under Umpqua Health or its subsidiaries or health plans medical benefits.
d. Practitioners/providers opting into health plan networks and deliver care to members under health plan medical benefits.

The above credentialing requirements also apply to practitioners/providers in the following settings:

a. Individual or group practices;
b. Facilities;
c. Rental networks that are part of the organization's primary network and the organization has members who reside in the rental network area; and
d. Telemedicine.
e. PPO Network
    i. NCQA considers this to be an independent relationship if:
        1. Information about the network is included in member materials or on an ID card that directs members to the network (e.g., network name, phone number, logo).
        2. There are incentives for members to see the PPO's practitioners/providers.
            a. In this type of contractual arrangement, Umpqua Health must credential the practitioners/providers or delegate credentialing to the PPO network.

Under CMS (Medicare applicants only), credentialing is not required for:

a. Health care practitioners/providers who are permitted to furnish services only under the direct supervision of another practitioner.

b. Hospital-based health care professionals who provide services to enrollees incident to hospital services, unless those health care professionals are separately identified in enrollee literature as available to enrollees;
c. Students, residents, or fellows.

Under NCQA, credentialing **is not required** for:

a. Practitioners/providers who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting.
b. Practitioners/providers who practice exclusively in free-standing facilities and provide care for health plan members only because members are directed to the facility.
c. Pharmacists who work for a pharmacy benefit management (PBM) organization to which the organization delegates utilization management (UM) functions.
d. Covering practitioners (e.g., locum tenens).

    ii. Locum tenens who do not have an independent relationship with the health plan are outside NCQA's scope of credentialing. If locum tenens will be needed for more than 60 days, Umpqua Health will follow the normal contracting process and adhere to the credentialing process in accordance with the Credentialing manual.

e. Practitioners/providers who do not provide care for members (e.g., board-certified consultants who may provide a professional opinion to the treating practitioner).
f. Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

If participating practitioners/providers (employees or subcontractors) are not required to be licensed or certified by the State of Oregon Board or licensing agency, Umpqua Health will document and certify the date that the applicant's education, experience, competence and supervision are adequate to permit the person to perform his or her specific assigned duties to ensure accurate reporting by UHA under Exhibit G (CCO Contract Exhibit B, Part 8(18)(c)).

a. Such providers must meet the definitions for Qualified Mental Health Associate (QMHA) or Qualified Mental Health Professional (QMHP) and provide services under the supervision of a Licensed Medical Practitioner (LMP); or,
b. For participating providers not meeting either the QMHP or QMHA definition, Umpqua Health shall document and certify that the applicant's education, experience, competence, and supervision are adequate to permit the individual to perform his or her specific assigned duties.

If programs or facilities are not required to be licensed or certified by a State of Oregon Board or licensing agency, then Umpqua Health obtains documentation from the program or facility that demonstrates accreditation by nationally recognized organizations that is recognized by the OHA for the services provided (e.g. Council on Accredited Rehabilitation Facilities (CARF), or The

Joint Commission (TJC)) where such accreditation is required by OHA rules to provide the specific service or program (CCO Contract, Exhibit B, Part 8(18)(c)).

Roseburg Family Medicine Residency (RFMR) Physicians who are licensed in Oregon may qualify for credentialing before completion of their residency based on the following criteria:

a. The RFMR Program Director must submit a communication to the Contracting Specialist with the Provider Request Questionnaire to demonstrate that the practitioner/provider meets the eligibility criteria for moonlighting privileges.
b. RFMR eligibility criteria for moonlighting privileges include:
    iii. RFMR Program Director approval;
    iv. In-training exam scores >/= 60th percentile;
    v. Punctuality, attendance, and participation in all conferences and learning sessions;
    vi. Quality performance in all areas of clinical competence based on evaluations and the contents of the residents' file; and
    vii. Meet the Oregon Medical Board requirements for an unrestricted medical license in Oregon.
c. If there is a decline in academic performance, the residency reserves the right to prohibit moonlighting until further notice and the RFMR Director will notify Umpqua Health when a resident's moonlighting privileges have been suspended or revoked.
d. Umpqua Health will make final credentialing determination for UHN participation for all Roseburg Family Medicine Residency (RFMR) Physicians.

Application for Participation

The credentialing process consists of two stages for practitioners/providers aiming to become a participating in-network practitioner/provider with Umpqua Health, encompassing contracting and credentialing.

1. The applicant must complete the Provider Request Questionnaire, which involves:
    a. Completing the Provider Request Questionnaire
    b. Submitting the application to Umpqua Health, along with requested documentation such as the practitioner's/provider's Oregon license and any board certifications. (See the complete list below)
    c. The application and accompanying file are reviewed by Umpqua Health Leadership during the monthly Contracting Workgroup meeting. Applicants receive written notification of the Contracting Workgroup's decision.
2. Upon approval by the CEO, CFO, and CMO, the Contracting Team sends an initial prescreen questionnaire to the Credentialing Department via email to commence the credentialing process. Upon applicant approval, the Contracting Specialist notifies the Credentialing Department, which then initiates the credentialing process by requesting the necessary OPCA or required documentation.

Practitioners/providers are required to use the current mandated version of the Oregon Practitioner Credentialing Application (OPCA) and the Oregon Practitioner Re-Credentialing Application (OPRA) approved and published by the Authority for initial credentialing and recredentialing.

- Authority approved applications are available on the Advisory Committee's website at https://www.oregon.gov/oha/hpa/ohit-acpci/pages/state-app.aspx
- Upon the issuance of an updated version of the OPCA and/or OPRA application released by the Authority, Umpqua Health will have ten (10) months to comply with implementation of the new application (OAR 409-045-0035).
    - Umpqua Health will inform applicants of the current mandated versions of the applications. If an invalid application version is submitted, Umpqua Health's Credentialing Specialist will contact the applicant and request resubmission of the current mandated application.

Required Supporting Documentation

- Current CV with work history
- Oregon State professional licenses/certifications.
- DEA or CDS certificate, if applicable.
- Board certification, if applicable.
- Professional degree(s) or training program(s) certificate of completion.
- Diploma or certification where medical school was completed in a foreign country, if applicable.

- Professional liability insurance certificate.
    - Must provide proof of professional liability for the previous (5) five years.
    - Any history of claims made against professional liability, if applicable.
- Hospital admit plan.
- Signed Seclusion and Restraint Attestation of QI01- Freedom of Seclusion and Restraint policy review, if applicable.
- Signed and dated OPRA or OPCA attestation page confirming the correctness and completeness of the application.
- Practitioner/Provider must specifically address:
    - Reasons for any inability to perform the essential functions of the position with or without accommodation.
    - Attest to no substance use or provide reasons for impairment from any substance or drug use.
    - History of loss of license and/or felony convictions.
    - History of loss or limitations of privileges or disciplinary activity.
    - Any gap greater than 2 months in professional history and provide an explanation.

Healthcare practitioners/providers applying for network participation must fully complete and submit a current OPCA and be accompanied by supporting documentation (see section Required Supporting Documentation) to initiate the credentialing process. An incomplete application or missing documentation will be returned to the applicant. An application will not be considered complete until Umpqua Health has received all required components.

i. Applicants must include a current copy of their CV with the OPCA.
ii. A signed attestation must accompany the OPCA confirming the correctness and completeness of the application.
iii. Pages requiring applicant initials/dates and or signature must be initialed and dated and/or signed either physically "wet signature" or by utilizing a unique electronic signature (e.g., Adobe authenticated signature or DocuSign). This is required by CMS, NCQA, and the mandated Oregon applications.
    1. All signatures must be included, or the application will be returned to the applicant, and the application status will remain incomplete.
iv. Any yes response to OPRA attestation questions.
v. Reasons for any inability to perform the essential functions of the position with or without accommodation.
vi. Any present illegal drug use.
vii. History of loss of license and/or felony convictions.
viii. History of loss or limitations of privileges or disciplinary activity.
ix. Correctness and completeness of the application.
x. Current, malpractice coverage, and any claims against the practitioner's/provider's malpractice insurance, if any.
xi. Provider must specifically address:
xii. A signed Authorization and Release of Information must accompany the OPCA.
    1. The Authorization and Release of Information form allows Umpqua Health to conduct its primary source verification.

Non-licensed provider applicants must fully complete and submit a Non-Licensed Provider Credentialing application and be accompanied by supporting documentation to initiate the credentialing process. An incomplete application or missing documentation will be returned to the applicant. An application will not be considered complete until Umpqua Health has received all required components.

i. Applicant must meet the requirements, qualifications and competencies outlined in sections under the Traditional Health Worker Requirements and the Non-Licensed Provider Qualifications and Competencies.
ii. A signed attestation must accompany the Non-Licensed Provider Credentialing application.
iii. Pages requiring applicant initials/dates and or signature must be initialed and dated and/or signed either physically "wet signature" or by utilizing a unique electronic signature (e.g., Adobe authenticated signature or DocuSign). This is required by CMS, NCQA, and the mandated Oregon applications.
    1. All signatures must be included, or the application will be returned to the applicant, and the application status will remain incomplete.
iv. A signed Authorization and Release of Information must accompany the Non-Licensed Provider Credentialing application.
    1. The Authorization and Release of Information form allows Umpqua Health to conduct its primary source verification.
v. Applicants must have a clinical supervisor and provide supervision plan by a licensed health care professional. The supervision plan must include the clinical supervisor's name and copy of certificate or license.
    1. Supervision plan components include but are not limited to the following:
        a. Clinician name (applicant) and credentials.
        b. Clinician name (applicant) certification/license numbers and expiration date (including all applicable certification or licensure).
        c. Date of supervision plan implemented.
        d. Anticipated date of supervision completion, if applicable.
        e. Type of supervision (e.g., hours of supervision provided (frequency), consultation, in-person supervision, documentation review, group supervision).
        f. Expected trainings to be completed.
        g. Clinical supervisor's name and credentials.
        h. Clinical supervisor's certification or licensure and expiration date.
        i. Clinical supervisor's duties, responsibilities, and scope of competence.
        j. Must be signed by both clinician and clinical supervisor.

            1. Clinical supervisors must meet the requirements outlined in section: Non-Licensed Provider Qualifications and Competencies.
            2. Umpqua Health will primary source verify supervising clinical supervisor certification/license through the appropriate certificate/license issuer.

Initial Credentialing

Umpqua Health's protocol is to inform new medical professionals that they must obtain the necessary DMAP and Medicare numbers to complete the credentialing process.

Primary source verification of elements is completed by qualified Umpqua Health staff or its delegate for practitioner/provider types outlined in section Practitioners/Providers Within Credentialing Scope and may be written, electronic or oral.

a. Oral verification can only be used for verification of work history gap. Oral verification requires a dated and signed note in the credentialing file by the staff completing the verification. The credentialing system auto generates time and date as well as unique identifier of user. The credentialing staff also scans the written notice electronically in the credentialing file if received.
b. All written verification received by mail are scanned and stored electronically.
c. Written verification received via fax are automatically date stamped upon receipt via facsimile.
d. All primary source verification from the primary source website is electronically loaded into the credentialing system and automatically date stamped.
e. All primary source verification received via email are automatically timed and date stamped by the email server.
f. Electronic verification requires a dated and signed note in the credentialing file by the staff completing the verification. The notation must state who verified the item and verification source.

Umpqua Health shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the NPDB and provide accurate and timely information about license or certification expiration and renewal dates in the DSN Provider Capacity Report in accordance with, Ex. G of the Oregon Health Plan Contract.

Umpqua Health shall apply the same credentialing and enrollment criteria required of practitioners/providers enrolling with OHA as Fee for Service Providers.
Telemedicine practitioner/provider requirements shall be consistent with policies PN13 – Telehealth/Telemedicine and PN14 – Tele dentistry.

Primary Source Verification elements must be verified within 180 days prior to the UHA Credentialing Sub-Committee's decision. The following items will be verified by primary sources unless otherwise noted:

a. Applicant information.
b. Specialty information.
c. Board certification, *if applicable*.
    1. Board certification is currently not required by Umpqua Health.If an applicant indicates certification is held, documentation must be submitted with the OPCA and verified by the appropriate

medical board.

2. A query will be conducted in the National Practitioner Databank (NPDB) on the applicant to confirm the absence of sanctions or limitations on licensures from the appropriate licensing board.

d. Any Oregon State licenses, registrations and/or certificates held.
    1. State licenses will be verified through the appropriate Board (e.g., Oregon State Medical Board (OMB) of licensing) or applicable license/certificate issuer to ensure licensure or certification(s) are active and absent of any licensing action. When applicants provide care to members in any other State, Umpqua verifies licensure in all states where the applicant provides care to members. Applicant will hold a current and unrestricted Oregon license or certification to practice within the acceptable "Scope of Practice" rules in Oregon.
    2. If an applicant is not required to be licensed or certified by a State of Oregon board, licensing agency, or recognized Credentialing Body, then the applicant will be credentialed as Non-Licensed Provider.
        a. Applicants must meet the definition for either:
            i. Traditional Health Worker;
            ii. QMHA or QMHP; or
            iii. Certified Alcohol Drug Counselor (CADC)
        b. Must not be permitted to provide services without the supervision of a licensed medical practitioner.
    3. If programs or facilities are not required to be licensed or certified by a State of Oregon board or licensing agency, then Umpqua Health will obtain documentation from the program or facility that demonstrates accreditation by a nationally recognized organization recognized by the OHA for the services provided (e.g. Council on Accredited Rehabilitation Facilities (CARF), or The Joint Commission (TJC) where such accreditation is required by OHA rule to provide the specific service or program.

e. Current certifications and any other certifications held, if applicable.
    i. For THWs: Verification of certification and registry will be completed from OHA's THW Registry (OAR 410-180-0300): https://traditionalhealthworkerregistry.oregon.gov/
        1. THW Types:
            a. Doula.
            b. Peer Support Specialist (PSS).
            c. Peer Wellness Specialist (PWS).
            d. Family Support Specialist.
            e. Youth Support Specialist.
            f. Personal Health Navigator (PHN).
            g. Community Health Worker (CHW).
        2. For QMHP/A and other non-licensed provider certification: Verification is completed through Mental Health & Addiction

Certification Board of Oregon (MHACBO).

f. Education (e.g., undergraduate, graduate, if applicable, medical/professional, residencies, fellowships, preceptorships, or other clinical training programs, *if applicable*).
    i. The practitioner/provider must complete his/her graduation from accredited medical school. Successful completion of an accredited residency program is the minimum requirement for all physician applicants. Residency must be verified and applicable to their specialty if practitioner/provider is not board certified.
        1. For physicians who are not board certified, a primary source verification of the highest level of education in the following areas will be completed:
            a. Residency training program.
            b. Fellowship training program.
            c. Educational Commission for Foreign Medical Graduates (ECFMG) must be verified for foreign graduates.
        2. For non-physicians:
            a. Graduate education.
            b. Accredited medical education.
            c. Clinical training.
    ii. Education is not reverified during the re-credentialing process unless new education was obtained since the last credentialing period.
    iii. Expired board certification meets requirements because primary source verified education and training information would not change with expiration of board certification.
g. Postgraduate/internship, *if applicable*.
h. The Federal Drug Enforcement Agency (DEA) certificate must be current and unrestricted, or an applicant may hold a Controlled Dangerous Substances (CDS) certificate. A current copy of the certificate must be included with OPCA. Umpqua Health will allow a verification print out from the DEA website if one is not submitted with the OPCA.
    i. Must state current Oregon practice address.
        1. If the DEA certificate does not state a current practice address, verification the applicant has submitted a change of address will be confirmed.
        2. The applicant must submit a copy of the DEA with the current Oregon address to Umpqua Health to proceed with the credentialing process.
    ii. Applicants with pending DEA or CDS certificates may be approved. However, documentation including a copy of the applicants Oregon State Medical License and DEA certification from the covering practitioner/provider who will be writing the prescriptions is required, until the certificate is approved.
    iii. An individual's capability to practice safely and competently, with or without accommodation, is contingent upon the absence of current physical, mental health, or substance abuse issues that may impede their

performance.

i. Absence of suspension or probation from professional medical societies or hospital privileges.
    a. Absence of Medicare or Medicaid sanctions. Verification is completed through the NPDB, the Office of Inspector General (OIG) and System for Award Management (SAM). Including, a CMS Provider Audit Report queried through Umpqua Health's third-party exclusion monitoring vendor. If any sanctions are present, if possible, Umpqua Health will make three (3) attempts to obtain information from the source of the sanction and obtain an explanation from the practitioner/provider which will be documented within the credentialing file for the UHA Credentialing Sub-Committee to make an informed decision.
    ii. Umpqua Health will not refer health plan members to or use practitioners/providers who have been terminated from OHA or excluded as Medicare, CHIP, or Medicaid providers by Centers for Medicare and Medicaid Services (CMS) or who are subject to exclusion for any lawful conviction by a court for which the practitioner/provider could be excluded under 42 Code of Federal Regulation (CFR) §§1001,101 or 455.3(b).
    iii. Umpqua Health will not employ or contract with practitioners/providers excluded from participation in Federal health care programs under 42 CFR § 438, 214(d).
    iv. Verification will be completed to ensure clinical privileges are in good standing at the hospital designated by the health care professional as the primary admitting facility if the physician or other health care professional has admitting privileges:
        1. Health care professionals who can have admitting privileges may choose not to have them, as they may not manage care in the inpatient setting. However, if a health care professional does have admitting privileges, he/she is required to list those privileges.
        2. Lack of privileges does not exclude a health care professional from participating in a health plan.
        3. Information may be obtained by contacting the facility.

j. Verification of Social Security Death Master (SSDM) File.
    a. Prior to finalizing the credentialing/re-credentialing file, the SSDM File verification is completed. If a green indicator is displayed no review is needed. If an "*" is present, the verification of the applicant has not been completed.

k. Verification of Medicare Opt-Out

l. The NPDB is queried for every practitioner/provider. Individual practitioners/providers are enrolled in Continuous Query with NPDB. All adverse information reported will be evaluated by the UHA Credentialing Sub-Committee. Enrolled practitioners/providers are continuously monitored and UHA credentialing staff is alerted when a new report is received or an existing report is revised, corrected, or voided. Enrollments are renewed yearly for as long as the practitioner/provider is enrolled with Umpqua Health.

m. Call coverage arrangement for the practitioner/provider, *if applicable*.
    i. If a practitioner/provider indicates there is call coverage, documentation must be submitted with the OPCA.
n. Hospital admit plan, *if applicable*.
    a. Prior and current hospital affiliations, if applicable, must be in good standing at the facility(s) designated by the practitioner/provider.
    b. If the practitioner/provider does not have hospital clinical privileges, they must have a formalized inpatient coverage arrangement with another credentialed practitioner/provider, or a hospital admit plan on file.
        (1) If Umpqua Health has no admitted plan on file, one will be requested.
        (2) Applicants must include if they do not have admitting privileges at a local facility.
        (3) There are exceptions and the UHA Credentialing Sub-Committee Chair will approve if the hospital admin plan is not required for a particular practitioner/provider or provider type.
            a. Non-licensed providers do not require a hospital admit plan.
o. Professional Practice or Work History must include a minimum of five (5) years employment history, if applicable, through the practitioner's/provider's OPCA.
    i. Any lapses of more than two (2) months require an explanation from the applicant either submitted with the OPCA or on a separate sheet of paper.
    ii. A Curriculum Vitae (CV) will not be considered a sufficient substitution.
    iii. Work history may not be applicable to some non-licensed provider types.
    iv. Only current work history is verified during the re-credentialing process unless new employment was obtained since the last credentialing period.
p. Three (3) peer references must be provided.
    i. Peer references must have the same level of education and licensure or higher as the applicant and be directly familiar with the applicant's clinical skills and current competence through recent observation. Relatives listed as a peer reference will not be accepted.
    ii. A minimum of two (2) responses must be received from peer references which are considered "not clean". To proceed with the credentialing/re-credentialing process. Once the file is clean, we will require the references to be added to the OPCA and OPRA. If Umpqua Health does not receive sufficient responses, Umpqua Health will request additional peer references from the applicant.
q. Applicants must maintain a log of Continuing Medical Education (CME).
    i. Applicants must submit a current CME log upon Umpqua Health's request.
r. Umpqua Health requires current professional liability insurance coverage to be held at a minimum of $1 million per occurrence and $3 million aggregate.
    i. Umpqua Health will accept a professional liability coverage face sheet indicating the insurance effective date and expiration date.
        1. If face sheet comes directly from the carrier, no verification is required, NPDB will be utilized to confirm to any malpractice history.
    ii. Professional liability coverage may be provided and held by the

applicant's employer.

iii. The certificate of professional liability insurance is reviewed to confirm that the effective dates are current and that the coverage is active in Oregon. A future effective date is acceptable only if it is no later than the provider's documented start date at the practice. The provider's credentialing effective date will not be established, and no services may be rendered to members, until the liability insurance is active and verified.

UHA conducts primary source verification of all liability insurance certificates. In cases where a prospective effective date is accepted, the Credentialing team must confirm that no services are rendered until the policy becomes active. This requirement is communicated to the provider in writing, and monitoring is conducted to ensure compliance prior to the initiation of services.

iv. The Federal Tort Letter as an addendum to the application, must indicate the insurance effective date and expiration date (the future effective date is acceptable).

v. Umpqua Health obtains confirmation of the past 5 years of malpractice settlements from the malpractice carrier or queries the NPDB. Malpractice history must not contain a pattern of excessive suits over a five (5) year period based on incident date.

1. This will be verified through the NPDB or the malpractice insurance carrier.
2. If there are claims history information on current or previous malpractice coverage derived from the NPDB or malpractice insurance carrier, the applicant is required to submit relevant documentation pertaining to those claims with the OPCA to complete the credentialing process.
    a. All malpractice claim history will be submitted to the UHA Credentialing Sub-Committee for review.
    b. If the claim history is deemed acceptable, the credentialing process will continue.
    c. If deemed not acceptable, the UHA's Credentialing Sub-Committee will determine the most suitable way to analyze and review history of claims before OPCA is accepted or denied.

s. Umpqua Health requires each practitioner/provider to have a unique provider identification number (NPI) that is verified through the National Plan and Provider Enumeration System (NPPES).

a. NPI and taxonomy codes are reported to OHA in UHA's DSN Provider Capacity Report (as required under Ex. G of the Oregon Health Plan Contract) for purposes of Encounter Data submission, prior to submitting encounter data in connection with services by the practitioner/provider and that complies with 42 U.S. Code (USC) 2320d-2(b).

t. Proof of enrollment as a Medicaid provider with the OHA. Umpqua Health through its UHA CCO Contract is contractually required to confirm that any practitioner/provider designated as "moderate" or "high" risk by CMS has been screened by OHA and enrolled in Oregon's Medicaid program prior to entering a contract with the practitioner/provider.
    i. Umpqua Health may execute provisional provider contracts pending the outcome of screening and enrollment with OHA, for no longer than 120 days.
    ii. Umpqua Health will terminate the contract immediately if notified by OHA that the applicant is precluded from being enrolled as a Medicaid provider. Notwithstanding the foregoing, Umpqua Health may not execute provisional provider contracts with moderate or high-risk providers who are required to undergo fingerprint-based background checks until the applicant has been approved for enrollment by OHA.
    iii. Umpqua Health will notify the Compliance Department upon termination of any contract with a precluded practitioner/provider.
        1. For practitioner/providers or provider types designated by OHA as "moderate or "high-risk," Umpqua Health will verify OHA's Provider Enrollment files to confirm a provider's enrollment with OHA. https://www.oregon.gov/oha/HSD/OHP/Pages/Plan-Tools.aspx
        2. OHA is responsible for performing site visits for such "moderate" or "high" risk practitioners/providers and for ensuring that such "high" risk practitioners/providers have undergone a fingerprint-based background check.
        3. For a practitioner/provider who is actively enrolled in Medicare and has undergone a fingerprint-based background check as part of Medicare enrollment, OHA deems the practitioner/provider to have satisfied the same background check requirement for OHA Provider Enrollment.

u. Proof of enrollment as a Medicare provider.
    i. As required under Umpqua Health's delegated credentialing statement of work with health care clients, Umpqua Health must ensure verification of enrollment as a Medicare provider with the CMS if applicant has not opted out of Medicare.

v. UHN Demographic Questionnaire.

i. Data provided in the questionnaire is used to aid members in selecting a health care practitioner/provider. The questionnaire is not used to make credential decisions, and the collected information can be used to improve health equity and eliminate health disparities as it collects information on the following components:
    i. Applicants' languages (other than English) and their ability to read, write and/or speak.
        1. Oregon Administrative Rules (OAR) 950-050-0160 states that a health care practitioner/provider must document proficiency in the

preferred language of the person with limited English proficiency (LEP) or communicates in the signed language of choice.

2. Bilingual practitioners/providers contracted with Umpqua Health that offer services in non-English languages will be asked to submit proof of language proficiency during the credentialing process.
3. Applicant must provide a copy an adopted language service policy and abide by language proficiency requirements, consistent with nationally recognized professional standards of care as outlined by organizations such as American Medical Association, the Joint Commission, NCQA or other equivalent national standard.Evidence of proficiency must be made available to the Oregon Health Authority (OHA) and relevant practitioner/provider licensing and certification boards upon request. Visit the Clinician Language Proficiency Requirement Checklist for a full overview of the language.

ii. Applicants' race and ethnicity.
iii. Completion of Cultural Competency Training.
iv. Languages available through the practice/clinic.
v. Ensure applicant knowledge of the requirement to make a good faith effort to obtain a health care interpreter from the central registry and process for using a non-registered interpreter when identified one is not available to provide interpreting for that visit or episode of care. Including documentation requirements of good faith effort (OAR-950-050-0160).

All primary source verification documents used during the initial credentialing process include a single signature and date for all verifications with a statement confirming all verifications were completed.

All primary source verification is documented on the UHN Initial Credentialing Checklist. This checklist is completed by UH credentialing staff and includes the verification made, date requested, date verified, verification source. If a report is used, the date of report is included. For example, when verifying a provider's DMAP number, the file date of the Weekly DMAP Provider File downloaded from the OHA is included on the checklist. If a verification is for a license or certificate, the expiration date is included in the Notes/Comments section of the checklist.

Work history from the past 5 years is documented on the checklist with dates of employment. Any Gaps noted in the providers work history from entry into medical/professional school to present are documented along with an explanation from the provider. Any flags noted will be called out in the "Flags" section.

Once completed, the UHN Initial Credentialing Checklist is initialed by UH Credentialing staff then added to the credentialing file for review by the UHA Credentialing Sub-Committee.

After the committee has reviewed the entire credentialing file and voted for approval, the UHA

Credentialing Sub-Committee Chair will initial, sign and date the UHN Initial Credentialing Checklist. This checklist includes a statement of attestation that all verifications for the provider listed above and on the OPCA have been reviewed and approved. Once UH Credentialing staff has sent notification to the provider of the UHA Credentialing Sub-Committee's decision in writing, the checklist will be updated with the date the notification was sent, and the checklist will be finalized. This final, signed, and dated checklist is included the final credentialing file along with a copy of the notification to the provider.

Assessment of Organizational Providers

Umpqua Health assesses and validates, in accordance with federal, state, and NCQA standards organizational providers before it contracts with a provider and every 36 months thereafter. When assessing organizational providers, Umpqua Health will ensure that the organizations are in good standing with the following:

a. Applicable State or Federal agency.
    i. Agent of the applicable State or Federal agency.
    ii. Copies of credentials (e.g., State licensure) from the provider.
b. Applicable accrediting body for each type of organizational provider.
    i. Agent of the applicable accrediting body.
    ii. Copies of credentials (e.g., accreditation report or letter) from the provider.

Umpqua Health will independently evaluate the status of the organization and not rely on an attestation from the organization.

For unaccredited facilities, Umpqua Health will conduct site visits. Specifically, the following assessment will occur:

a. Onsite quality assessment for each organizational type.
b. Process to ensure organization is properly credentialing its providers.

Umpqua Health may substitute a CMS or State quality review in lieu of a site visit under the following circumstances:

a. The CMS or state review is no more than three (3) years old.
    i. If the CMS or State review is older than three (3) years, Umpqua Health will conduct its own onsite quality review.
b. Umpqua Health obtained a survey report or letter from CMS or the State, from either the provider or the agency, stating that the facility was reviewed and passed inspection.
    i. The report meets Umpqua Health's quality assessment criteria or standards.

A summary of each evaluation will be presented and approved at the UHA Credentialing Sub-Committee.

The following types of facilities will be reviewed under this policy:

a. Hospitals;
b. Home health agencies;
c. Skilled nursing facilities;
d. Free-standing surgical centers; and
e. Behavioral health.
    i. Inpatient.
    ii. Residential.
    iii. Ambulatory.

Umpqua Health will maintain a log that assesses providers against the requirements above. Example:

Org. Name	Org. Type	Confirmation Dates and Statuses		
		Licensing & Regulatory	Accrediting Body	Site Visit
ABC	Hospital	9/1/17; Active	10/1/18; Name; Active	10/1/18; CMS Compliant
DEF	Free-standing surgical center	11/1/18; Active	None	10/31/18; CMS Compliant

Practitioner/Provider Credentialing Notifications

Upon completion of the credentialing and re-credentialing process and decision from the UHA Credentialing Sub-Committee, the practitioners/provider will be notified in writing of approval and/or denial via mail, secured email, or fax within ten (10) business days of the UHA Credentialing Sub-Committee decision. UHA will provide written notice prior to the contract expiration date to any participating practitioner/provider whose contract will not be renewed by UHA.

Other Licensed and Non-Licensed Provider Qualifications and Competencies

Umpqua Health shall, in accordance with OAR 309-019-0125 and in accordance with UHA's CCO Contract, ensure all non-licensed providers, including Qualified Mental Health Associates (QMHA) and Qualified Mental Health Professionals (QMHP) meet qualifications and competencies.

The Credentialing Department and UHA's Credentialing Sub-Committee collect evidence of education, training, competencies, of non-licensed provider applicants including QMHPs and QMHAs to deliver behavioral health and substance abuse disorder (SUD) services and the collection of applicable credentials for supervising providers. This process helps lead to early detection of incomplete/lack of education or training during the initial credentialing and re-credentialing process outlined in this manual.

General

Program staff providing treatment services or Peer-Delivered Services in substance use disorders, problem gambling, or mental health treatment programs shall be trained in and familiar with strategies for the delivery of trauma informed and culturally responsive treatment services. All treatment services shall be provided in a trauma informed and culturally responsive manner. Umpqua Health will obtain proof of training received.

Program staff include, but are not limited to:

a. Licensed Medical Professional (LMP);
b. Licensed Practical Nurse (LNP);
c. Registered Nurse (RN);
d. Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;
e. Psychologist licensed by the Oregon Board of Psychology;
f. Professional Counselor (LPC) or Marriage and Family Therapist (LMFT) licensed by the Oregon Board of Licensed Professional Counselors and Therapists;
g. Clinical Social Worker (CSW) licensed by the Oregon Board of Licensed Social Workers;
h. Licensed Master Social Worker (LCSW) licensed by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105;
i. Licensed Psychologist Associate granted independent status as described in OAR 858-010-0039;
j. Licensed Occupational Therapist licensed by the Oregon Occupational Therapy Licensing Board

Board registered interns, including:

a. Psychologist Associate Residents as described in OAR 858-010-0037; Umpqua Health will ensure a documented supervision plan has been established. Umpqua Health will monitor status changes of Psychologist Associate Residents upon completion of supervision requirements below to ensure verification of full licensure/certification.
    i. Applicants must complete a one (1) year full-time internship or one year of other supervised learning practicum deemed equivalent by the Board. The internship or practicum must meet the requirements of OAR 858-010-0012 or 858-010-0013.
    ii. Applicants must complete three (3) years of full-time post-master's degree supervised work experience in accordance with OAR 858-010-0036, except that:
        1. The resident shall be designated at all times by the title "psychologist associate resident"; and
        2. A Resident Supervision Contract will be effective for a period not

to exceed four years. The Board may extend the contract beyond four years.

b. Licensed Psychologist Associate under continued supervision as described in OAR 858-010-0038. Umpqua Health will ensure a documented supervision plan has been established and overseen by the appropriate provider type.
    i. Before the initial license is issued, the psychologist associate and the supervising psychologist must submit a "Contract for Continued Supervision of a Licensed Psychologist Associate." Day-to-day supervision of the licensed psychologist associate is the responsibility of the supervisor and includes such face-to-face consultation as is required by the nature of the work of the psychologist associate and is consistent with accepted professional practices in psychology.
    ii. Licensed Professional Counselor Intern or Marriage and Family Therapist Intern registered with the Oregon Board of Licensed Professional Counselors and Therapists as described in OAR 833-050-0011. Umpqua Health will ensure a documented supervision plan has been established and obtain a copy of the Licensing Board approval. The associate registration method is required for applicants who seek acceptance of post-degree supervised clinical experience completed in Oregon after June 30, 2002. The associate registration method requires applicants to obtain Board approval of an associate registration plan for completing the required supervised direct client contact.
c. Certificate of Clinical Social Work Associate issued by the Oregon Board of Licensed Social Workers as described in OAR 877-020-0009. Umpqua Health will ensure a documented supervision plan has been established and approved by the licensing board and monitor for completion.
    i. Shows that the person will meet the requirements in OAR 877-020-0010(3) while working in an agency that:
        1. Provides the associate with sufficient support to progress toward licensure;
        2. Screens patients who are served by the agency and by the associate; and
        3. Either:
            a. Is licensed by the Oregon Department of Human Services; or
            b. If not required to be licensed by the Oregon Department of Human Services, is in compliance with the requirements to conduct business in Oregon.
    ii. Requires a minimum of 3,500 practice hours of which at least 2,000 hours must involve direct contact with a client of the agency.
    iii. Provides for all clinical social work practice by the associate to be supervised and that supervision of the associate meets the requirements of OAR 877-020-0012.
    iv. Provides that the associate meet with the plan supervisor for a minimum of one hour not fewer than two times a month. This requirement of supervision is not met through a training or administrative activity. The

associate may meet alone with the supervisor (individual supervision) or may meet with the supervisor and as many as four other mental health professionals (group supervision).

d. Registered Bachelor of Social Work issued by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105.

Community Health Workers (CHW)

Qualification and Competencies

CHWs working in substance use disorders treatment and recovery programs shall be certified as described in OAR 410-180-0310 and who:

a. Has expertise or experience in behavioral health;
b. Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;
c. To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the members of the community where the worker serves;
d. Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;
e. Provides health education and information that is culturally appropriate to the individuals being served;
f. Assists community members in receiving the care they need;
g. CHW staff may:
    i. Give peer assistance and guidance on health including behavioral health behaviors; and
    ii. Provide skills restoration services.

Community Health Worker, Peer Wellness Specialist, Personal Health Navigator Certification Requirements (OAR 410-180-0310).

a. To be certified an individual shall:
    i. Complete all required training offered by an Authority approved 80-hour training program for that individual's Traditional Health Worker (THW) type;
    ii. Complete an Authority approved oral health training;
    iii. Complete all application requirements to be in the state registry;
    iv. Complete the Authority certification process; and
    v. Successfully gain acceptance into the state registry.
b. Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Supervision:

a. Mental Health/Behavioral Health
    i. Clinical supervisors shall meet QMHP requirements and have completed two years equivalent of post-graduate clinical experience in a mental health treatment setting.
    ii. Peer Delivered Services Supervisors shall be a certified Peer Support Specialist (PSS) or Peer Wellness Specialist (PWS) with at least one (1) year of experience in behavioral health treatment services, as resources are made available, or by a qualified supervisor for the program in which the Peer renders services.

b. SUD

    i. Clinical supervisors shall be certified by a division recognized credentialing body as follows:
        1. Four-thousand (4000) hours of supervised experience in substance use counseling;
        2. Three-hundred (300) contact hours of education and training in substance use related subjects; and
        3. Successful completion of a professional psychometric examination by a division recognized credentialing body. A substantively equivalent portfolio evaluation by a division recognized credentialing body may be accepted in lieu of a professional psychometric examination using procedures approved by the Division.
    ii. For clinical supervisors not holding a certification shall have a health or allied provider license. The license must be issued by one of the following state bodies and the supervisor shall possess documentation of at least 120 contact hours of academic or continuing professional education in the treatment of substance use disorders.
        1. Oregon Medical Board;
        2. Oregon Board of Psychologist Examiners;
        3. Oregon Board of Licensed Social Workers;
        4. Oregon Board of Licensed Professional Counselors and Therapists; or
        5. Oregon State Board of Nursing.
    iii. Clinical supervisors will need to have one of the following qualifications:
        1. Five (5) years of paid full-time experience in the field of substance use disorders counseling;
        2. A bachelor's degree and four years of paid full-time experience in the social services field with a minimum of two years of direct substance use disorders counseling experience; or
        3. A master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct substance use or co-occurring disorders counseling experience.

c. Problem gambling treatment

i. Clinical supervisors shall meet the requirements for clinical supervisors in either mental health or substance use disorders treatment programs and have completed 10 hours of training specific to problem gambling within six (6) months of designation as a problem gambling services supervisor.

Peer Delivered Services

a. Will be a certified Peer Support Specialist (PSS) or Peer Wellness Specialist (PWS) with at least one (1) year of experience in behavioral health treatment services, as resources are made available, or by a qualified supervisor for the program in which the Peer renders services.

PSS and PWS, including family and Youth Support and Wellness Specialists. See section Traditional Health Worker Requirements for specific PSS certification requirements.

a. Will meet the requirements in OAR 410-180-0300 to 410-180-0380 for certification and continuing education.
b. A PSS and PWS will be:
    i. A self-identified individual currently or formerly receiving mental health, problem gambling, or substance use services;
    ii. A self-identified individual in recovery from a substance use disorder;
    iii. A self-identified individual in recovery from problem gambling; or
    iv. A person who has experience parenting a child who:
        1. Is a current or former recipient of mental health or substance use treatment; or
        2. Is facing or has faced difficulties in accessing education and health and wellness services due to a behavioral health barrier.
c. A PSS and PWS will demonstrate:
    i. The ability to support others in their recovery or resiliency;
    ii. Personal life experience and tools of self-directed recovery and resiliency; and
    iii. Demonstrate cultural responsiveness and effective communication.

Substance use disorders program staff shall:

a. Demonstrate competence in the following areas:
    i. Cultural responsiveness,
    ii. Screening for substance use disorder,
    iii. Recognition of intoxication and withdrawal,
    iv. ASAM assessment and level of care placement,
    v. DSM diagnostics,
    vi. Development of a service plan,
    vii. Case management and care coordination,
    viii. Facilitation of drug testing, and
    ix. Delivery of individual, group and family counseling,
    x. Program policies and procedures for service delivery and documentation, and identification, implementation, and coordination of services identified to facilitate intended outcomes, and identification of health and safety

risks to self or others.

b. Receive clinical supervision that documents progress towards certification and recertification; or

i. At date of hire provide substance use disorder treatment, if the program staff is not certified to provide substance use disorder treatment, they shall register with the Division recognized credentialing body within 30 days of hire and obtain professional substance use disorder treatment certification within two (2) years from the date of hire;

c. If, during the first two (2) years of employment, or a prorated timeframe if employed part time, the program staff has not yet been certified and is employed by a program that is certified by the Division, the program staff may request the program submit a request for variance with the Division;

d. For program staff holding certification in substance use disorder counseling, qualifications for certification shall have included at least:

i. 1000 hours of supervised experience in substance use counseling;

ii. 150 contact hours of education and training in substance use related subjects; and

iii. Successful completion of a professional psychometric examination by a division recognized credentialing body. A substantively equivalent portfolio evaluation by Division recognized credentialing body may be accepted in lieu of a professional psychometric examination using procedures approved by the Division.

e. Program staff not holding certification from a Division recognized credentialing body in substance use disorder counseling shall have a license or registration from a Division recognized credentialing body and at least 60 contact hours of academic or continuing professional education in the treatment of substance use disorders. The license or registration shall have been issued by one of the following state bodies:

i. Oregon Medical Board;

ii. Oregon Board of Psychologist Examiners;

f. Oregon Board of Licensed Social Workers;

g. Oregon Board of Licensed Professional Counselors and Therapists; or

h. Oregon State Board of Nursing.

i.

QMHA:

a. Demonstrate the following minimum competencies:

i. Cultural responsiveness,

ii. Effective communication,

iii. Care coordination,

iv. Inter- and intra-agency collaboration,

v. Working alliances with individuals,

vi. Assist in the gathering and compiling of information to be included in the assessment,

vii. Screen for suicide and other risks, and

viii. Implement timely interventions, teach skill development

strategies, case management, and transition planning.

b. Render services and support within their scope to individuals engaged in a division approved behavioral health services provider; and

c. Meet the following minimum qualifications:

i. Bachelor's degree in psychology, social work, or behavioral science field;

ii. An equivalent degree as evidenced by providing transcripts indicating applicable coursework meeting the required competencies and approved by a division certified behavioral health provider; or

iii. A combination of at least three years of relevant work, education, training, or experience.

iv. Receive clinical supervision that documents progress towards certification and recertification.

QMHP:

a. Demonstrate the following minimum competencies:

i. Cultural responsiveness,
ii. Effective communication,
iii. Care coordination,
iv. Inter- and intra-agency collaboration,
v. Working alliances with individuals,
vi. Suicide and other risk assessments and interventions,
vii. Creating and monitoring safety plans,
viii. Completion of bio-psycho-social assessments and additional assessments, updating assessments when clinical circumstances change,
ix. Generating a differential DSM diagnosis,
x. Prioritizing health, wellness, and recovery needs,
xi. Writing measurable service objectives,
xii. Creating, monitoring, and revising service plans,
xiii. Delivery of mental health and recovery treatment services in individual, group and family formats within their scope,
xiv. Gathering and recording data that measures progress toward the service objectives and documenting services, supports and other information supportive of the service plan.

b. Render services and support within their scope to individuals engaged in a division approved behavioral health services program;

c. Meet the following minimum qualifications:

i. Bachelor’s degree in nursing and licensed by the State of Oregon. Nurses are accountable to abide by the Oregon Nurse Practice Act to determine if job descriptions are compliant with the competencies listed above;

ii. Bachelor’s degree in occupational therapy and licensed by the State of Oregon;

iii. Graduate degree in psychology, social work, recreational art or music therapy, or behavioral science field;

iv. An equivalent degree as evidenced by providing transcripts indicating applicable coursework meeting the required competencies and approved by a

division certified behavioral health provider; or

v. Qualify as a Mental Health Intern, as described in these rules.

d. Receive clinical supervision that documents progress towards certification and recertification.

Rehabilitative Behavioral Health Service Providers, including medical staff.

a. Shall demonstrate cultural responsiveness and meet the requirements and qualifications in OAR 410-172-0660.
    i. Physician or Physician Assistant licensed in the State of Oregon;
    ii. Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;
    iii. Psychologist licensed by the Oregon Board of Psychology;
    iv. Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;
    v. Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;
    vi. Licensed Master Social Worker licensed by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105;
    vii. Licensed Psychologist Associate granted independent status as described in OAR 858-010-0039;
    viii. Licensed Occupational Therapist licensed by the Oregon Occupational Therapy Licensing Board;
    ix. Organizational certificate of approval issued by the Health Systems Division (Division) as described in OAR 309-012-0130 through 309-012-0220.
b. Board registered intern providers shall be supervised by a provider as described in section 9(a) under an active board approved plan of practice and supervision.
c. Providers exempt from licensure or registration per ORS 675.090(f), 675.523(3), or 675.825(c) shall be employed by or contracted with a provider organization certified by the Authority under ORS 430.610 to 430.695 as described in (10)(ix) of this policy and meet one of the following qualifications:
    i. QMHP;
    ii. QMHA;
    iii. Mental Health Intern (MHI); or
    iv. Peer-Support Specialist.

Mental Health Intern (MHI)

a. Be currently enrolled in a graduate program for a master's degree in psychology, social work, or related field of behavioral science;
b. Have a collaborative educational agreement between the Division certified provider and the graduate program for the student;
c. Demonstrate cultural responsiveness, effective communication and competence in care coordination, development of working alliances with individuals, inter- and intra-agency collaboration, and the rendering of services and supports within their scope and in accordance with the service plan, including transition planning; and

d. Work within the scope of practice and competencies identified by collaborative educational agreement and the policies and procedures for the credentialing of clinical staff as established by the provider and the graduate program.

Student Intern

a. Be currently enrolled in an educational program that results in an undergraduate degree in a behavioral health field;
b. Demonstrate cultural responsiveness, effective communication and competence in care coordination, development of working alliances with individuals, inter- and intra-agency collaboration, and the rendering of services and support within their scope and in accordance with the service plan, including transition planning;
c. Have a collaborative education agreement between the Division certified provider and the educational institute for the student;
d. Work within the scope of practice and competencies identified by the collaborative educational agreement and the policies and procedures for the credentialing of clinical staff as established by the provider; and
e. Receive, at a minimum, weekly individual supervision by a qualified clinical supervisor employed by the provider of services.

If a provider (whether employees or subcontractors) is not required to be licensed or certified by a State of Oregon board or licensing agency, Umpqua Health shall document, certify, and report in UHA's Delivery System Network (DSN) Provider Report required under Exhibit G of the CCO Contract, the date of the provider's education, experience, competence, and supervision are adequate to permit performance of such provider's specific assigned duties.

a. If a provider is not required to be licensed or certified by a State of Oregon board or licensing agency, then the provider must either:
    i. Meet the definition for Traditional Health Worker and must not be permitted to provide services without the supervision of a licensed medical practitioner; or
    ii. Meet the definition for QMHA or QMHP and must not be permitted to provide services without the supervision of a licensed medical practitioner; or
        1. If not meeting either definition of a QMHA or QMHP have the education, experience, competence necessary to perform the specified assigned duties and Umpqua Health must document and report to the Oregon Health Authority (OHA) in UHA's DSN Provider Report:
            a. The education, experience, and competence of the applicant, and
            b. The applicant will not be permitted to perform the specific assigned duties without the supervision of a licensed medical practitioner.

Traditional Health Worker (THW)

THW applicants requesting network participation must fully complete a Non-Licensed Provider Credentialing Application and provide supporting documentation, including OHA's THW approval letter, to Umpqua Health's Credentialing Department prior to initiating the credentialing or re-credentialing process. Applicants must hold or apply for a Medicare number to proceed with the credentialing process Umpqua Health verifies certification and registry from OHA's THW Registry: https://traditionalhealthworkerregistry.oregon.gov/

Required Documentation

1. Oregon State professional licenses/certifications.
2. Evidence of active THW certification, registry enrollment and OHA approved oral health training, if applicable.

Umpqua Health shall, in accordance with OAR 410-141-3510 and in accordance with UHA's CCO Contract, require all Traditional Health Worker (THW) types, whether subcontractor or Umpqua Health employees, to complete requirements outlined in OARs 410-180-0300 through 410-180-0380 prior to initial credentialing or re-credentialing for network participation. THWs must complete and meet requirements for, and pass the background check, as described under OAR 410-180-0326.

The Credentialing Department and UHA's Credentialing Sub-Committee collect evidence of credentials, screen the credentials, report credential information of participating THW to deliver physical, behavioral health, and oral health services. This process aids in early identification of incomplete or insufficient education or training in the THW's scope of stated practice during the initial credentialing and re-credentialing process, as detailed in this manual.

THWs whether they are Umpqua Health employees or subcontractors will need to complete and meet requirements for, and pass the background check, as described under OAR 410-180-0326.

THWs must not be permitted to provide services without the supervision of a licensed medical practitioner.

Certification Requirements:

a. Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.
b. For Community Health Worker, Peer Wellness Specialist, Personal Health Navigator must meet requirements outlined in OAR 950-060-0020.
    i. Complete all required training offered by an Authority approved 80-hour training program for that individual's traditional health worker (THW) type;
    ii. Complete an Authority approved oral health training;
    iii. Complete all application requirements to be in the state registry;
    iv. Complete the Authority certification process; and
    v. Be successfully accepted into the state registry.

c. For Peer Support Specialist must meet requirements outlined in OAR 950-060-0030.
    i. Complete all required training offered by an Authority approved 40-hour training program for peer support specialists by specialization;
    ii. Complete an Authority approved oral health training;
    iii. Complete all application requirements to be in the state registry;
    iv. Complete the Authority certification process; and
    v. Be successfully accepted into the state registry."
    vi. Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.
d. For Birth Doula must meet requirements outlined in OAR 950-060-0040.
    i. Complete all required training specified in OAR 950-060-0150 (Birth Doula Certification Curriculum Standards) through:
        a. An Authority approved birth doula training program; or
        b. A combination of programs that results in meeting all the requirements through equivalent credit.
    ii. Complete an Authority approved oral health training;
    iii. Be CPR-certified for children and adults;
    iv. Create a community resource list on an Authority approved form;
    v. Document attendance at a minimum of three births and three postpartum visits using an Authority approved form;
    vi. Complete all application requirements to be in the state registry;
    vii. Complete the Authority certification process; and
    viii. Be successfully accepted into the state registry.

For THWs to maintain their certification status, they must complete continuing education requirements outlined in OAR 950-060-0050.

All community health workers, peer wellness specialists, and personal health navigators must complete curriculum standards outlined in OAR 950-060-0140.

All birth doulas seeking certification with the state must complete curriculum standards outlined in OAR 950-060-0150.

An Authority certified THW shall comply with Standards of Professional Conduct set forth in OAR 950-060-0080. Violation of the standards may result in the suspension or revocation of certification or denial of an application for renewal.

Pursuant to 25 USC 1621t and 1647a, Umpqua Health shall not apply any requirement that any entity operated by the Indian Health Service (IHS), an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition.

a. Umpqua Health shall not require the licensure of a health professional employed by such an entity IHS under the State or local law where the entity is located, if the professional is licensed in another State.
b. Umpqua Health shall offer contracts to all Medicaid eligible Indiana Health Coverage Programs (IHCPs) and provide timely access to specialty and primary care within its networks to Umpqua Health enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within Umpqua Health network.

OHA's Certification and Registry Process (OAR 950-060-0060)

THWs must complete OHA approved training programs to qualify for state certification. When state certification is obtained, THWs must complete the THW certification and registry process with OHA prior to requesting network participation and enroll as an Oregon Medicaid Provider (DMAP). Applicants soliciting how to become a THW will be referred to the Application and Renewal Process 1) for Traditional Health Worker (THW) Certification and Registry Enrollment outlined in OARs 950-060-0060or 2) for Authority Training Program Approval outlined in 950-060-0110.

THWs will need to submit their application and supporting documents by one of the following three methods:

a. Traditional Health Worker Program
   Office of Equity and Inclusion
   421 SW Oak St. Suite 750
   Portland, Oregon 97204
b. Fax: 971-673-1128
c. Email: thw.program@dhsoha.state.or.us thw.program@dhsoha.state.or.us
   1. Per the OHA THW website, email is the quickest and most preferred method.

THWs will need to provide the following to OHA:

a. Traditional Health Worker Full Certification and Renewal Application.
b. Copy of their training certificate from an OHA-approved training program.
c. Clear copy of a government-issued identification.
d. Proof of Oral Health training.

THWs must:

a. Must enroll as an Oregon Medicaid Provider
b. Must not be listed on the Medicaid provider exclusion list.
c. Must pass a criminal background check.
d. Training program applications are available on the THW program webpage or by request from the OHA's Office of Equity and Inclusion.

Denial, Suspension, or Revocation of Training Program Approval

If at any time OHA denies, suspends, or revokes a THW's training program approval, the THW must notify Umpqua Health within 30 days of receiving notification.

a. If a THW receives such notice, there is an opportunity to request a reconsideration and a meeting with the Authority. THW must submit a written request within 30 days of the date the Authority mails the written decision.
    i. The request must contain a detailed statement with supporting documentation explain why the applicant believes the Authority's decision is in error.
b. The Authority will issue a written decision on reconsideration following review of the materials submitted by the applicant and schedule a meeting with the applicant if applicable.

Provider Notification

Upon completion of the credentialing process and decision from the UHA Credentialing Sub-Committee, the provider will be notified in writing of approval and or denial via mail, email, or fax within (10) ten business days of the UHA Credentialing Sub-Committee decision. UHA will provide written notice prior to the contract expiration date to any participating practitioner/provider whose contract will not be renewed by UHA.

Temporary Status (Provisional Credentialing)

To continuously provide quality of patient care and serving the community in an efficient manner, Umpqua Health may grant a one-time 60-day temporary status to pending providers who are applying to the UHA for the **first time** and meet the necessary completed verifications. Umpqua Health provider applicants may obtain temporary status while their credentialing status is pending.

Procedures

Umpqua Health will only grant a one-time 60-day temporary status to a practitioner/provider upon review by UHA Credentialing Sub-Committee. Approval of temporary status is subject to but not limited to:

a. A gap in available practitioners/providers would pose an increased risk to the Medicaid program.
b. All procedures for the initial credentialing process are completed.
c. The same process for presenting provisional credentialing files to the credentialing sub-committee for review and approval.
d. Provisional credentialing for practitioners/providers credentialed by a delegate will not be conducted by Umpqua Health.

e. Provisionally credentialed practitioner/provider will not be listed in the directory.
f. Provisional credentialing is not applicable to moderate and high-risk provider types, per OHA.

The practitioner/provider applying for network participation must:

a. Submit a completed current OPCA with attestation.
    i. Must not contain any missing required documentation.
    ii. Submit a current valid Oregon license to practice.
    iii. Must be a clean file.
b. Successfully pass of all primary source verifications (CR2 - Verification of Credentials).
    ii. Temporary status will not be granted if any of the required elements are unable to be verified.

Once the completed OPCA and required documentation has been verified and all monitoring agencies queried, the application will be reviewed by the UHA Credentialing Sub-Committee Chair or designee.

a. If approved, the Credentialing Specialist will notify the applicant, delegates, and the Contracting Department in writing.
b. If approved, exclusion monitoring will be conducted via Umpqua Health's third-party exclusion monitoring vendor.
c. If provider is not approved, the Credentialing Specialist will notify the applicant of the area of concern to see if a correction can be made.
    iii. If not, the applicant's credentialing file will be presented at the next UHA Credentialing Sub-Committee meeting to determine a plan of action.

At the UHA Credentialing Sub-Committee's next meeting, the full committee will review the practitioner/provider.

Practitioner/Provider Notifications

Approval notification will be sent via email, mail, or fax within three – five (3-5) business days of the UHA Credentialing Sub-Committee decision.

Where recommendations are made not to credential or re-credential a practitioner/provider, the decision will be communicated within three (3) days by telephone, email, or facsimile transmission and within five (5) days by registered mail. UHA will also provide written notice prior to the contract expiration date to any participating practitioner/provider whose contract will not be renewed by UHA.

Where recommendations for non-summary termination have been made, decisions will be transmitted to the provider within three (3) days by telephone, email, or facsimile transmission and within five (5) days by registered mail.

Where recommendation for immediate termination has been made, the UHA Credentialing Sub-Committee Chair or designee will contact the practitioner/provider immediately by telephone and within one (1) day by registered mail to inform the practitioner/provider of this recommendation.

Excluded Providers

Umpqua Health may not employ or contract with providers excluded from participation in State or Federal health care programs.

UHA will not accept billings for services to members provided after the date of the provider's exclusion, conviction, or termination. UHA will recoup any monies paid for services to members provided after the date of the provider's exclusion, conviction, or termination.

UHA will not pay for any item or service that would otherwise be a Covered Service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) under any of the circumstances specified in the OHA Health Plan Contract.

Re-Credentialing Process

Umpqua Health in accordance with OAR)410-141-3510, and the UHA CCO Contract require all healthcare practitioners/providers and non-licensed provider types to complete initial credentialing prior to participation and re-credentialing every 36 months (to the day) pursuant to PPACA, Section 6402, 42 CFR §§§ 438.214, 455.400 through 455.470 (excluding § 455.460). The rec-credentialing process includes completion of the OPRA or Non-licensed Provider Application, primary source verification of specific elements as delineated in this policy, followed by review and decision by the UHA Credentialing Sub-Committee.

Umpqua Health's Credentialing Department and UHA's Credentialing Sub-Committee collect evidence of credentials, screen the credentials, report credentialed information of participating practitioners/providers including acute, primary, dental, behavioral, substance use disorders, long term services and supports (LTSS), telemedicine practitioners/providers and facilities used to deliver covered services. This process helps lead to early detection of incomplete/lack of education or training in applicants' scope of stated practice. In addition, this manual is provided as a guidance document for oversight through UHA's Quality Improvement Committee to assist with routine monitoring of Umpqua Health provider network.

General

1. Primary source verification, as followed in CR3, Element A of the NCQA guidelines, is completed by the Umpqua Health's Credentialing Department for practitioner/provider types outlined in the prior section Practitioners/Providers Within Credentialing Scope and may be written, electronic or oral.
    a. Oral verification can only be used for verification of work history gap. Oral verification requires a dated and signed note in the credentialing file by the staff completing the verification. The notation must state who verified the item and how it was verified.
    b. All written and electronic verification requires a dated and signed note in the credentialing file by the staff completing the verification. The notation must state who verified the item and verification source.

2. Umpqua Health maintains records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the NPDB (see section -Credentialing Files).
3. Umpqua Health applies the same credentialing and enrollment criteria required of practitioners/providers enrolling with OHA as Fee for Service Providers.
4. Umpqua Health complete verification of Medicare Opt-Out at the time of re-credentialing.

5. Telemedicine practitioner/provider requirements shall be consistent with policies PN13 – Telehealth/Telemedicine and PN14 – Tele dentistry.

Recredentialing Process

1. The re-credentialing application shall include all the information necessary to update and re- evaluate the qualifications of the practitioner/provider.
    a. A practitioner/provider must submit a completed current OPRA or Non-licensed Provider Application.
    b. Current documentation qualifying the practitioner/provider to the appropriate scope of practice must accompany the application:
        i. Current Curriculum Vitae (CV).
        ii. Oregon State professional licenses.
        iii. Current Education, if any, completed following initial credentialing period to support any new licensure/certification.
        iv. Current unrestricted Federal Drug Enforcement Agency (DEA) certificate, if applicable.
        v. Current professional liability insurance certificate, that meet Umpqua Health's standard requirements.
        vi. Current hospital admit plan.
            1. Must be included if the provider does not have admitting privileges at a local facility.
        vi. Current work history if there has been any change following initial credentialing period.
        vii. Continuing Medical Education (CME).
            1. Must include the last two (2) years of completed CME certifications.
    c. Provide evidence of completing annual cultural competency continuing education.
    d. Signed and dated OPRA attestation page.
    e. Signed and dated OPRA's Authorization and Release of Information page.
    f. Signed Seclusion and Restraint Attestation and policy, if applicable.
    g. Provider must specifically address:
        i. Any yes response to OPRA attestation questions.
        ii. Reasons for any inability to perform the essential functions of the position with or without accommodation.
        iii. Any present illegal drug use.
        iv. History of loss of license and/or felony convictions.

v. History of loss or limitations of privileges or disciplinary activity.
vi. Correctness and completeness of the application.
vii. Current malpractice coverage, and any claims against the practitioner's/provider's malpractice insurance, if any.

h. Demonstrate compliance with standards of care, ensuring that practitioners/providers adhere to established standards of care and professional conduct.

2. Primary source verification is completed by qualified Umpqua Health staff or its delegate, and may be written, electronic, or oral. Oral verification can only be used for verification of work history gap.
3. All primary source verification documents used during the recredentialing process include a unique electronic signature that includes the verifier's name and the date of verification.

   All primary source verification are documented on the UHN Recredentialing Checklist which is completed by UH credentialing staff. The checklist includes the verification performed, date requested, date verified, source of verification. If a report is utilized, the report date is noted. For example, when verifying a provider's DMAP number, the file date of the Weekly DMAP Provider File downloaded from the OHA is recorded on the checklist. For license or certification verification, the expiration date is documented in the Notes/Comments section of the checklist.

   Once completed, the UHN Recredentialing Checklist is initialed by UH Credentialing staff then added to the credentialing file for review by the UHA Credentialing Sub-Committee. After the committee has reviewed the entire recredentialing file and voted for approval, the UHA Credentialing Sub-Committee Chair will initial, sign and date the UHN Recredentialing Checklist. This checklist includes a statement of attestation that all verifications for the provider listed above and on the OPRA have been reviewed and approved.

   Once UH Credentialing staff has sent notification to the provider of the UHA Credentialing Sub-Committee's decision in writing, the checklist will be updated with the date the notification was sent, and the checklist will be finalized. This final, signed, and dated checklist is included the final recredentialing file along with a copy of the notification to the provider.

4. Quality of care reviews, claims review, grievances, and any corrective action are reviewed and taken into consideration at the time of re-credentialing.
   a. UH Credentialing staff will follow the process outlined in QI13 - Potential Quality of Care (PQOC) Referrals, Investigation and Remediation.
   b. Any findings or grievances will be included with the credentialing file presented to the UHA's Credentialing Sub-Committee.
   c. If a practitioner/provider who has opted into health plan client, Umpqua Health will reach out to the health plan client representative or agent to collect and review information about relevant member complaints, quality reviews, including under and over utilization issues if any, and evidence of quality improvement activities.
      i. Request to health plan client must be made at the time of re-credentialing.

Practitioner/Provider Credentialing Notifications

Upon completion of the credentialing and re-credentialing process and decision from the UHA Credentialing Sub-Committee, the practitioners/provider will be notified in writing of approval and/or denial via mail, secured email, or fax within ten (10) business days of the UHA Credentialing Sub-Committee decision. UHA will provide written notice prior to the contract expiration date to any participating practitioner/provider whose contract will not be renewed by UHA.
Once UHA's Credentialing Sub-Committee has reviewed/approved a practitioner/provider, he or she is re-credentialed at least every three (3) years (not to exceed 36 months to the day). The re-credentialing form shall include all information necessary to update and re-evaluate the qualifications of the practitioners/provider (OAR 410-141-3510).

Practitioner/Provider Rights

Practitioners/providers have certain rights when credentialed with Umpqua Health in accordance with NCQA standards. Outlined below outlines how Umpqua Health will notify providers of their rights when applying for appointment or re-appointment.

Providers/practitioners applying for network participation have the right to review information acquired during primary source verifications supporting their credentialing or re-credentialing applications.

a. Should a provider/practitioner request a review of their application, they must call the Credentialing Specialist and schedule an appointment.
b. The appointment will be scheduled within ten (10) business days, allowing the Credentialing Specialist time to review the chart and remove protected items such as peer review references or recommendations.
c. Umpqua Health is not required to provide access to:
    i. References.
    ii. Recommendations.
    iii. Peer review protected information.

Providers/practitioners have the right to correct erroneous information in the event information obtained from primary source verification varies from that submitted by the provider/practitioner.

a. The provider will be notified by telephone and in writing. The provider will have ninety (90) days to make corrections.
    iv. Telephone notification will be followed by written notification if no response is received within thirty (30) days.
    v. A written response from the provider, in any format (written, or verbally) will be accepted and documented in the applicant's credentialing file.
    vi. Submissions may be addressed to the Credentialing Specialist to present at the next scheduled UHA Credentialing Sub-Committee.
    vii. If the information received adequately addresses the variance issues, the provider's application will be reviewed at the following UHA Credentialing Sub-Committee meeting.
    viii. If the information is not received, the UHA Credentialing Sub-Committee

will defer the applicant for three (3) sessions. At that point, the process will be suspended. The provider may reapply at any time with corrected information.

b. If approved the provider will receive a letter from the UHA Credentialing Sub-Committee, within ten (10) business days.

Providers/practitioners have the right to be informed of the status of their application, upon request.

a. The provider/practitioner may call, email, or send a written request to the Credentialing Department for status.
    ix. The Credentialing Specialist will respond to the provider in the same manner the request was received by the department.
    x. Emails and letters will be printed and added to the provider's file. Phone calls will be noted in the provider's file.

Notification of Provider Rights. Umpqua Health notifies providers/practitioners in writing of:

a. Their right to request, and be informed of the status of their application.
b. The information Umpqua Health is permitted to share and process in response to inquiries regarding the application process.

Umpqua Health Alliance (UHA) Credentialing Sub-Committee

Umpqua Health and UHA's Credentialing Sub-Committee are committed to continuously improving the quality of patient care and serving the community by overseeing Umpqua Health's contracted providers as well as managing the implementation and maintenance of the associated policies and procedures pursuant to 42 CFR §§ 455.410 through 455.470, OAR 409-045-0025 through 409-045-0135 and is in alignment with UHA's CCO Contract with OHA, the delegated credentialing statement of work with health plan client, and the NCQA requirements. Detailed below is Umpqua Health's process that assures a systematic approach to selecting, evaluating, and monitoring of Umpqua Health's contracted providers and practitioners, as outlined in the UHA Credentialing Sub-Committee Charter.

Participating Providers (Peer Review Body)

The UHA Credentialing Sub-Committee members include:

a. Committee Chairperson: Chief Medical Officer (CMO), who has overall responsibility for the credentialing/re-credentialing process.
b. A minimum of three (3) Umpqua Health participating network providers, preferably diverse types of practitioners and specialties representative of the types of practitioners participating in Umpqua's Health network to support the Chair in reviewing and approving/not approving providers for panel participation.
c. Two (2) Umpqua Health credentialing staff to support the UHA Credentialing Sub-Committee Chair by reviewing files for completeness, generating the minutes and provider letters, distribution of the agenda and rosters, among other duties.

The CMO or designated Medical Director has overall responsibility for the credentialing process.

The CMO or designated Medical Director's responsibilities include:

d. Co-Chairing the sub-credentialing committee as well as all the responsibilities of a sub credentialing committee member, as outlined in this manual.
e. Reviewing credentialing files of Providers/Practitioners with clean credentialing files, as outlined in this manual.
f. Ability to remove a sub credentialing committee member due to poor attendance.
g. Review quality of care grievances and/or issues and refer to the committee, when appropriate.
h. All other duties regarding Practitioner participation in the Credentialing Committee.

Committee Review

UHA's Credentialing Sub-Committee meets every month over Zoom with the option to meet in person, as needed, and screens all applicant's membership to Umpqua Health, health plans, or provider groups, as appropriate, by reviewing their credentialing file upon the initial credentialing process outlined in section Initial Credentialing Process and upon reapplication during the re-credentialing process outlined in section Re-Credentialing Process.

The Committee confirms the application submitted contains all supporting documents and the primary source verification completed by the Credentialing Department.

The Committee gives thoughtful consideration while reviewing a practitioner's/provider's qualifications against the primary source verification. Credentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, practitioner/provider acting with the scope of their license or certification, or patient type (e.g., Medicaid) in which the practitioner/provider specializes.

Practitioner/Provider applications are voted on by the UHA Credentialing Sub-Committee.

a. The current quorum is stipulated in the UHA Credentialing Sub-Committee Charter.
b. Credentialing staff do not hold voting rights.

The UHA Credentialing Sub-Committee reserves the right to terminate or suspend a provider's participation in Umpqua Health.

Confidential minutes are taken and maintained by the credentialing staff and approved by the CMO.

The documentation reviewed in the credentialing file of the applicant at the time of credentialing or re-credentialing must be less than 180 days old.

1. Credentials of practitioner/providers who do not meet Umpqua Health's criteria for participation in the network are reviewed.

Umpqua Health will report the following to OHA (OAR 410-141-3510):

a. Any practitioner's/provider's license or certification that has expired or was not renewed;

b. Any practitioner/provider subject to licensing termination, suspension, or certification sanctions;
c. If Umpqua Health knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere");
d. If Umpqua Health removes a practitioner/provider or fails to renew a practitioner's/provider's contract if the practitioner/provider fails to meet objective quality standards and/or
e. Any provider found to be excluded from Federal or State funded programs.

Review of Files that Meet Established Threshold ("clean")

The Umpqua Health Credentialing Department forwards all "clean" practitioner/provider files to the Credentialing Sub-Committee for evaluation. (The "clean file" description can be found in the section **Managing Files that Meet the Criteria.)** This can occur during committee meetings or be reviewed and endorsed by a designated Medical Director or Chief Medical Officer through handwritten signature, initials, or a unique electronic identifier. Additionally, this process can be facilitated via secured email, ensuring the inclusion of all necessary credentials for practitioners.

1. Evidence of review and approval can be a handwritten signature, handwritten initials, or a unique electronic identifier.
2. Umpqua Health uses appropriate controls for ensuring only the designated CMO or qualified physician can enter the electronic signature.
3. The UHA Credentialing Sub-Committee will approve, defer, or deny network participation with specified health plan.
4. Approved recommendations of practitioner/provider's credentials or re-credentials are forwarded to the appropriate Boards, Networks, and Plans.

Correcting Erroneous Information from Other Sources ("dirty files")

Umpqua Health notifies practitioners/providers of their right to review information obtained from outside sources (e.g., malpractice insurance carriers, state licensing boards) to support their credentialing application. Umpqua Health is not required to make available:

a. References.
b. Recommendations.
c. Peer-review protected information.

Umpqua Health notifies practitioners/providers of their right to correct erroneous information.

a. The practitioners/providers will have 90 days to make corrections.
b. A written response from the provider in any format will be accepted.
c. Submissions will be addressed to the credentialing staff.

Umpqua Health is not required to reveal the source of information that was obtained to meet verification requirements or if Federal or State law prohibits disclosure.

Umpqua Health documents receipt of corrected information in the practitioner's/provider's credentialing file.

a. All information received is date stamped and initialized by the credentialing staff and filed in the provider's credentialing file.

Application Status

The UHA Credentialing Sub-Committee may assign one of the four (4) credentialing statuses to a practitioner's/provider's application during the review process:

a. Approved;
b. Deferred;
c. Temporary ; or
d. Terminated/Denied.

Disciplinary Action

The UHA Credentialing Sub-Committee will forward disciplinary actions taken to the appropriate quality improvement committees, boards, networks, plans, and/or authorities.

UHA Credentialing Sub-Committee Report Review, Action Taken, and Vote

The UHA Credentialing Sub-Committee shall review the report of the Fair Hearing Committee at its next meeting and shall make a final decision in the matter, which decision may be to accept, reject, or modify any findings, conclusion, or recommendation. Any member of the UHA Credentialing Sub-Committee who participated in the decision of the ad hoc Fair Hearing Committee shall be disqualified from voting on any appeal from that decision.
Any action taken by the UHA Credentialing Sub-Committee to place a provider on probation or to terminate the provider, shall be made only upon the concurrence of two-thirds (2/3) of the members of the UHA Credentialing Sub-Committee entitled to vote in such a decision.

The UHA Credentialing Sub-Committee shall prepare a written statement of its final decision, and the reasons therefore, and that report shall be promptly transmitted to the aggrieved provider/practitioner by special notice. The decision of the UHA Credentialing Sub-Committee shall be final and immediately effective.

Report actions to appropriate authorities, when applicable, and Umpqua Health's Credentialing Department will be the duty of the UHA Credentialing Sub-Committee Chair or designee.

Verification of Credentials

Umpqua Health conducts timely verification of information of credentialing and re-credentialing applicants to ensure that applicants have the legal authority, relevant training, and experience to provide quality care to health plan members in accordance with State and Federal laws, NCQA, CMS, and health plan client standards. Umpqua Health counts back from the decision date to the verification date to assess the timeliness of verification. All credentials must be current at the time of the credentialing sub-committee decision date.

Licensure

Umpqua Health will verify that applicants have a valid and current license to practice and there are no current limitations on the practitioner's/provider's license at the time of the credentialing decision 42CFR §455.412. Umpqua Health verifies all licenses held in all states where the practitioners/providers are licensed or provide care to health plan members.

License verification will be obtained directly from:

a. The state licensing or certification agency or its website;
b. A contracted agent of the primary source or its website;.
    a. If a contracted agent is used, Umpqua Health must obtain documentation indicating a contractual relationship between the primary source and the agent that entitles the agent to verify credentials on behalf of the primary source.
c. An NCQA-accepted source listed for the credential or its website.
d. Verification time limit: 180 calendar days.

DEA or CDS Certificates

Current certifications of Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificates will be verified for applicants who are qualified to prescribe, dispense, or administer controlled substances and seeking credentialing or re-credentialing.

a. Applicant who dispenses drugs must be registered with the OMB as a dispensing physician.
b. Verification time limit: Prior to the credential decision.

Certifications must be valid and current in each state where the applicant provides care to members. Acceptable verification sources:

c. DEA or CDS agency;
d. DEA or CDS certificate;
e. Documented visual inspection of the original DEA or CDS certificate;
f. Confirmation of the National Technical Information Service (NTIS) database;
g. Confirmation from the American Medical Association (AMA) Physician Masterfile (DEA only);
h. American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File (DEA only); or
i. Confirmation from the state pharmaceutical licensing agency, where applicable, pending DEA certificates.

Pending DEA certificates

a. The organization may credential a practitioner/provider whose DEA certificate is pending if it has a documented process for allowing a practitioner/provider with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending until the practitioner has a valid

DEA certificate.

b. **DEA- and CDS-eligible practitioners who do not have a certificate.**

    i. The organization verifies that all DEA- and CDS-eligible practitioners who do not have a valid DEA/CDS certificate, and for whom prescribing controlled substance is in the scope of their practice, have in place a designated practitioner to write prescriptions on their behalf. The organization documents the practitioner's lack of DEA/CDS certificate in the credentialing file and obtains the name of a designated alternate prescriber from the practitioner. If the alternate prescriber is a practice rather than an individual, the file may include the practice name. The organization obligated to arrange an alternate prescriber.

c. If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA/CDS certificate but must describe their process for handling instances when a patient requires a controlled substance. The organization includes the practitioner's statement and process description in the credentialing file.
d. For applicants who do not have eligible DEA or CDS certificates, Umpqua Health will note this in the credentialing file and arrange for another practitioner/provider to write prescriptions.

Education and Training

Umpqua Health verifies the highest of the following three levels of education and training obtained by applicants as appropriate:

a. Board certification.
b. Residency, if not board certified.
c. Graduation from medical or professional school (Post-Graduate training), if residency not completed and if not board certified
d. Clinical education, *as applicable*.

Umpqua Health requires persons authorized to practice a profession regulated by a board, as defined in ORS 676.850, provide proof of participating at least once every three (3) years in a completing cultural competency continuing education [opportunity relating to cultural competency] approved by the Oregon Health Authority under ORS 413.450 and CCO Contract, Exhibit K, Section 10(d).

a. Verification time limit: Prior to the credential decision.

Umpqua Health may verify education and training through any of the following:

a. Primary source.
b. State licensing agency, specialty board or registry, if it performs primary source verification.
    i. Umpqua Health:

1. Obtains written confirmation of primary source verification from the primary source at least annually, or
2. Provides a printed, dated screenshot of the state licensing agency, specialty board or registry website displaying the statement that it performs primary source verification of applicant's education and training information, or
3. Provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution.
4. Sealed transcripts, if Umpqua Health provides evidence that it inspected the contents of the envelope and confirmed that the applicants completed (graduated from) the appropriate training program.

Other acceptable verification sources for physicians (MD, DO):

a. Graduation from Medical School:
   ii. AMA Physician Masterfile.
      1. If an applicant states that education and training were completed through the AMA's Fifth Pathway program, Umpqua Health confirms it through primary-source verification from the AMA.
   iii. American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
   iv. Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.
b. Completion of Residency Training:
   v. AMA Physician Masterfile.
   vi. AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
   vii. Federation Credentials Verification Service (FCVS) for closed residency programs.
   viii. NCQA only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) (in the United States) or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

Board Certification Status

Umpqua Health verifies the current board certification in each clinical specialty area for which the applicant is being credentialed and he/she states that he/she is board certified on the application.

a. Umpqua Health documents the expiration date of the board certification in the credentialing file of the applicant.

b. If an applicant has a "lifetime" certification status and there is no expiration date for the certification, Umpqua Health verifies that board certification is current and documents the date of verification.
    i. Verification time limit: 180 calendar days.
c. Expired board certification meets requirements because primary source verified education and training information would not change with expiration of board certification.

Board certification will be verified using any of the following sources:

d. For all practitioner types:
    i. The primary source (appropriate specialty board).
    ii. The state licensing agency serves as the primary source, verifying board certification.
e. For physicians (MD, DO):
    i. American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided.
        1. ABMS's "Is Your Doctor Board Certified" will not be used to verify board certification.
    ii. AMA Physician Masterfile.
    iii. American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File
    iv. Boards in the United States that are not members of the ABMS or AOA, if Umpqua Health may utilize boards that are not members of the ABMA or AOA. Examples of those boards include, (National Commission on Certification of Physician Assistants (NCCPA) , American Nurses Credentialing Center (ANCC) , American Midwifery Certification Board, American Psychological Association, American Speech-Language Hearing Association (ASHA), Behavior Analyst Certification Board, Commission on Dietetic Registration, Pediatric Nursing Certification Board (PNCB), The National Board of Physicians & Surgeons (NBPAS) . In such cases, Umpqua Health obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.
f. For other healthcare professionals:

i. Umpqua Health obtains verification from the primary source registry and obtains confirmation that verifies the board certification status.

Work History

Work history refers to the relevant work that is applicable to the position being sought. If the applicant is a new practitioner/provider, he/she may not have five (5) years of relevant work history.

Employment Dates

a. Umpqua Health obtains a minimum of the most recent five (5) years of work history as a health professional through the applicant's application or curriculum

vitae (CV). If the applicant has fewer than five (5) years of work history, the period starts at the initial licensure date.

b. The application or CV includes the beginning and ending month and year for each position of employment experience unless the applicant has had continuous employment for five years or more with no gap.
    i. Verification time limit: 365 calendar days.

Gaps in Work History

a. Umpqua Health documents its review of the applicant's work history and any gaps of the application, CV, checklist, or other identified documentation methods (i.e., signature or initials of staff who reviewed the history and the date of review).
b. If a gap in employment exceeds two (2) months, the applicant clarifies the gap verbally or in writing.
    ii. Verbal clarification will be documented in the credentialing file, or the written notice will be saved in the applicant's credentialing file.
c. If the gap in employment exceeds one (1) year, the applicant clarifies the gap in writing and Umpqua Health documents its review and flags for UHA's Credentialing Sub-Committee.

Malpractice History

Umpqua Health obtains confirmation of the past five (5) years of malpractice settlements from the malpractice carrier or queries the National Practitioner Databank (NPDB). The five (5)year period may include residency or fellowship years. Umpqua Health is not required to obtain confirmation from the carrier for applicants who had a hospital insurance policy during a residency or fellowship.

a. Verification time limit: 180 calendar days.

Verification Elements and Timeframes

Credentialing Element	Frequency	Timeframe	Regulation/Standard
Credentialing Process from time complete application is received.	Initial and Recred	90 days	(ORS743b.454)
Application/Attestation	Initial and Recred	365 days	(NCQA)
License	Initial and Recred *Monitored Monthly*	180 days	(NCQA)
DEA/CDS	Initial and Recred	Prior to decision	(NCQA)
Education/Training	Initial only *Verify any new education at Recred.*	Prior to decision	(NCQA)
Board certification	Initial and Recred	180 days	(NCQA)

Work history	Initial only *Verify any new work history at Recred*	365 days	(NCQA)
Malpractice history	Initial and Recred *Monitored Monthly*	180 days	(NCQA)
License sanctions	Initial and Recred *Monitored Monthly*	180 days	(NCQA)
Medicare/Medicaid sanctions	Initial and Recred *Monitored Monthly*	180 days	

Unreturned Credentialing Packets

Umpqua Health's Credentialing Department is committed to the timely processing of credentialing or re-credentialing packets submitted by practitioners/providers requesting to apply or reapply to Umpqua Health's provider network panel for UHA network participation. Here Umpqua Health outlines how it will reconcile credentialing or re-credentialing packets that have not been returned to Umpqua Health's Credentialing Department.

The Credentialing Specialist will document the dates and how notification attempts were made by Umpqua Health to the practitioner/provider in order to obtain the unreturned credentialing packet.

a. Dates are documented in Umpqua Health's credentialing database.

The Credentialing Specialist will contact the practitioner's/provider's office a minimum of twice in an attempt to obtain an unreturned credentialing packet from the applicant.

a. Contact will be made via phone and/or letter via mail, fax, and/or email.

The Credentialing Specialist will review with the UHA Credentialing Sub-Committee Chair all outstanding provider credentialing or re-credentialing packets with an unreturned status.

b. The UHA Credentialing Sub-Committee will review and determine the course of action.
    i. Upon UHA Credentialing Sub-Committee recommendation, the Credentialing Specialist will send the practitioner/provider a written notice of denial for participation to applicable health plan via certified mail.
        a. Grounds for written notice of denial include, but are not limited to:
            a. Provider OPCA or OPRA is not submitted to the Credentialing Department within designated period.
            b. Submission of an incomplete OPCA/OPRA where additional documentation requested is not received within the designated period.

Provider Appeals

1. All recommendations for termination or denial of a practitioner/provider's re-credentialing are subject to the appeals process (CR10 – Disciplinary Action, Appeals, and Fair Hearings).

Oversight of Credentialing Files and Ongoing Monitoring

Umpqua Health is directly responsible for continuous monitoring of provider credentialing files to ensure full compliance with Umpqua Health's credentialing and re-credentialing requirements, regulatory, contractual, and legal requirements and to ensure quality and safety of care to health plan members as outlined in the NCQA, OAR, the CFR, and UHA's CCO Contract.

Here Umpqua Health ensures proper monitoring of individual/organization providers/practitioners and contracted/sub-contracted providers/practitioners credentialing files on an ongoing basis. The Credentialing Department must determine credentialing files meet specific criteria (i.e., clean files). Umpqua Health outlines how it manages provider/practitioner credentialing information, including discrepancies and how Umpqua Health monitors for sanctions, tracks complaints, adverse events, and quality issues against applicants throughout the 36-month period between formal re-credentialing cycles.

Managing Files that Meet the Criteria

1. Umpqua Health's Credentialing Department manages practitioner/provider credentialing files by reviewing monthly reports to determine and approve their files meet Umpqua Health's credentialing criteria (i.e., clean files). The Credentialing Department will bring to the Chief Medical Officer (CMO) any discrepancies found on any of the monthly reports which will also be presented at the next UHA Credentialing Sub-Committee meeting. All practitioner/provider files are submitted to the UHA Credentialing Sub-Committee at the time of initial credentialing and re-credentialing.
2. Monthly reports reviewed:
    a. State license and certification verification are on a continuous query using a third-party vendor (e.g., license status, expiration date, sanctions, administrative action, licensure type change, licensure number, name changes);
    b. DEA license status using a third-party vendor;
    c. Active Insurance status verification;
    d. Exclusion verification;
        i. Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE).
        ii. Excluded Parties List System (aka System for Award Management (SAM))
        iii. State Medicaid Exclusions;
    e. Medicare Opt-Out (health plan client participants).
    f. CMS Preclusion Verification (health plan client participants);
    g. Social Security Death Master File;
    h. Oregon Medical Board's (OMB) Board Action Report

(https://www.oregon.gov/omb/board/pages/board-actions.aspx);

i. Oregon Board of Licensed Professional Counselors and Therapist Enforcement Action Report (https://www.oregon.gov/oblpct/Pages/Compliance.aspx);
j. Oregon Board of Licensed Social Workers Disciplinary Action Report (https://www.oregon.gov/blsw/Pages/DisciplnaryActionReport.aspx);
k. Oregon Board of Psychology Board Action Report (https://www.oregon.gov/psychology/documents/discipline_report.pdf);
l. Oregon State Board of Nursing Disciplinary Actions (https://www.oregon.gov/osbn/pages/disciplinary.aspx); and
m. National Practitioner Data Bank (NPDB) continuous queries.

3. Clean files do not consist of the following:
    a. History of adverse licensure action or government program participation activity;
    b. History of disciplinary action by any professional review body including loss or limitation of medical staff membership, clinical privileges, professional liability insurance coverage or health plan participation;
    c. Physical or mental impairment that adversely affects or could adversely affect the provider's ability to carry out the scope of his or her duties on behalf of Umpqua Health, with or without accommodation;
    d. Current illegal drug use;
    e. Not meeting adequate professional experience, education, and training in the requested area of practice;
    f. History of malpractice occurrences within the past five (5) years;
    g. For re-credentialing applicants, history of significant member grievances, quality of care/service and or adverse invents. (Please refer to Quality Improvement and Grievance and Adverse Events Monitoring section)

Discrepancies and/or Correcting Erroneous Information in Credentialing Application

1. Umpqua Health's Credentialing Department utilizes the following process for notifying practitioners/providers regarding any discrepancies and/or erroneous information identified in the credentialing information provided during the initial credentialing or re-credentialing primary source verification process.
    a. The provider will be notified by telephone and/or in writing, to review the information submitted and to correct any erroneous information.
    b. Telephone notifications will be immediately followed by written documentation for tracking purposes.
    c. A written response from the provider, in any format, will be accepted.
    d. Submissions may be addressed to the CMO or Credentialing Specialist.
    e. If the information received adequately addresses the variance issues, the provider's application will be reviewed at the following UHA Credentialing Sub-Committee meeting.
    f. If the information is not received the process will be suspended. The provider may reapply at any time with corrected information.
    g. If approved the provider will receive a letter within 10 business days of the UHA Credentialing Sub-Committee's decision.
    h. Any significant discrepancies found are reported to the CMO immediately with all identified discrepancies red flagged for review.

i. Upon receipt of the information which indicates an immediate and significant risk, the CMO will immediately (but in any case, not more than 48 hours), review the information provided by the Credentialing Department, gather additional information which would aid in the verification and investigation of the information received and prepare a written report.
ii. The CMO and the UHA Credentialing Sub-Committee will review the written report and if agreed an immediate or significant threat to members exists, termination of the provider's credentials will be recommended.

i. CMO will contact the provider immediately by telephone and a termination notice will be sent within one day by certified mail to inform them of the recommendation.

j. CMO will advise the Credentialing Department of any required provider notification.
    i. Notification can be written or verbal.
    ii. All recommendations for termination or denial to credential are subject to the appeals process.

2. Practitioners/providers applying for network participation have the following rights:
    a. Review information submitted supporting their credentialing or re-credentialing applications.
        i. Should the provider request a review of their application they must call Umpqua Health's Credentialing Specialist and schedule an appointment.
        ii. The appointment will be scheduled within ten (10) business days, allowing the Credentialing Specialist time to review the file and remove protected items such as peer review references or recommendations.
    b. Correct any erroneous information.
        i. A written response in any format from the provider will be accepted.
    c. Receive the status of their credentialing or re-credentialing application upon request.

Licenses or Certifications Status of Expired, Sanctioned, or Administrative Action

1. Upon the UHA Credentialing Sub-Committee's denial or termination of a practitioner/provider from the provider network, a written notification, including the rationale for the decision, are sent to the provider. All notifications shall be provided within ten (10) business days of the credentialing or re-credentialing determination.
    a. Denial notifications;
    b. Termination notifications:
        i. Provider notification;
        ii. Updating Provider Directory (PN2 - Provider Directory Workflow); and
        iii. Collaborating with Customer Care.
    c. A Provider Information Form (PIF) is completed and distributed accordingly after the completion of the UHA Credentialing Sub-Committee meeting and once the signed Abide by Agreement is received (if approved) from the practitioner/provider.
    d. Umpqua Health will make a good faith effort to give written notice of all

terminations of a provider within seven (7) days after the receipt or issuance of the termination notice.
    i. If termination is for-cause see section Termination or Denial of Providers, subsection Reporting a Provider's Termination.
2. Umpqua Health will notify health plan clients within five (5) business days of any:
    a. Adverse action affecting a practitioner's/provider network participation status, practice, or clinical privileges, including termination, suspension, limitation, restriction, whether the practitioner/provider is subject of a formal investigation, or the imposition of mandatory consultative requirements.
    b. Report made about the practitioner/provider to any State or Federal regulatory agency, CMS, State Licensing Board such as the Oregon Medical Board, whichever is applicable to the reporting party.

Notification of Decisions

1. Umpqua Health sends a notification letter to every practitioner/provider of the UHA Credentialing Sub-Committee's or CMO's decision regarding their participation in Umpqua Health's Provider Network. This notification shall be provided within ten (10) business days of the credentialing or re-credentialing determination. UHA will provide written notice prior to the contract expiration date to any participating practitioner/provider whose contract will not be renewed by UHA. Credentialing staff shall maintain copies of letters sent to practitioners/providers and maintain a record suitable for audit of the date when notifications are sent. Credentialing staff will also make a notation in each credentialing file checklist of when notifications are sent.
2. Umpqua Health will notify health plan client within 10 business days on all new and recredentialed practitioners/providers following each UHA Credentialing Sub-Committee meeting in which credentialing actions were taken.
    a. This information should include additions, deletions, changes, which include newly credentialing and re-credentialed practitioners/providers, terminations, and resignations and changes in practitioner information.

Ensuring Confidentiality

1. All practitioner/provider information obtained during Umpqua Health's credentialing process is private and confidential except where otherwise specified by law or at the discretion of the UHA Credentialing Sub-Committee of Organization Board of Directors. The policy is applicable to both voting and non-voting members of the UHA Credentialing Sub-Committee, invited guests of the UHA Credentialing Sub-Committee and any other Umpqua Health staff involved in the data collection and file preparation for the credentialing and re-credentialing process.
2. Information, documents and/or evidence created, collected, maintained, or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept confidential by all participants except as required by law, or at the direction of the UHA Credentialing Sub-Committee or the Organization Board of Directors, in order to encourage candor and careful assessment necessary to affect peer review and quality assurance.
3. Umpqua Health employees with a legitimate "need to know" will have access to the

provider files (e.g., Compliance Officer, CMO, Board Members, UHA Credentialing Sub- Committee members, credentialing staff, etc.). Any request by a practitioner/provider to see their credentialing file will be managed by the credentialing staff.

4. Electronic files and records including minutes and reports of the UHA Credentialing Sub- Committee must be password protected. All hard copy files will be stored in locked files cabinets. Credentialing staff shall be responsible for maintaining the security and confidentiality of both electronic and hard copy records.
5. Any printed materials reviewed during the UHA Credentialing Sub-Committee meeting left by members shall be shredded upon the conclusion of each meeting.

a. Master copies shall be securely retained for Umpqua Health's records in accordance with Policy CO23- Record Retention and Destruction.

6. All UHA Credentialing Sub-Committee members and Umpqua Health staff with access to confidential credentialing files are required to read and sign the confidentiality, Conflict of Interest Disclosure and Nondiscriminatory Statement provided by Umpqua Health. All are advised that breach of confidentiality is considered a major offense and may result in immediate disciplinary action including suspension or termination of employment.

Nondiscriminatory Credentialing/Recredentialing

1. Umpqua Health will not discriminate against any applicant on the basis of race, gender, color, religion, ethnic/national identity, ancestry, sexual orientation, age, veteran, marital status, Physicians/Practitioners that serve high risk populations, those who specialize in certain types of procedures or in the treatment of costly conditions.
2. Umpqua Health maintains a diverse credentialing sub-committee and requires the committee members to sign a statement affirming annually that they make their credentialing/recredentialing decisions in a non-discriminatory manner.
3. To proactively prevent discriminatory actions, all demographic information noted above is removed from files being reviewed by the credentialing sub-committee.
4. Umpqua Health's Credentialing Department will also conduct periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selecting practitioners. Umpqua Health will look at all credentialing/recredentialing decisions and breakdown by types of decisions, age, and gender to guarantee there are no obvious trends of discrimination when making credentialing decisions.
5. Umpqua Health will also investigate all practitioner complaints for evidence of alleged discrimination.

Monitoring

1. Ongoing monitoring of sanctions and complaints accomplished by collecting and reviewing the following information using NCQA approved sources such as, appropriate state agencies, and NPDB:
    a. Medicare or Medicaid sanctions.

        i. Will be reviewed within thirty (30) days of release.
    b. Sanctions or limitations on licensure.
        i. Will be reviewed within thirty (30) days of release.
    c. Complaints noted under the provider's state license and/or board certification.
        i. Will be reviewed at least every six (6) months.
    d. Identifiable adverse events, grievances, quality of care and services
        i. Will be reviewed at least every six (6) months for all practitioners/providers.
2. If Umpqua Health knows or has reason to know that a practitioner/provider has been convicted of a felony or misdemeanor related to a crime, or violation of federal or State laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere"), Umpqua Health will immediately provide such information to the Compliance Department who will notify OHA via Administrative Notice.
3. Umpqua Health Network shall provide training for participating providers and their staff regarding the credentialing of providers and the delivery of covered services, applicable administrative rules, and UHA's and UHN's administrative policies as set forth in UHA's CCO Contract.
4. Umpqua Health will verify certification and registry status for all contracted THWs annually to ensure the provider has an active certification.

Quality Improvement and Grievance and Adverse Events Monitoring

1. Collecting and reviewing of member complaints.
    a. UHA has implemented a grievance process for member complaints (CE01 – Grievance Appeals and Hearings) to ensure members have method to report any issues that may arise from Umpqua Health's Provider Network. UHA investigates practitioner/provider specific member complaints upon receipt.
    b. UHA tracks and monitors trends of grievances received.
        i. If UHA should receive a grievance that falls under a qualifying event from a member; UHA will immediately notify the Credentialing Department and Provider Network and the UHA Credentialing Sub-Committee of such action for investigation and resolution (See Disciplinary Action Appeals and Fair Hearings section of this manual).
        ii. Potential Quality of Care (PQOC) is referred to the Quality Department. PQOC is a possible adverse variation from expected standards of professional care and safety. The Quality Department will gather all pertinent information, investigate the issue, and ensure that it has all the pertinent information to enter the concern into the system or source of record.
        iii. If Umpqua Health receives three (3) grievances on a single practitioner/provider within a twenty-four 24-month rolling period, or since the last re-credentialing cycle, Umpqua Health will notify the Credentialing Department and Provider Network of such action. Grievances will be brought to the attention of the UHA Credentialing Sub-Committee for review and potential corrective action (See

Disciplinary Action Appeals and Fair Hearings section of this manual).

c. Umpqua Health evaluates the history of complaints, PQOC's for all active participating providers on a quarterly basis. (See Potential Quality of Care (PQOC) Referrals, Investigation and Remediation).

2. if Umpqua Health receives level 2, 3 or 4 quality of care and service investigations greater than 3, specific to the provider, in a rolling year, or since the last re-credentialing cycle, the practitioner/ provider will be brought to the attention of the UHA Credentialing Sub-Committee for review and potential corrective action.

3. Monitoring Adverse Events

a. Adverse events are instances which indicate or may indicate that a patient has received inadequate quality care. These include critical incidents, never events and sentinel events. Umpqua Health monitors adverse events through tracking quality-of-care concerns. Adverse events may also be identified using hospital claims data and utilization management review process to identify and to capture potential patient safety concerns based on the criteria developed by National Quality Forum (NQF) and CMS. Adverse events may also be reported or submitted by members, practitioners/providers, and Umpqua health staff.

b. Adverse events are grouped by practitioner/provider and trended to identify frequency of adverse events for any single practitioner/provider.

c. Umpqua Health evaluates the history of adverse events for all active participating providers quarterly. (See Potential Quality of Care (PQOC) Referrals, Investigation and Remediation).

i. if Umpqua Health receives adverse events investigations greater than 3, specific to the provider, in a rolling year or since the last re-credentialing cycle, the practitioner/ provider will be brought to the attention of the UHA Credentialing Sub-Committee for review and potential corrective action.

Review of quality and safety issues are shared with UHA's Quality Improvement and Quality Advisory Committees and the Network Performance Committee.

a. Upon receipt of information, which indicates an immediate and significant risk posed by a credentialed practitioner/provider, the UHA Sub-Credentialing Sub-Committee Chair or designee will immediately, but in any case not more than 48 hours, review the information, gather other information which would aid in the verification and investigation of the information received and prepare a written report.
b. The UHA Credentialing Sub-Committee Chair and designee will review the written report and if they agree that an immediate or significant threat to patients exists, they will recommend summary termination of a practitioner's/provider's credentials. (If they decide that an immediate threat does not exist, they may recommend non-summary termination to be considered at the next UHA Credentialing Sub-Committee meeting).

In the event the conduct of a practitioner/provider (See section Code of Conduct for Providers) within Umpqua Health's provider network fails to take action on areas identified for improvement and the UHA Credentialing Sub-Committee deems that failure to act would result in danger to the health and safety of any health plan member, the Chief Medical Officer or designee, may restrict or suspend a practitioner's/provider's ability to continue providing services, up to and including termination (See section Termination or Denial of Providers).

a. Should a practitioner/provider receive an adverse decision from the UHA Credentialing Sub-Committee based off the provider's quality of care, the practitioner/provider may follow the process outlined in section Disciplinary Action Appeals and Fair Hearings.
b. Umpqua Health will engage in a multifaceted risk response process to address any deficiencies that have become known to the organization. The Compliance Department in conjunction with the Provider Network Department Director and Quality Improvement will follow the process outlined in CO21 – External Risk Response Process.

Security Controls

Primary source verification information.

a. Umpqua Health obtains credentialing/re-credentialing applications directly from the practitioner/provider applying for network participation.
b. Verification of credential information shall come directly from primary source or its website, via secure email, by mail, fax or received orally. (Only work gap verifications are obtained orally).
c. All primary source verification from the primary source website is electronically loaded into the credentialing system and automatically stamped.
d. All primary source verification documents received via fax are automatically stamped upon receipt via fax and saved into an electronic file for that practitioner/provider.
e. All primary source verification received via email are automatically time and date stamped by the email server.
f. All primary source verification received by mail is scanned in the credentialing system by the Credentialing Specialist. The Credentialing Specialist enters in the receipt date which is automatically saved in the system with a receipt date.
g. Oral verification can only be used for verification of work history gap. Oral verifications are entered by a Credentialing Specialist into the Credentialing system upon receipt. Once the entry is submitted and recorded into the Credentialing system, the receipt date is automatically recorded.
h. All primary source verification document includes a unique electronic signature that includes the verifier's name and the date of verification.
i. All primary source verification is reviewed by the assigned credentialing staff and tracked on the electronic credentialing Checklist. This checklist is completed by UHA credentialing staff and includes the verification made, date requested, date received, date verified, name or initials of staff who reviewed/verified information and verification source.

Credentialing files are scanned and stored electronically effective 4/1/2019. All hard copy files are stored in locked filing cabinets. In accordance with UHA's CCO Contract, records will be retained for ten (10) years from the date of the documents (CO23 – Record Retention and Destruction).

a. Files are labeled by practitioner's/provider's:
    i. Last name;
    ii. First name; then by
    iii. Credentials.
b. Credentials inside files are organized by OPCA or OPRA:
    iv. Attestation and any explanation provided if applicable;
    v. Continuing medical education (CME);
    vi. On-call, admit plan;
    vii. Seclusion & restraint attestation;
    viii. License verification;
    ix. Drug Enforcement Administration (DEA) license if applicable;
    x. Medical malpractice insurance;
    xi. National Practitioner Data Base (NPDB);
    xii. Office of Inspector General (OIG) exclusions;
    xiii. System for Award Management (SAM);
    xiv. Google search;
    xv. National Plan and Provider Enumeration System (NPPES);
    xvi. Education;
    xvii. Board certification if applicable;
    xviii. Work history;
    xix. Hospital affiliation if applicable; and
    xx. Peer references.
    xxi. Provider criminal background check (https://www.criminalscreens.com).
    xxii. Sanctions/Disciplinary actions if applicable.
        1. Conduct under review;
        2. Corrective Action Plans (CAP);
        3. Improvement Plans;
        4. Financial penalties;
        5. Sanctions;
        6. Disciplinary actions;
    xxiii. Appeals and Fair Hearings
c. A practitioner/provider application and supporting documentation are reviewed by the Credentialing Specialist or designated reviewer "Reviewer" and the UHA Credentialing Sub-Committee.
    xxiv. The Reviewer utilizes a unique electronic identifier and signature (e.g. Adobe Stamp and Sign) that can only be entered by the signatory or handwritten initials and signature are used.
    xxv. The Reviewer utilizes an internal tracking log from the time the application is received, during primary source verification, through to the UHA Credentialing Sub-Committee decision.
    xxvi. Files that meet Umpqua Health's credentialing criteria are submitted to the UHA Credentialing Sub-Committee for review.

1. Following review and approval, the Chief Medical Officer will initial each primary source verification on the check list and use either a handwritten signature or unique electronic identifier (e.g. Adobe Stamp and Sign).

Securing information.

a. Umpqua Health limits physical access to credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources.
    i. To prevent unauthorized access, Umpqua Health's Credentialing Specialist assigns access as applicable to assigned job duties. Umpqua Health may grant limited access "read only status" to:
        1. Provider Network staff and the Contracting Department to complete onboarding of a practitioner/provider.
        2. The UHA Credentialing Sub-Committee to review credentialing files that are up for initial credentialing or re-credentialing.
b. All Umpqua Health systems are password protected (see IT11 – Information Security) including user requirements to:
    i. Use strong passwords.
    ii. Avoid writing down passwords.
    iii. User IDs and passwords are unique to each other.
    iv. Change passwords periodically.
    v. Disabling or removing password of staff who leave the organization and alerting appropriate staff who oversee computer security.
c. System Modifications.
    i. Umpqua Health utilizes PANDA, which offers system generated reports. All modifications to digitally stored credentialing files are tracked via the PANDA system generated report that tracks modifications in real time and identifies when, how and why information has been modified and who modified the information.
    ii. If a modification is made to the information entered in the PANDA system, The Credentialing Staff member who made the changes will be auto prompted by the system to make a note as to why the information was modified.
    iii. Any modification within the practitioner's/provider's credentialing file is tracked within the third-party credentialing database. Umpqua Health's Credentialing Specialist as the file Administrator has permission to make modifications to documentation only under the circumstances below:
        1. Updating current licensure/certification, including DEA.
        2. New licensure/certification, including DEA.
        3. Board certifications status.
        4. Current malpractice insurance or any insurance carrier changes.
        5. Documentation of any disciplinary action, sanction, or termination.

Credentialing process audit.

a. Umpqua Health Credentialing Manager audits a random sample of 5% of the practitioners completed credentialing/ recredentialing files at least annually to ensure the following: Primary source verification is stored, reviewed , dated and tracked according

to Umpqua Health CR Manual, that all modifications made reflect, when, how, who and why modifications were made, that only authorized personnel made changes to credentialing/recredentialing files, and changes made are under the allowed circumstances. The audit also reviews and ensures that only authorized Umpqua staff performed activities within the credentialing/recredentialing files.

b. At a minimum, the sample includes at least ten (10) credentialing files and ten (10) recredentialing files. If fewer than ten (10) practitioners were credentialed or recredentialed since the last quarterly audit, the Credentialing Manager audits the universe of files rather than a sample.
c. The file universe includes all files with or without modifications, however the sample that will be audited includes only files with modifications. The Credentialing Manager will randomly select a sample from the entire file universe; and will continue to pull files from the entire universe until 5% of files in the sample of both credentialed and recredentialed files have modifications.
d. Results from the audit are shared with the Credentialing Director. In the event issues of non-compliance are identified, the Credentialing Manager and Director will address the issue with the identified Credentialing staff. If issues are related to unauthorized system access, the findings are shared with the Information Technology Leader to remediate system related issues.
e. Identified issues related to Credentialing Staff will be addressed promptly. Remediation steps may include retraining, and an increased volume of audits. The Credentialing Manager will continue the quarterly monitoring process to assess the effectiveness of actions on all findings until improvement is demonstrated in at least one non-compliance area over at least three consecutive quarters.
f. The Umpqua Health Credentialing Check List Audit Form will be used to ensure processes are in alignment with the CCO Contract, NCQA, State and Federal Requirements.
g. Umpqua Health's Credentialing Department will also conduct periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selecting practitioners.

Site Visits (42 CFR §455.432) Umpqua Health shall, in accordance with OAR 410-141-3510, 42 CFR § 455.432, NCQA Standards, and in agreement with UHA's CCO Contract with OHA to require all providers/practitioners are in compliance with Umpqua Health' s scheduling and conducting of site visits.

Here Umpqua Health provides an oversight of the participating provider panel with an objective assessment and verification of compliance with Federal and State enrollment requirements.

Procedures

OHA is responsible for performing site visits for practitioners/providers deemed "moderate" or "high" risk and for ensuring "high" risk practitioners/providers have undergone fingerprint-based background checks. OHA has established categorical risk levels for Providers and Provider types listed on the OHA webpage for tools for OHP health plans https://www.oregon.gov/oha/HSD/OHP/Pages/Plan-Tools.aspx. For a practitioner/provider who is actively enrolled in Medicare and has undergone a fingerprint-based background check as part

of Medicare enrollment, OHA deems this practitioner/provider to have satisfied the same background check requirement for OHA Provider Enrollment. OHA's Provider Enrollment files are updated weekly and provided on the OHA webpage.

1. Umpqua Health must require any enrolled practitioner/provider to permit Centers for Medicare & Medicaid Services (CMS), its agents, its designated contractors, or the OHA to conduct unannounced on-site inspections of all practitioner/provider locations.
2. Umpqua Health must conduct pre-enrollment and post-enrollment site visits of the provider's facility who are designated as "moderate" or "high" categorical risks to the Medicaid Program.
    a. If OHA or Centers for Medicare & Medicaid Services (CMS) has conducted an onsite review of the provider's facility within the last three (3) years from the provider's scheduled enrollment date with Umpqua Health; Umpqua Health will not need to conduct an onsite visit of the facility.
        i. Umpqua Health must receive a letter from OHA or CMS stating the provider has passed OHA's or CMS' onsite review.
    b. If the provider's OHA or CMS onsite visit exceeds three (3) years from the date of the provider's scheduled enrollment or the provider has not received a passing inspection, Umpqua Health will need to conduct their own onsite visit of the provider's facility.
    c. The purpose of the site visit will be to verify the information submitted to OHA is accurate and to determine compliance with Federal and State enrollment requirements.
    d. If the provider has satellite facilities located within the service area, Umpqua Health will conduct a site visit for each satellite facility but may limit the site visit to the main facility.
3. A site visit is conducted by an Umpqua Health Provider Network Representative for the purpose of evaluating a department or institution to provide support and to identify areas in need of improvement.
    a. The following criteria is implemented for inspection:
        i. A formal appointment is made prior to the site visit.
        ii. Umpqua Health's Provider Network will make a reminder phone call to the practitioner's/provider's facility prior to the scheduled site visit.
        iii. Facility overview consists of but is not limited to:
            1. Physical environment;
            2. Policies/procedures;
            3. Quality improvement; and
            4. Record keeping practices.
4. The Umpqua Health Provider Network Representative shall possess a photo ID issued by Umpqua Health and a letter of authorization issued by Umpqua Health prior to the visit. The practitioner/provider may review and verify these items, but items cannot be retained or copied by the practitioner/provider or supplier.
5. The site visits fall into three (3) categories:
    a. Specific visits.
    b. Departmental visits.
    c. General visits.
6. To assess the quality of care during the site visit a checklist will be used to determine if

the site under review meets State regulations and to document any findings. A results letter, which will include a request for evidence of correction, will be sent to the provider's facility after final assessment of the site is completed. The quality of care will be reflected by the facility's adherence to State guidelines.

7. Umpqua Health's site visits will be used to outline key provider accomplishments, strengthen the relationship between Umpqua Health provider offices, identify promising practices, and support the training and any technical assistance they may need. Site visits will be conducted monthly, quarterly, or annually, as needed.
8. Failure to cooperate with Umpqua Health upon inspection may result in the denial or revocation of enrollment unless OHA determines that termination or denial of enrollment is not in the best interest of the Medicaid Program and OHA documents that determination in writing.
    a. Umpqua Health may terminate or deny the provider's network participation if CMS or OHA:
        i. Determines that the provider has falsified any information provided on the application; or
        ii. Cannot verify the identity of any provider applicant.
    b. If the provider refuses to allow the Network Representative to schedule, enter or visit the facility, the provider will be terminated from any contractual agreements that are in place with Umpqua Health.
9. If OHA determines a document submitted by Umpqua Health has failed to comply with the standards for approval of such document, OHA will provide UHA's Contract Administrator with Administrative Notice and shall be remediated according to CCO Contract, Exhibit D, Section 5.

Disciplinary Action, Appeals, and Fair Hearings

Umpqua Health holds practitioners/providers responsible who fail to comply with established standards relating to quality of care and service, compliance with OARs, ORS, CFRs, CMS, and the NCQA credentialing standards and may be subject to disciplinary action in accordance with the CFR. Here Umpqua Health outlines how it will implement disciplinary actions or corrections regarding practitioner/provider performance.

Investigation and Disciplinary Action

Any information that may result in possible disciplinary action will be immediately referred to the UHA Credentialing Sub-Committee Chair or designee.

The UHA Credentialing Sub-Committee Chair or designee will conduct a preliminary investigation of the circumstances and review the case with Umpqua Health counsel, as appropriate.

If immediate suspension is not necessary, the UHA Credentialing Sub-Committee Chair or designee refers the matter for further review.

If the UHA Credentialing Sub-Committee supports the corrective action, the

practitioner/provider shall be given notice. This notice shall include:

a. That corrective action is proposed.
b. The reason(s) for the proposed action.
c. The provider's right to request a hearing on the proposed action.
d. That the provider has 30 days in which to request a hearing.
e. A summary of rights for the hearing will be noted in the letter.

Disciplinary Action

Action taken by the UHA Credentialing Sub-Committee may include:

a. Exoneration;
b. Warning;
c. Letter of admonition;
d. Letter of reprimand,
e. Request for corrective action plan;
f. Suspension;
g. Terms of probation;
h. Requirements of consultation; and/or
i. Termination of network participation.

Appeals

Umpqua Health has an internal review process for a practitioner/provider aggrieved by a decision under OAR 410-141-3510(3) including an alternative dispute resolution or peer review process.

a. An aggrieved provider may appeal the determination of Umpqua Health's internal review to the Oregon Health Authority (OHA) (OAR 410-141-3510(4)).

The appeals process allows an aggrieved provider to submit an appeal to Umpqua Health in writing addressed to the UHA Credentialing Sub-Committee Chair or designee within 30 days of adverse action.

Once Umpqua Health has received an appeal, the practitioner/provider will be advised on the processes and procedures for a fair hearing following an adverse decision regarding credentialing, re-credentialing, disciplinary action, and/or termination. Appeal and Fair Hearing processes and procedures are outlined below in this policy.

a. The practitioner/provider may request to review the information used by the UHA Credentialing Sub-Committee to make their decision regarding the applicant excluding references, peer reviews and recommendations.
b. All appeals will be reviewed by the UHA Credentialing Sub-Committee or designated committee.
c. To meet compliance requirements Umpqua Health will follow the rules from the Quality Improvement Act of 1986 in regard to the appeals process.

An appeal can be submitted for the following:

a. If the practitioner/provider expresses discrimination occurred.
    i. Umpqua Health may not discriminate, with respect to participation, reimbursement, or indemnification against any health care practitioner/provider who is acting within the scope of their license or

certification as specified in 42 CFR § 438.12 and under OAR 410-141-3510 on the basis of such license or certification. This does not:

1. Prohibit Umpqua Health from including practitioners/providers only to the extent necessary to meet the needs of UHA members.
2. Require that Umpqua Health contract with any health care practitioner/provider willing to abide by the terms and conditions for network participation established by UHA;
3. Preclude Umpqua Health from using different reimbursement amounts for different specialties or for different practitioners/providers in the same specialty; or
4. Preclude Umpqua Health from establishing varying reimbursement rates based on quality or performance measures consistent with UHA's responsibilities under the CCO Contract.
    a. For purposes of this policy, quality and performance measures include all factors that advance the goals of health system transformation including:
        i. Factors designed to maintain quality of services and control costs and are consistent with its responsibilities to members; or
        ii. Factors that add value to the service provided including but not limited to expertise, experience, accessibility, or cultural competence.
    b. The requirements in procedure 2(a)(i)(4) do not apply to reimbursement rate variations between providers with the same license or certification or between specialists and non-specialty providers.

b. If a practitioner/provider does not agree with UHA's Credentialing-Sub Committee decision for network participation.

To resolve appeals made to the OHA under OAR410-141-3510(2) and (3), the OHA will provide administrative review of the provider's appeal using the administrative review process established in OAR 410-120-1580. The OHA will invite the aggrieved practitioner/provider and Umpqua Health to participate in the administrative review. In deciding whether there has been discrimination, the OHA will consider UHA's:

1. Network adequacy;
2. Practitioner/provider types and qualifications;
3. Practitioner/provider disciplines; and
4. Practitioner/provider reimbursement rates.

A prevailing party in an appeal under OAR 410-141-3510(3) through (4) will be awarded the costs of the appeal.

Fair Hearing Process

The hearing shall be conducted by an Ad Hoc Fair Hearing Committee composed of five (5) practitioners/providers appointed by the UHA Credentialing Sub-Committee Chair from among the Umpqua Health participating provider panel.

a. The UHA Credentialing Sub-Committee Chair is to designate the Ad Hoc Fair Hearing Committee Chair.
b. The Fair Hearing Committee shall consist of peers and not include any direct economic competitors of the aggrieved practitioner/provider.
c. The UHA Credentialing Sub-Committee provides written notice to the aggrieved practitioner/provider of the date, time, place as well as composition of the Fair Hearing Committee once appointed.

The aggrieved practitioner/provider shall be required to assert the committee composition in writing and deliver the attestation to the UHA Credentialing Sub-Committee Chair within forty-eight (48) hours after receiving the notice of the composition of the Fair Hearing Committee.

a. Any challenge the practitioner/provider has with any member of the committee whom the practitioner/provider asserts to be a direct economic competitor, or to be otherwise biased, will be disqualified from service on the committee.
b. Failure to challenge any proposed ad hoc Fair Hearing Committee member in that method, within the time provided, shall operate as a waiver of any such objections, which shall not thereafter be raised.
c. If a challenge is raised, the UHA Credentialing Sub-Committee Chair shall determine the legitimacy of the challenge.
d. The UHA Credentialing Sub-Committee Chair, at its discretion, may remove any potentially biased proposed appointee and replace the appointee, whether or not a challenge was received by the aggrieved provider.

The aggrieved practitioner/provider who requests a hearing shall be present in person at any hearing requested. Failure to appear shall operate as a waiver of the hearing as if no hearing had ever been requested.

If a Hearing Officer is employed for purposes of the hearing, that individual shall be the presiding officer and shall rule on evidentiary and procedural matters and may postpone or adjourn the hearing from time to time for the convenience of the panel, witnesses, or other participants.

a. The Hearing Officer may assist in procedural matters in deliberations but shall have no vote therein.

b. If a Hearing Officer is not employed, the Chair of the Fair Hearing Committee shall serve the functions of the Hearing Officer but may vote.

The aggrieved practitioner/provider may be represented at the hearing by one other person of the practitioner’s/provider's choice, including a lawyer, provided proper notice of such intent was given at the provider's request for the hearing.

Both the proponent and the aggrieved provider have the right to:

a. Call, examine and cross-examine witnesses (including the aggrieved provider), on matters relevant to the stated charges;

b. Introduce exhibits relevant to the stated charges;

c. Impeach any witness on relevant matters;

d. Rebut any evidence, which was accepted by the Fair Hearing Committee; and

e. Present final summation and argument relevant to the stated charges.

f. Have a record of the hearing made by the use of a public court reporter (if not provided by Umpqua Health at the aggrieved provider's own expense).

g. Submit a written memorandum on relevant matters at the close of the hearing.

The hearing need not be conducted strictly according to rules of evidence and procedure applicable in a court of law. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted regardless of the admissibility of such evidence in a court of law. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by the presiding officer and entitled to notarized documents in the state where the hearing is held.

If Umpqua Health does not provide a verbatim transcript of the hearing and the aggrieved practitioner/provider arranges for use of a public court reporter, that aggrieved practitioner/provider shall provide a copy of the transcript to Umpqua Health upon its payment of the cost of reproducing that copy.

The Fair Hearing Committee shall, after the close of the evidence, adjourn to deliberate among itself without the presence of the proponents or the aggrieved practitioner/provider, and shall decide its recommendation by majority vote of those eligible to vote, including the Fair Hearing Committee Chair.

a. If a committee member is absent from any part of the proceedings, that member shall not participate in the deliberations or vote unless a verbatim transcript (written or audio) is available for the portion of the proceedings which the committee member was unable to attend, and the absent committee member has reviewed that record prior to the deliberation.

Within 30 days after the close of the hearing, the Fair Hearing Committee shall prepare its written report stating its conclusions, the reasons therefore, and its recommendations to the UHA Board.

a. If the entire UHA Board has served as the Fair Hearing Committee, such report shall be its final decision.
b. A copy of the report of the Fair Hearing Committee shall promptly be sent to the aggrieved practitioner/provider by registered mail, simultaneous with the transmission of the original to the UHA Credentialing Sub-Committee.

Delegation of Credentialing

Umpqua Health provides delegated credentialing services for the Umpqua Health Alliance (UHA) and Health Plan Client(s) (Collectively "health plans"). Umpqua Health adheres to and fully complies with UHA's CCO Contract requirements, CMS regulations, NCQA credentialing standards, health plan client standards, and all State and Federal regulations. UHA is solely and ultimately responsible for adhering to all terms and conditions held in its CCO Contract and health plan client is solely and ultimately responsible for adhering with all terms and conditions held in its contract with CMS.

Here Umpqua Health outlines how it provides delegated credentialing services for the health plan participating provider panel (42 CFR § 438.230(b)(1)).

UHA's Credentialing Sub-Committee will review UHA's or external entity's provider application and credentialing requirements for any variances that may have occurred during the primary source verification and will review credentialing requirements upheld by NCQA credentialing standards, CMS, State and Federal regulations, and health plan policies and procedures (OAR 410-141-3510).

Pre-delegation Evaluation

1. Umpqua Health must obtain prior written consent from Umpqua Health Management, UHA, and health plan clients to further subdelegate all or any part of the credentialing services to a subcontractor.
2. In the event of partial delegation to a Credentialing Verification Organization (CVO), for purposes of obtaining required primary source verification, per the Delegated Credentialing Statement of Work with health plan client, Umpqua Health agrees to contract with a CVO that is fully NCQA or URAC certified. If the CVO is not certified Umpqua Health will assume oversight responsibility as required by NCQA/URAC. Umpqua Health
3. For new delegation agreements, Umpqua Health will evaluate the applicant's capacity to meet NCQA requirements and all other regulatory requirements before delegation of credentialing activities begins.
4. If variances are identified, the required application corrections must be resubmitted by the applicant, the Credentialing Department will determine whether the required changes will be acceptable. If that is not acceptable, the Credentialing Department will notify the entity's representative and try to resolve the differences. The Oregon Practitioner Credentialing /Re-Credentialing Application is the standard form accepted. For Organizations or Facilities, the Organization/Facility Credentialing Application will be utilized. The Credentialing Department will present its recommendations to the requesting agency.

Delegation Agreement

If an agreement is signed with the entity, upon which delegated activities are mutually agreed upon, Umpqua Health will agree to allow the entity and NCQA access to credentialing files and

a written summary of the UHA Credentialing Sub-Committee's minutes pertaining to the external provider reviewed (e.g. Credentialing Roster). Access will granted only if confidentiality can be properly maintained.

UHA will execute a Delegated Services Agreement in accordance with CO35- Subcontractor - General Requirement Standards and CO36- Subcontractor – Written Agreement Requirement Standards policies. Delegate responsibilities will be outlined in its Delegated Services Agreements, which will identify scope of work, reporting obligations, and oversight functionality, and actions Umpqua Health will take when delegate fails to meet terms of agreement.

Review of Delegate's Credentialing Activities/ Subcontractor Oversight

Reporting

Umpqua Health will review and analyze at least semi-annually reports that are designed to provide oversight and monitoring of the Delegated Entity. At a minimum, reports include a listing of newly credentialed and terminated practitioners, facilities, practitioner, and facility demographic changes.

The external entity must provide full disclosure of the basis for a decision not to approve the credentials of a practitioner/provider or the need to take disciplinary action, including termination. The entity must have an appeals process offered to the practitioner/provider (see Disciplinary Action, Appeals, and Fair Hearings section in this manual).

Performance Monitoring

At least annually, Umpqua Health will monitor the external entities' performance as outlined in the delegation agreement.

Annual evaluation shall include, but is not limited to:

a. review of Delegated entities Policies and Procedures and credentialing/re-credentialing files.
b. Review system controls policies and procedures and an audit of delegates files for system controls monitoring. Umpqua Health will select 5% of delegates files for audit. At a minimum, the sample includes at least ten (10) credentialing files and ten (10) recredentialing files. If fewer than ten (10) practitioners were credentialed or recredentialed since the last annual audit, Umpqua Health audits the universe of files rather than a sample.
c. Umpqua Health will also ensure that the delegate monitors, at least annually, that the delegate follows the delegation agreement or its own policies and procedures regarding system controls.

Additionally, Umpqua Health will provide oversight of the delegate in accordance with the Evaluation of Subcontractor policy in the Compliance Program Manual.

Opportunities for Improvement

Umpqua Health uses information from its pre-delegation evaluation, monitoring, ongoing reports, or annual evaluation to identify areas of improvement.

a. For delegation arrangements that have been in effect for more than twelve (12) months, Umpqua Health will follow up on opportunities for improvement, if applicable.
b. Umpqua Health will review Delegates follow up action to ensure:
    i. All opportunities identified have been addressed.
    ii. That delegates remediation plan and conclusion is reasonable, and algins with evaluation findings and opportunities.

Consequences for Failure to Perform

Umpqua Health's Compliance Department will with coordinate with the Credentialing Department to assess and assigned a risk response to remediate the practitioner's/provider's area of non-compliance, in accordance with the CO21 – External Risk Response. The activities of a risk response will vary depending on the issue and severity.

1. The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that result in revocation of the agreement by NCQA standards, CR 8: Delegation of CR-Factor 6.

Right to Approve, Suspend, and Terminate

Umpqua Health reserves the right to approve, suspend, or terminate any practitioner/provider in the event of immediate and significant risks are identified.

Upon receipt of information which indicates an immediate and significant risk posed by a credentialed practitioner/provider, the UHA Credentialing Sub-Committee Chair or designee will immediately (but in any case not more than 48 hours), review the information, gather other information which would aid in the verification and investigation of the information received, and prepare a written report. The UHA Credentialing Sub-Committee Chair or designee will review the written report and, if they agree that an immediate or significant threat to health plan members/patients exists, they will recommend summary termination of a practitioner's/provider's credentials. (If they decide an immediate threat does not exist, they may recommend non-summary termination to be considered at the next UHA Credentialing Sub-Committee meeting.) The UHA Credentialing Sub-Committee Chair or designee will contact the practitioner/provider and the credentialing delegate's Medical Director immediately by telephone and within one (1) day by registered mail to inform the delegates of this recommendation.

a. A practitioner/provider whose continued practice of medicine poses an immediate threat to the health or safety of health plan members/patients.
b. Inappropriate sexual conduct.
c. Criminal behavior (not including minor traffic violations or similar behaviors).
d. A confirmed complaint by the State Medical Board or County Medical Society.
e. Other information indicates an immediate threat to the health or safety of health plan members/patients.

All recommendations for termination, or not to re-credential, are subject to the appeals process of our credentialing delegates.

Entity/Provider Notifications

The following communications will be used to notify delegating entities of credentialed or re-credentialed providers:

a. Umpqua Health will forward the Credentialing roster to the delegating entity, after approval by Umpqua Health's UHA Credentialing Sub-Committee. Committee approved minutes will be available at the delegating entity's request, or at the time of the annual site audit.
b. Umpqua Health's Contracting Specialist will request from the delegated entity, by email, if it is found that any of their providers have taken any extended leaves of absence, retirement, or any other reason that would prohibit their ability to provide services to the health plan's membership.

Provider Termination

Termination of providers under delegated contracts.

a. For those contracts for which Umpqua Health are delegated to credential/re-credential. Umpqua Health will occasionally need to recommend termination of the credentials of a provider. Termination can take, but is not limited to, the following forms.
    i. Recommendations not to credential, (the term 'credential', in all its forms, includes re-credentialing) will be made at credentialing meetings, and will be based upon the aggregate of information available to the committee including, but not limited to, that provided by the Utilization Management and Peer Review data. UHA's Credentialing Sub-Committee will review the recommendations and decide whether to recommend re-credentialing or not, to our credentialing delegates. Such decisions will be comminicated to our credentialing delegates within two days by telephone, e-mail, or facsimile transmission and within five (5) days by registered mail.
    ii. Recommendations for non-summary termination will be made at credentialing meetings and will be based upon the aggregation of information available to the committee including, but not limited to, the provided by the Utilization Management and Peer Review data. Such information may include other quality or utilization concerns that do not pose an immediate threat to patients. UHA's Credentialing Sub-Committee will review the recommendations and decide to recommend to our credentialing delegates to terminate the credentials of a practitioner/provider. Such decisions will be communicated to the practitioner/provider involved and to our credentialing delegates within two (2) days by telephone, email, or facsimile transmission and within five (5) days by registered mail.
b. Upon UHA's Credentialing Sub-Committee's recommendation to terminate a practitioner/provider from its Provider Network, Umpqua Health must notify the Compliance Department.

Termination of delegate. Umpqua Health will require an unbroken string of recredentialing at least every three (3) years to the day. Umpqua Health will require a delegate to submit all credentialing and re-credentialing files from the delegate upon contract termination.

a. If files are obtained from the delegate, Umpqua Health is not required to start over with initial credentialing; Umpqua Health may continue the process begun by the delegate and recredential practitioners when they are due.
b. If files cannot be obtained from the delegate, Umpqua Health must perform initial credentialing within 6 months of the delegate's termination date. Umpqua Health is responsible for ensuring that credentialing occurs according to NCQA standards.

Signed Agreement

Please refer to the signed agreement for each delegating entity. In the event personally identifiable information (PII) is available in the credentialing applications, provisions are in place to limit the amount of exposure. Umpqua Health has implemented the Health Insurance Portability and Accountability Act (HIPAA) privacy and security policy and procedures in place, which follow the applicable Federal rules.

Provider Directory

All information collected during the credentialing and recredentialing process, as well as practitioner or provider change requests received in between recredentialing cycles, is entered into the credentialing system by the Credentialing Department to ensure consistency.

UHA uses information directly obtained from the credentialing database to inform how to populate provider demographic fields other systems.

Data from the credentialing system automatically populates the electronic Provider Directory, which is used to print paper copies of the directory.

Umpqua Health conducts quarterly audits of our provider directory and practitioner directories to ensure the information provided to members is consistent with the information obtained during the credentialing process.

a. On a quarterly basis, Credentialing Specialists audit a statistically valid sample of practitioners and providers.
b. Information in the practitioner file (electronic or hardcopy) is compared to the information displayed in the online practitioner/provider directory. Information audited includes, but is not limited to:
    i. Name
    ii. Address
    iii. City, State, and Zip
    iv. Phone number

v. Fax number
vi. Gender
vii. Specialty
viii. Hospital affiliations
ix. Group affiliations
x. Board Certification
xi. Accepting new patients
xii. Languages spoken at the office other than English
xiii. Education
xiv. Training

If 90% or above of the sample is correct, no further action is needed. If a discrepancy is identified, the Credentialing Specialist will contact the practitioner to obtain an explanation or updated information and process any resulting change to the practitioner's file.

If **less than** 90% of the sample is found to be correct, a root-cause analysis (RCA) is completed by the Credentialing Specialist, in collaboration with impacted departments and teams.

The results of the RCA are presented to the Credentialing Manager.

The Credentialing Specialist and the Credentialing Manager will develop an action plan to remediate the issue and re-measure against that specific deficiency during the next regular audit.

Locum Tenens

Umpqua Health ensures the continuous provision of quality of member/patient care and serving of the community in an efficient manner. To ensure there is no gap in access of care at times the use of a locum tenens will be utilized. Here Umpqua Health outlines how it will formally acknowledge the use of locum tenens by providers, criteria required to use locum tenens, and what practitioners/providers must do when using locum tenens.

Notifying Umpqua Health of a Locum Tenens

Practitioners/providers must notify Umpqua Health at UHNProviderServices@UmpquaHealth.com if a locum tenens is needed to cover their practice during an absence.

Requirements of locum tenens (OAR 847-008-0020):

a. Must have an official Oregon State medical license (as applicable based on practice location) and only perform services within their scope of license.
b. Must not have practiced more than 240 consecutive days in a two-year period and a total of 240 days on an intermittent basis in a two-year period with a locum tenens registration status.
c. Oregon State medical license must not be registered as inactive and must be

reactivated to locum tenens registration status prior to practicing in Oregon.

d. The locum tenens must be the same type of practitioner/provider as the authorizing practitioner/provider (for instance: an MD can only authorize another MD as a locum tenens, a DC can only authorize another DC, an ARNP can only authorize another ARNP, etc.). There is one exception to this rule, MD and DO are now interchangeable according to licensure and board certification. To be considered for locum tenens status, the temporary practitioner/provider must be one of the following types:
    i. Doctor of Medicine (MD)
    ii. Physician's Assistant (PA)
    iii. Doctor of Dental Surgery (DDS)
    iv. Doctor of Dental Medicine (DMD)
    v. Doctor of Podiatry (DPM)
    vi. Doctor of Optometry (OD)
    vii. Doctor of Osteopathy (DO)
    viii. Doctor of Chiropractic (DC)
    ix. Doctor of Naturopathy (ND)
    x. Advanced Registered Nurse Practitioner (ARNP)
    xi. Physical Therapists (PT)

Upon receiving a practitioner's/provider's notification request for the use of a locum tenens, Umpqua Health's Provider Services will request the following:

a. Dates the locum tenens will be covering.
b. The practitioner/provider the locum tenens is covering for.
c. Reason for locum tenens coverage.
d. Copy of locum tenens' State license.
e. Copy of locum tenens' DEA certificate.
f. Locum tenens' current malpractice face sheet.
g. Completion of disclosure of exclusion monitoring and Exclusion Form.
h. Professional questions to be completed by locum tenens; and
i. Attestation form to be signed by the locum tenens.

If practitioner/provider fails to notify Umpqua Health's Provider Services of the use of locum tenens, Umpqua Health will attempt to obtain the required information under this section procedure 2(a)-(i). If the requested information is not received by the assigned deadline, payments to the practitioner/provider will be suspended and services will not be reimbursed.

a. Umpqua Health will make three (3) attempts to obtain the information.
b. Locum tenens claims will be paid if billed correctly with the Q6 or Q5 modifier but if claims for locum tenens providers are received after the sixty (60) days of acting as a locum and the requested information has not been received by Umpqua Health, all claims will be suspended & denied and UHA will request reimbursement for all claims paid prior.

Exclusion Monitoring of Locum Tenens

Exclusion reports for locum tenens providers will be completed monthly to verify that there are no Medicare or Medicaid sanctions.

Locum Tenens Billing and Credentialing Requirements

Umpqua Health recognizes that an absentee practitioner/provider enrolled under Umpqua Health's participating provider panel may retain locum tenens or as part of a reciprocal billing arrangement. The absentee practitioner/provider must bill with their individual assigned practitioner/provider number and receive payment for covered services provided by the locum tenens.

a. Services provided by the locum tenens must be billed with a modifier Q6.
b. Services provided in a reciprocal billing arrangement by the locum tenens must be billed with modifier Q5.
c. In entering the Q5 or Q6 modifier, the absentee physician is certifying that the services are provided by a locum tenens identified in a record of the absentee physician that is available for inspection and are services for which the absentee physician is authorized to submit a claim.
d. A physician or other person who falsely certifies that the requirements are met may be subject to possible civil and criminal penalties for fraud including and up to termination, and the enrolled practitioner's/provider's right to receive payment or to submit claims may be revoked.
e. This does not apply to substitute arrangements among practitioners/providers in the same medical practice when claims are submitted in the name of the practice or group name.

A locum tenens may not assume a deceased physician's professional practice without first enrolling with Umpqua Health and completing the initial credentialing process.

In accordance with 1842(b)(6)(D)(iii) of the Social Security Act and CMS general billing requirements locum tenens may not bill longer than sixty (60) consecutive days, unless a participating practitioner/provider is being called to active duty in the Armed Forces, then a locum tenens may be used for longer than the 60-day limitation (Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSE), Section 116 of Public Law 110-173).

a. Umpqua Health's policy for the use of a locum tenens by a participating practitioner/provider is limited to 60 days per 12-month period. However, Umpqua Health may, within its sole discretion, and under exceptional circumstances, grant an extension to this rule.
    a. If a locum tenens is needed for more than sixty (60) days Umpqua Health will follow the initial credentialing procedures.
    b. Any claims received on the 61st day will be denied or funds recouped.

Code of Conduct for Practitioners/Providers

Umpqua Health is dedicated to holding all participating network providers responsible to operate in a compliant and ethical manner, with high levels of integrity and to maintain and possess exceptional levels of ethical standards. Ethics should be a guiding principle for any behavior or decision conducted on behalf of Umpqua Health.

Umpqua Health' s code of conduct is reflected in the practitioner/provider handbook and shared during onboarding, outlines expectations for its participating network provider panel and contracted facilities as in the Umpqua Health Code of Conduct and Ethics Program and addresses disciplinary actions to be taken when the code is violated. The desired outcome is to intercede in a manner that will minimize impact by correcting the problematic behavior before that behavior places patients at additional risk, be supportive of the provider, and maintain confidentiality.

Umpqua Health's participating network providers are required to comply with Umpqua Health's Code of Conduct and Ethic Program (Umpqua Health's Code of Conduct). Providers are to engage in appropriate, professional relationships among colleagues, members of the healthcare team, patients, families, or others which are conducive to the best patient care possible. Practitioner’s/provider's behavior that is perceived to adversely affect the quality of patient care or violates Umpqua Health's Code of Conduct, will be subject to the process outlined in this manual.

Who Can Report a Concern

Concerns being reported regarding a practitioner’s/provider's conduct may be brought to the attention of the UHA Credentialing Sub-Committee Chair by anyone including, but not limited to:

a. A colleague;
b. Members of the healthcare team;
c. Patients;
d. Members; or
e. A patient's/member's representative.

Such concerns may include, but are not limited to:

f. Violation of policies and procedures;
g. Suspicion of fraud, waste, and abuse;
h. Quality of care issues; and/or
i. Personal behaviors.

Documentation of Behavior

Reported incident(s) will be documented for the purposes of the individual event and to determine whether it is a part of a pattern of conduct.

a. Documentation should include:
    i. Date of incident;
    ii. Time of the incident, if possible;

iii. Name of person reporting the incident;
iv. Precipitating circumstances;
v. A precise description of the conduct being reported, including any specifics of the behavior involved or how it affected the patient in any way, if so, whom;
vi. What the consequences of the disruptive behavior were to patients or others; and
vii. Description of specific action taken, if any, at the time, including the names of those involved.

The report must be submitted to the UHA Credentialing Sub-Committee Chair for review.

Incident Review and Remediation

The UHA Credentialing Sub-Committee Chair may conduct the following:

a. An informal review;
b. Initiate corrective action plan/improvement plan (CO18 - Corrective Action Plan Process); or
c. An investigation.

The UHA Credentialing Sub-Committee Chair or an assigned delegate may meet with the practitioner/provider to discuss the incident and, if verified, indicate the provider's conduct that was inappropriate.

a. The initial approach may be designed to be informative and helpful to the practitioner/provider. The practitioner/provider will be notified that if the behavior continues, further action will be taken.
b. This meeting will be documented including the practitioner's/provider's response.
c. All documentation will be retained and stored in the practitioner's/provider's credentialing file.

If the reported conduct of the practitioner/provider is present in more than an isolated incident, the practitioner/provider will be notified of the possibility of formal action being taken.

a. Forms of formal action include, but are not limited to:
    i. A corrective action plan;
    ii. An improvement plan;
    iii. Financial penalties; and/or
    iv. Sanctions/disciplinary actions.

If further incidents occur, the practitioner/provider will be put on notification with a final warning of possible disciplinary action, including and up to termination from the practitioner/provider network.

Disciplinary Action

Further incidents shall result in the initiation of formal disciplinary action.

a. UHA's Board of Directors will be notified of the practitioner's/provider's

disciplinary action.

b. The Quality Improvement Committee may be notified when deemed appropriate.

If conduct of the practitioners/providers result in termination, Umpqua Health will follow its current process of engaging the UHA Credentialing Sub-Committee and notifying Oregon Health Authority in accordance with the UHA CCO Contract.

Reporting a Provider's Termination

All resultant suspensions or terminations of the practitioner's/provider's network participation will be reported to the appropriate authorities, the National Practitioner Data Bank (NPDB), and/or the Oregon Health Authority (OHA).

a. If a suspension or termination occurred to a health plan client participating practitioner/provider. Umpqua Health will notify health plan clients within ten (10) business days.

Reporting of a termination is the function of the UHA Board of Directors.

Participating practitioners/providers who choose to terminate with Umpqua Health through their Umpqua Health Network's provider service agreement without cause is required to provide a written notice of termination to Umpqua Health with an effective date at least 90 days the notification date.

a. If the participating practitioner/provider is participating in health plan client, practitioner/provider must provide at least sixty (60) days written notice.

Once notification is provided, Umpqua Health will notify:

a. OHA. The names of all practitioners/providers terminated from Umpqua Health's provider network, the reason for each termination, the number of members impacted by the termination and any other information required to be included as identified in the DSN Provider Capacity and Narrative Report.
b. Health Plan Client. Terminations or resignations and changes in practitioner/provider information will be reported within ten (10) business days.

Umpqua Health shall provide the Compliance Department notice within three (3) days of terminating any participating practitioner/provider contract when such participating practitioner/provider termination is for-cause termination to allow for timely reporting within 15 days of termination via Administrative Notice to OHA's Provider Enrollment Unit. Such for-cause terminations include but are not limited to the following:

a. Failure to meet requirements under the CCO Contract or UHA's subcontract with its subcontractor;
b. For reasons related to fraud, integrity, or quality;
c. Deficiencies identified through compliance monitoring of the entity; or
d. Any other for-cause termination.

Umpqua Health will not refer health plan members to or use practitioners/providers who do not have a valid license or certification required by applicable law.

1. If Umpqua Health knows or has reason to know that a practitioner/provider's license or certification is expired, has not been renewed, or is subject to sanction or administrative action, Umpqua Health must report such findings to the Compliance Department so that OHA is notified immediately through Administrative Notice of such circumstances.

Requirements for Reinstatement (42 CFR § 455.3(c))

For a practitioner/provider to be reinstated and contracted through UHA, the practitioner/provider must meet the screening requirements as outlined in policy CR3 - Screening of Providers.

If the break in network participation is more than 30 calendar days, the practitioner/provider will be initially credentialing again.

a. Umpqua Health re-verifies credentialing that are no longer within verification time limits.
b. Umpqua Health re-verifies credentials that will not be in effect when the UHA Credentialing Sub-Committee or CMO makes the credentialing decisions.

Training

Umpqua Health conducts training to staff and participating practitioners/providers regarding the credentialing of practitioners/providers and the delivery of covered services, applicable administrative rules, and UHA's and UHN's policies and procedures as set forth in Exhibit B, Part 9, Sect. 11(b)(8).

Participating practitioners/providers training courses are outlined in policy PN6 - Provider Orientation and Training.

Umpqua Health credentialing staff are required to completed the following trainings on an annual basis:

1. Compliance and FWA Prevention
2. Exclusion Monitoring;
3. HIPAA Privacy and Security;
4. Prohibited Affiliations;
5. Ownership Disclosure and Control, Business Transactions, and Information for Persons Convicted of Crimes Against Federal Related Health Care Programs (including Medicare, Medicaid, and/or CHIP programs); and
6. Screening Requirements (such as identification of moderate to high-risk providers and verification of Medicaid enrollment with OHA prior to credentialing).

Policy Review

All credentialing policies and procedures will have a preliminary review and approval by the policy owner prior to being submitted for review and approval by the QIC and the UHA Credentialing Sub-Committee.

Appendix of Archived Policies

CR1 – Practitioners Within Credentialing Scope
CR2 - Verification of Credentials
CR3 – Screening of Providers
CR4 – Oversight of Credentialing Files and Ongoing Monitoring
CR5 - Credentialing Committee
CR6 – Credentialing and Re-Credentialing Process
CR7 – Site Visit
CR8 – Provider Rights
CR9 – Temporary Status
CR10 – Disciplinary Action, Appeals, and Fair Hearings
CR12 – Delegated Credentialing for Other Facility/Managed Care Organizations
CR13 – Locum Tenens
CR14 – Termination or Denial of Providers
CR15 – Unreturned Credentialing Packets
CR17 – Code of Conduct for Providers
CR18 – Assessment of Organizational Providers
CR19 – Traditional Health Worker Requirements
CR20 – Non-Licensed Provider Qualifications and Competencies