Saint Alphonsus Health Alliance
Credentialing Manual

Effective May 2023

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Saint Alphonsus Health Alliance Credentials Verification Procedures

The Saint Alphonsus Health Alliance ("Alliance") is the clinically integrated provider network for the Saint Alphonsus Health System, whom both are wholly owned by Trinity Health. Applications for the Alliance, Saint Alphonsus Medical Group and Practitioners who have or are applying for privileges at Saint Alphonsus Regional Medical Center in Boise, Saint Alphonsus Medical Center - Nampa, Saint Alphonsus Medical Center - Ontario and Saint Alphonsus Medical Center - Baker City are primary source verified by the Trinity Health Center for Practitioner Information (THCPI), Trinity Health's central verification office, using the National Commission for Quality Assurance (NCQA) accepted verification standards.

1. Participation

Participation in the Alliance is a privilege extended to professionally competent Practitioners who continuously meet the qualification and responsibilities set forth in this Manual and any applicable policies and procedures, according to the needs of the Alliance. If a Practitioner leaves an existing contracting clinic and doesn't initiate a new contract request within thirty (30) calendar days this is considered a lapse in network participation. If a lapse occurs the Practitioner shall be required to complete a new credentialing application. The Practitioner is not considered a participating member until they receive a notice of credentials approval. The effective date as indicated on the notice of credentialing approval letter will determine the effective date of participation. Once the date of approval is known the Alliance will notify all applicable insurance companies. The insurance companies will assign an effective date for their plans. The Alliance recommends that the Practitioner contact the payers to confirm the effective dates the payer has assigned prior to treating patients.

If an Alliance practitioner has opted out of Medicare, they are not eligible to participate in any Medicare Advantage plans.

2. Non-Discrimination

The Alliance will not unlawfully discriminate in granting membership on the basis of age, disability, national origin, pregnancy, race/color, religion, gender, sexual orientation, patient types, or other basis protected by applicable state or federal law. Additionally, the Alliance administration conducts an analysis of denied credentialing and recredentialing applications from the network to look for and address any trends that may appear discriminatory in nature. A report is generated at least annually and presented to the Board for consideration and action planning.

3. Provider Types Credentialed and Recredentialed

NCQA credentialing guidelines and Alliance policy require credentialing and then recredentialing of our contracted Practitioners at least every three years. The Alliance currently credentials the following types of Practitioners who have an active Network Participation Agreement:

Physicians:

- Medical Doctors
- Doctor of Osteopathic Medicine
- Dental Specialists (DMD) – including oral and maxillofacial surgeons

Allied/Ancillary Practitioners:

- Audiologists
- Chiropractors
- Clinical Nurse Specialists
- Master's-Level Clinical Social Workers
- Master's Level Counselors and Therapists
- General Dentists (DDS) who provide covered medical/surgical services
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Doctoral or Master's Level Psychologists
- Registered Dietitians
- Registered Nurse Anesthetists
- Registered Nurse Midwives
- Registered Nurse Practitioners
- Speech Pathologists and Therapists

4. Completed Application

A completed application must include the following information requested on the application forms and attachments, including, but not limited to:

a. A current and valid, license to practice or provide services in the state(s) where the Alliance operates and the practitioner practices. If the practitioner has a current but restricted license the application will be considered a Category II application and subject to review.
b. Current, federal DEA registration and state-controlled substance license (if applicable).
c. Satisfactory completion by Physician of an approved postgraduate residency training program.
d. Current, valid professional liability insurance coverage in the amounts of at least $1/3M.
e. No record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or exclusion from such programs.

f. No record of conviction of, or plea of guilty or no contest without reasonable explanation for any:
    i. Felony
    ii. Misdemeanor
    iii. Violence
    iv. Controlled substance violations
g. No record of debarment from federal or state programs; suspensions or restrictions from participating in any private, federal, or state health insurance programs.
h. No record of denial, revocation, relinquishment or termination of appointment or clinical privileges at any hospital for reasons related to professional competence or conduct as disclosed by the Practitioner.
i. Five years of work history with an explanation of all work history gaps greater than one hundred and eighty (180) days. If obtaining Saint Alphonsus hospital privileges in conjunction with Alliance participation, any work history gap twenty-eight (28) days or longer must be disclosed.
j. Practitioner to provide explanation for any malpractice settlements or incidents reported to the National Practitioners Data Bank (NPDB) that occurs within five (5) years of signed application. If the Practitioner has knowledge that information pertaining to them has been reported to the NPDB, a narrative explaining incidents and medical malpractice must accompany the application.

*Practitioners who practice in the state of Oregon may submit the Oregon Practitioner Credentialing and Recredentialing Applications to the Alliance in lieu of the standard credentialing applications**. (ref. Oregon Health Authority, Public Health Division, Rule 333-505-0007 Health Care Practitioner Credentialing)***

*The process/approval time for a completed Oregon application shall be within 90 days of receiving a complete application**. (ref. Oregon Revised Statutes (ORS), Chapter 743, 743.918, (2))*** *The Alliance defines what a complete application is in the Alliance Practitioner Credentialing Manual.*

5. Contents of the Application

Each application for initial appointment to the Alliance will contain all information requested on the application forms and all required completed attachments, including but not limited to:

a. Signed and dated release of information form(s),
b. Signed conflict of interest form,
c. Medicare Acknowledgement Statement (if applying for hospital privileges),
d. Reasons for inability to perform the essential functions of the position,
e. Lack of present illegal drug use,
f. History of loss of license and felony convictions,
g. History of loss or limitation of privileges or disciplinary actions,

h. History of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or exclusion from such programs,
i. Signed and dated attestation regarding correctness and completeness of application,
j. Current Curriculum Vitae (CV),
k. Current professional liability insurance face sheet showing minimum requirements of $1,000,000/$3,000,000 in coverage. If a blanket policy for the practice is used a roster listing all covered practitioners from the insurance company is required.

6. Recredentialing Criteria

Upon notice of Recredentialing a Completed Recredentialing Application must be returned to the Alliance and shall include the following information requested on the application forms and attachments, including but not limited to:

a. Signed and dated release of information form(s),
b. Conflict of Interest,
c. Reasons for inability to perform the essential functions of the position,
d. Lack of present illegal drug use,
e. History of loss of license and felony convictions,
f. No record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or exclusion from such programs,
g. History of loss or limitation of privileges or disciplinary actions,
h. Signed and dated attestation regarding correctness and completeness of application,
i. Current professional liability insurance face sheet showing minimum requirements of $1,000,000/$3,000,000 in coverage. If a blanket policy for the practice is used a roster listing all covered practitioners from the insurance company is required.

7. Completed Recredentialing Application

During the Recredentialing process the Alliance will review and verify the following information:

a. A current and valid, license to practice or provide services in the state(s) where the Alliance operates and the practitioner practices. If the practitioner has a current but restricted license the application will be considered a Category II application and subject to review.
b. Current, federal DEA registration and state-controlled substance license (if applicable).
c. No record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or exclusion from such programs.
d. No record of conviction of, or plea of guilty or no contest without reasonable explanation for any:
    i. Felony
    ii. Misdemeanor
    iii. Violence

iv. Controlled substance violations

e. No record of debarment from federal or state programs; suspensions or restrictions from participating in any private, federal or state health insurance programs.
f. No record of denial, revocation, relinquishment or termination of appointment or clinical privileges at any hospital for reasons related to professional competence or conduct as disclosed by the Practitioner.
g. Practitioner to provide explanation for any malpractice settlements or incidents reported to the National Practitioners Data Bank (NPDB) that occurs within three (3) years of signed application. If the Practitioner has knowledge that information pertaining to them has been reported to the NPDB, a narrative explaining incidents and medical malpractice must accompany the application.

8. Incomplete Applications

Complete and timely responses to information requests or clarification requests during the application and verification process are required. The failure to disclose information requested by the Alliance may constitute an incomplete application. The Alliance determines, in its sole discretion, if an incomplete application will be considered for approval.

If an application is determined to be incomplete, it will not be processed and therefore is not subject to any hearing or procedural rights. The Alliance will notify the Practitioner of an incomplete application. If a completed application is not received within sixty (60) days of notification the application process will be closed, and the Practitioner will have to reapply for participation in the Alliance.

9. Authority to Release Information

When Practitioners apply for Alliance membership, they must sign an Authorization for Release of Information form that specifically releases all of his or her information to be used for all credentialing activities within Saint Alphonsus Health System (SAHS) entities. Practitioner-specific data will only be released to outside entities upon request and authorization of the practitioner.

10. Alliance Credentialing Procedures

Upon receipt of a complete application and an executed Participation Agreement, the Alliance will initiate the credentialing approval process. The Alliance, or the THCPI, will verify the following and will meet or exceed NCQA verification time limits:

a. State or Federal validation of current licensure; State sanctions, restrictions on licensure and limitations on scope of practice.
b. Medical school, internship/residency, fellowship, and post graduate education (if applicable) are validated through one of the applicable resources:
    - State licensing agency, specialty board or registry

- American Medical Association (AMA)
- American Osteopathic Association (AOA)
- Educational Commission for Foreign Medical Graduates (ECFMG)

c. Board certification (if applicable) are validated through one of the applicable resources:
    - American Board of Medical Specialties (ABMS) and their Member Boards
    - American Osteopathic Association (AOA) Boards
    - American Board of Foot and Ankle Surgery (ABFAS)
d. Non-recognized Certifying Bodies:
    - When a MD, DO or DPM are certified by a non-recognized Alliance certifying body, they will be listed as not certified. Their practicing specialty will be listed according to primary source verified highest level of education.
e. Verification of hospital privileges for the first in-network facility listed on the credentialing/re-credentialing application (for Practitioners who customarily maintain clinical privileges at a hospital). If no in-network facility is listed, privileges for the first hospital listed shall be verified. Per network policy, if no in-network hospital is identified, the Practitioner shall provide a hospital admittance plan that documents the Practitioner's alternative process for non-emergency admittance to an in-network facility.
f. Most recent prior (at least five years) clinical employment, unless self-employed or completing residency immediately prior to application,
g. Professional liability insurance in the amounts of at least $1/3M
h. Use NPBD to validate:
    - Validate Professional liability (malpractice) history for the past five (5) years
    - Review for sanctions or limitations on licensure
i. Narcotics registration certificate (federal and state), including pharmacy certificate (if applicable) validated through the drug enforcement agency and/or applicable state board of pharmacy
j. Office of Inspector General (OIG) exclusion report,
k. Excluded Parties List System (EPLS) also referred to as System for Award Management (SAM); Medicare and Medicaid Sanctions
l. State Medicare “opt-out” list,
m. State Medicaid Provider exclusion list
n. Criminal Background Check by checking the Idaho State repository for Practitioners in Idaho for any non SAHS hospital privileged providers.

11. Primary Source Verification

Primary Source Verification (PSV) means to solicit and obtain information directly from the source of verification (i.e. residency, medical school, state licensure). In such situations where an acceptable alternate can be used, such as a regulatory recognized database, information gathered from these sources shall be considered primary source verified.

Many of the PSV procedures are accomplished using electronic continuous queries which search websites for updates to documents. In this way the system maintains continuous surveillance of items that expire, such as licenses and board certifications.
Continuous queries are specifically used to monitor:

- Medical Licenses
- State Controlled Substance Licenses
- Federal DEA Registrations

In the event that the web-crawling process fails or is unavailable, representatives will access the appropriate site and primary source verify using web-grabbing technology, which is a screen shot of the documents which are dated and electronically initialed for proof of PSV timing.

Verification of primary source credentialing information will be completed within 180 days prior to the credentialing decision.

12. Central Data Repository

To aid in reducing redundant practices across SAHS, a Central Data Repository has been established to allow access to physician and practitioner information by multiple facilities and the Alliance. The Central Data Repository uses a web-based credentialing software to credential practitioners. Each facility and the Alliance have representatives who have appropriate authority to access information and rely on data that has been primary source verified. Changes to the data are entered into the data repository by THCPI and are immediately available for use by each facility and the Alliance.

Security of the data in the central data repository is maintained by the THCPI with support from Trinity Information Services (TIS).

13. Security and Confidentiality

The THCPI is responsible for assuring data security and protecting confidentiality. The Data Repository is housed on a secure network server protected from unauthorized external and internal access by multiple levels of security. Access to the data in the Repository is dependent upon recognition of the user, authentication of the facility or organization of the user, and the specific permissions granted to the user to enter, view, or update the information. All entries into the Data Repository by any representative are automatically dated and time stamped for auditing and proof of verification activities.

14. Practitioner Rights

A. Correcting Erroneous Information: Practitioners have the right to correct erroneous information submitted by third parties. When information is obtained from a third party which appears to be erroneous or varies substantially from the information

submitted by the Practitioner, the Practitioner will be notified per the following process:

- Be contacted by phone or in writing (including email) and provided a description of the erroneous information,
- Be provided the name and contact information of the third-party reporting agency which supplied the erroneous information,
- Be allowed no more than thirty (30) days from the date of notification to submit corrected information by phone or in writing (including email) to the Alliance,
- Be contacted by phone or in writing that corrections have been noted in the Practitioner's file and the status of the application.

B. Information Review: When information is obtained to support an application, the Applicant may contact the credentialing staff to review information submitted to support their application including any information collected during the verification process. Information collected in confidence from a third party such as reference checks, if applicable, will not be shared.

C. Application Status: Applicants may receive an update on the status of their application anytime during the credentialing process by contacting the credentialing staff by phone, email or by going to their practitioner application home page.

Practitioners are notified of their rights as part of the initial and recredentialing process on the Trinity Health website. Practitioners are asked to attest to their review and acceptance of Alliance policies and procedures. Information requests will be responded to within a timely manner.

15. Processing Times

Applications will be processed as promptly as possible based on the completeness and accuracy of information provided.

16. Credentialing Committee

The Alliance Provider Network Committee (PNC) reviews credentialing applicants. The PNC consists of network participating practitioners who utilize their expertise to provide meaningful advice for credentialing decisions. Discussions pertaining to credentialing decisions by PNC shall be documented in committee meeting minutes.

The PNC has assigned authority and responsibility for development and management of the Credentialing Program to the Alliance Executive Medical Director or designee. The Executive Medical Director or designee has oversight and approval of the program, credentialing activities, policies and procedures and is a voting member on the Provider Network Committee. The Executive Medical Director or designee's responsibilities are:

- To convene bi-monthly meetings or as needed in order to conduct the business of the PNC.
- To sign off and approve credentialing files that meet the Alliance's credentialing criteria.

In the event the Executive Medical Director or designee is not available to carry out any of these responsibilities as identified in this section, the assigned designee shall assume this role.

17. Review of Completed Applications

Category I: Applications which satisfactorily meet all of the criteria in this manual per the judgment of the Alliance administration shall be designated as Category I Applications and will be forwarded directly to the Executive Medical Director or designee for consideration and approval. Category I applications may also be forwarded to the PNC for consideration, if necessary. ***(See Exhibit A: Health Alliance Criteria for Category 1 Applicants)***

Category II: Applications which do not meet the definition of a Category I will be reviewed and determined by the PNC. Applications that contain deficient items for which there is a reasonable explanation after further review are known as Category II Applications.

18. Determinations of Application

In making a decision whether to approve an initial or recredentialing application, the PNC, medical director or designated physician shall have discretion to consider all factors presented by the application, including the information provided by the Practitioner, information supplied by Alliance administration and any other information deemed relevant to the PNC, medical director or designated physician. The PNC may:

- Approve (full 3-year cycle),
- Approve (less than 3-year cycle),
- Approve with conditions,
- Approve with follow-up,
- Deny,
- Pend an application for more information, or
- Request external review on issues.

If external review is requested by the PNC, the practitioner will be notified.

If at any point a practitioner fails to meet the credentialing and/or recredentialing standards, or is considered to pose a risk, the PNC may:

- Deny,
- Terminate,

- Summarily suspend the practitioner, or
- Decline to review the matter and refer it to Operations/Contracting.

A list of the approved applicants will be provided to PNC. Any complete applications that are denied by the PNC will be reviewed for final decision by the Alliance Board.

19. Notice of Final Decision and Appeal

The Alliance will provide the Practitioner with notice of the Alliance's final decision regarding approval of the application within sixty (60) days of determination.

If a Practitioner desires to appeal a decision by the Board, he or she may do so in writing per Alliance policy and procedure. Any appeal must be received by the Alliance within thirty (30) days after Practitioner notification. The Board shall provide notice of decision regarding any appeal to the Practitioner's address listed in the application.

20. Reapplication After Adverse Appointment Decision

A Practitioner who has received a final adverse decision regarding appointment will not be eligible to reapply for a period of one (1) year unless such requirement is waived in writing by the Alliance Board. Any such reapplication will be processed as an initial application.

21. Reporting Process

The Alliance will comply with all applicable reporting obligations, including making reports to the National Practitioner Data Bank and to the applicable state licensing board when required to do so by applicable law.

22. Ongoing Monitoring

The Alliance identifies and when appropriate acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

The Alliance implements ongoing monitoring and makes appropriate interventions by:

1. Collects and reviews Medicare and Medicaid sanctions through continuous query of NPDB.
2. Collects and reviews sanctions or limitations on licensure through continuous query of NPDB.
3. Collects and reviews complaints upon receipt (if any) and evaluates the practitioner's history of complaints, if applicable, as well as reviews history of complaints for all practitioners at least every six months.
4. Collects and reviews information from identified adverse events every six months. The Alliance may limit monitoring of adverse events to primary care practitioners and high-volume behavioral healthcare practitioners.

5. Collects and reviews information from the Centers for Medicare & Medicaid Services (CMS) Medicare Opt-Out website.
6. Implements appropriate interventions when instances are identified of poor quality related to factors 1-4.

23. <u>Practitioner Directories</u>

The Alliance ensures that information provided to contracted payers and in practitioner directories are consistent with credentialing data, including, but not limited to, education, training, board certification (if applicable), specialty and state licensure.

To ensure practitioner data integrity, Alliance Operations Support sends out quarterly practice data validation requests to verify that the information the Alliance has on file for each practitioner and practice location is accurate. The requests are logged, the replies are tracked, and any data updates are made accordingly.

In instances where a credentialed practitioner elects to change contracted and published specialties, the Credentialing Operations Department should confirm that the practitioner meets the criteria for the new specialty. This process should include re-verification of additional education and training related to the new specialty and re-verification of the board certification (if applicable) related to the new specialty.

Approved by Provider Network Committee (PNC)

On: May 9, 2023

Approved by the Alliance Board

On: _____

Exhibit A: Health Alliance Criteria for Category 1 Applicants

1. There are no negative or questionable recommendations, or any other data received from any source which is believed to be of significance to the Applicant's appointment.

2. The Applicant's history shows an ability to work cooperatively, and relate to others in a harmonious, collegial manner.

3. There are no material discrepancies in information received from the Applicant or references.

4. There are no gaps in time for which the Applicant has accounted for.

5. The Applicant has not changed practice locations more than three times in the past ten years or has not held more than five medical licenses across the United States without reasonable explanation.

6. The Applicant has not been involved in three or more malpractice claims in the past ten (10) years or any settlements or judgments in the past five (5) years.

7. There are no pending or previous disciplinary actions by a state licensing board, a state or federal regulatory agency, or other health care organizations.

8. There are no NPDB entries other than a malpractice history that meets the requirements of subsection above.

9. There are no sanctions or investigations present from the Office of Inspector General (OIG).

10. The Applicant's employment, medical staff membership, or clinical privileges have never been reduced, suspended, diminished, revoked, refused, or limited at any health center or other healthcare facility voluntarily or involuntarily.

11. The Applicant has had no voluntary or involuntary cancellation of license/Drug enforcement Administration.

12. The Applicant has had no professional liability insurance coverage denied or voluntarily relinquished, and/or canceled, non-renewed or limits reduced.

13. The Applicant completed a standard education/training sequence.

14. All requested information has been returned promptly.