POLICY AND PROCEDURE

DEPARTMENT: Credentialing	**DOCUMENT NAME:** Oversight of Delegated Credentialing
PAGE: Page 1 of 10	**REPLACES DOCUMENT:**
EFFECTIVE DATE: 08/2020	**REVIEWED/REVISED DATE:** 10/2020; 05/2022
PRODUCT TYPE: All	**REFERENCE NUMBER:** LA.CRED.12

SCOPE:
Louisiana Healthcare Connections ("LHCC") Credentialing and Quality Improvement Department.

PURPOSE:
To provide appropriate structures and mechanisms for monitoring the credentialing of practitioner and providers when the authority to perform credentialing activities is delegated to another entity. In addition, to encourage a collaborative oversight process that allows for the sharing of results and development of action plans in order to maximize the efficiencies of the relationship.

POLICY:
LHCC may delegate the responsibilities for credentialing activities to participating practitioner groups, organizational providers, or to qualified subcontracted vendors. LHCC may also delegate credentialing of physicians to a physician group or hospital-based clinics. LHCC recognizes and accepts the Delegate Group's credentialing determination for the practitioners' delegated group and to also cover a practitioner's affiliations with additional non-delegated groups, when applicable. Additional credentialing is not required unless and until the practitioner is no longer covered under the credentialing program of the Delegated Group.

LHCC evaluates the delegated entity's capacity to perform the delegated activities prior to a delegation agreement. LHCC determines if the delegate has the capability to perform credentialing duties in compliance with LHCC's minimum standards outlined in the Credentialing Program Description and in accordance with NCQA and/or other external requirements. Upon positive determination, LHCC may delegate to the agency the authority to perform this function. When LHCC elects to delegate credentialing functions, a document (contract, agreement, letter, or other written record) is signed by both parties before delegated activities are performed, that clearly defines performance expectations for both LHCC and the delegated entity.

LHCC retains accountability for delegated services and as such monitors the performance of the delegated entity through the approval of the delegate's credentialing program (or portions of the program that are delegated), through routine reporting and annual or more frequent evaluation to determine whether the delegated activities are being carried out according to NCQA and/or LHCC

standards. LHCC also retains the right to reclaim the responsibility for performance of this function should standards not be maintained.

If the delegate chooses to sub-delegate a portion of the credentialing activities, LHCC retains ultimate responsibility for the function. Prior written approval must be received from LHCC prior to sub-delegating any activity. The delegate will oversee the work performed by the sub-delegate, as outlined in the original delegation agreement. Failure on the part of the delegate to oversee any sub-delegated activity may result in termination of the delegation agreement with LHCC.

PROCEDURE:

I. Pre-Delegation Review
   A. Prior to delegation, LHCC Credentialing, Quality Improvement, and/or Compliance designee(s) is responsible for conducting an evaluation that consists of a written review of the entity's credentialing program, associated policies and procedures, staffing capabilities, and performance record. For Vendor delegate contracts, the Louisiana Healthcare Connections Quality Improvement designee conducts the pre-delegation review on behalf of LHCC or in collaboration with LHCC designee(s) as available.
   B. The entity's applicable Credentialing Program and/or policies and procedures are reviewed against LHCC, NCQA, HIPAA, or other regulatory standards such as state requirements.
   C. The file review includes, as applicable to the delegated activities, an audit of initial credentialing and recredentialing files. LHCC incorporates the use of the 8/30 rule established by NCQA for a delegate's practitioner credentialing and recredentialing file review. Thirty (30) credentialing files and thirty (30) recredentialing files are randomly selected for review. If the first eight (8) files in each category are 100% compliant for all criteria then no further files are reviewed in that category. If any criterion is non-compliant in the first eight (8) files, then the remaining 22 files are reviewed for the non-compliant criterion. LHCC will review 100% of the practitioner files if the delegate does not have thirty (30) files in each category. The time period for the file selection is within three (3) years for the pre-delegation review or since the last review.
   D. The pre-delegation review may be accomplished through an exchange of documents, through pre-delegation meetings, and/or an on-site review.

E. Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106) for providers and other vendors shall be reviewed during the pre-delegation audit of any proposed vendor in accordance with Compliance Policy LA.Comp.27.
F. The pre-delegation review is completed prior to the activation of the delegation agreement.
G. Summary of the pre-delegation review is recorded on the Report of Delegation Oversight Activities which is presented to the Credentialing and/or Quality Improvement Committee for review and approval.

II. Written Delegation Agreement

A. A mutually agreed upon written document, signed by both parties, serves as the delegation contract. The agreement includes, but is not limited to, the following elements:
   1. Responsibilities of LHCC and the delegate.
   2. Specific credentialing activities being delegated which may include any or all of the following:
      - Maintenance of credentialing committee
      - Initial credentialing process for practitioners and/or providers
      - Primary source verifications process
      - Ongoing monitoring of license and sanctions
      - Recredentialing process for practitioners and/or providers
      - Initial site visit process, if required
      - Credentialing appeal process
      - Appropriate reporting to authorities
      - Decision making processes
   3. Frequency and type of reporting, which includes reporting at least twice annually.
   4. The process by which LHCC evaluates the delegate's performance,
   5. LHCC's retained right, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making.
   6. Explicit statement of consequences and corrective action process if the delegate fails to meet the terms of the agreement, up to and including revocation of the delegation agreement.
B. If the delegation arrangement includes the use of Protected Health Information (PHI) the delegation agreement also includes the following

provisions (this may be done in the form of a Business Associate Agreement signed by the delegated entity)[1]:

- A list of the allowed uses of PHI
- A description of the delegate safeguards to protect the information from appropriate use or further disclosure
- A stipulation that the delegate will ensure that sub-delegates have similar safeguards
- A stipulation that the delegate will provide individuals/members with access to their PHI
- A stipulation that the delegate will inform LHCC if inappropriate uses of the information occurs
- A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends.

III. Reporting and Ongoing Monitoring

A. Delegate reporting is preferred quarterly, but must occur no less than twice annually. Reporting may include but is not limited to raw data, summary analysis of data, committee minutes or specialized reports designed exclusively to describe the findings of the credentialing activities. Reporting must include, at a minimum, the following items when applicable:

- Total number of practitioners within network
- Total PCPs within network
- Total specialists within network, by type
- Number of practitioners initially credentialed within and outside of the time frame noted in the unique requirement section for LHCC (if applicable).
- Number of practitioners recredentialed within and outside of the thirty-six (36) month timeframe (or per state time frame)
- Number of terminated, restricted and suspended practitioners by reason (with cause, administrative, resigned, etc.)
- Number of credentialing decisions appealed
- Number of organizational providers initially/recredentialed within and outside of designated timeframe

[1] Delegation arrangements with Credentialing Verification Organizations (CVO) do not include the use, creation or disclosure of Protected Health Information (PHI) in any form.

B. Vendor Delegate oversight meetings are preferred quarterly, but must occur no less than twice annually and may take place in the form of joint meetings or teleconferences. During the meetings, the quarterly reports are reviewed and analyzed for outliers and/or inconsistencies. Meeting minutes show evidence of substantive evaluation. Meetings for those Groups/Organizations delegated for credentialing functions only will meet on an as needed basis, but, no less than annually.
C. Summaries of the routine oversight meetings and evaluation of interim reporting are presented at the next regularly scheduled Credentialing and/or Quality Improvement Committee for review and approval.

IV. Annual Evaluation

A. LHCC Credentialing, Quality Improvement and/or Compliance designee(s) conducts an annual evaluation and documentation review to include the Credentialing Program, applicable policies and procedures, applicable file reviews, applicable ongoing monitoring documents and review of meetings minutes for compliance with LHCC and/or NCQA standards. (For Vendor delegate contracts, the Louisiana Healthcare Connections Quality Improvement designee conducts the annual evaluation on behalf of LHCC or in collaboration with LHCC designee(s) as available.)
B. The file review includes, as applicable to the delegated activities, an audit of initial credentialing and recredentialing files. LHCC incorporates the use of the 8/30 rule established by NCQA for a delegate's practitioner credentialing and recredentialing file review. Thirty (30) credentialing files and thirty (30) recredentialing files are randomly selected for review. If the first eight (8) files in each category are 100% compliant for all criteria then no further files are reviewed in that category. If any criterion is non-compliant in the first eight (8) files, then the remaining 22 files are reviewed for the non-compliant criterion. LHCC reviews 100% of the practitioner files if the delegate does not have thirty (30) files in each category. The time period for the file selection is within three (3) years for the pre-delegation review or since the last review.
C. The annual evaluation is based on the contents of the mutually agreed-upon delegation document and includes review and approval of the delegate's Credentialing Program or the delegated portions of the program. If portions of the credentialing process are delegated,

LHCC approves policies and procedures that the delegate uses to perform the selected activities.

D. The annual evaluation may be conducted on site and/or through telephone consultation and desktop documentation review.

E. Summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities which is presented to the Credentialing and/or Quality Improvement Committee for review and approval.

V. Deficiencies and Corrective Action

A. LHCC monitors the delegate on an ongoing basis to identify opportunities for improvement.

B. For delegation agreements that have been in effect for more than twelve (12) months, LHCC works collaboratively with the delegate to identify and follow up on at least one opportunity for improvement annually, if applicable. Sources for identifying areas for improvement may include but are not limited to: pre-delegation evaluation, annual evaluation, or ongoing reports.

C. A corrective action plan (CAP) is developed, as warranted, to improve performance. Each CAP includes, but not be limited to, the following:
   1. Expected, measurable results indicating completion of the CAP.
   2. Detailed action plan to complete activities required by the CAP.
   3. Due date for completion of CAP.

D. Reports regarding ongoing corrective action plans, if any, will be presented to LHCC Credentialing/Quality Improvement Committee at least quarterly.

E. When deficiencies are severe or unable to be resolved LHCC will withdraw the opportunity for or revoke the delegation arrangement.

~~E.~~ LHCC shall require the provider to immediately report cancellation of any required insurance coverage, licensure, or certification. Upon receipt of this report, LHCC shall immediately notify the Provider that it is prohibited from performing any work under the Contract unless and until the Provider provides written documentation to LHCC indicating that the Provider has reinstated all required insurance coverage, licensure, or certification.

Note: Per NCQA standards, in the instance where the delegate is NCQA Certified or Accredited, LHCC may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and omit the annual audit or evaluation. On pre-delegation, LHCC must evaluate the compatibility of the delegate's Credentialing Program with LHCC's Credentialing Program. Once

delegation occurs, LHCC must only ensure that the delegate provides the appropriate reports as determined by LHCC to ensure the delegate is compliant with the needs of LHCC. NCQA also does not consider activities done by a subsidiary, parent, or wholly owned sister organization to be delegation and therefore do not require delegated oversight.

Unique Delegated Credentialing Requirements:

1. LHCC requires that all delegated credentialing entities (subcontractors) credential their providers in accordance, at minimum, with the credentialing policies of LHCC, LDH and NCQA requirements for credentialing. LDH will have final approval over any delegated credentialing entity.

2. LHCC shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.

3. LHCC shall ensure all providers submitted from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.

REFERENCES:
LA.CRED.01 – Credentialing Program Description
NCQA Health Plan Standards and Guidelines
LA.Comp.27 – Ownership and Management Disclosures

EXHIBITS:
Exhibit 1 – Delegation Agreement Contract Exhibits - Template

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DEFINITIONS:

REVISION LOG:	DATE
• Converted corporate to local policy.	10/2020
• Revised language for RFP compliance under Section(s) 2.9.29.11.1	05/2022

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer is considered equivalent to a signature.

EXHIBIT 1
TO
DELEGATED SERVICES AGREEMENT

OVERSIGHT OF DELEGATED SERVICES POLICY AND MONITORING PLAN

I. Introduction

HMO may delegate certain activities that relate to benefit management, claims payment and processing, practitioner/provider network and services, credentialing, quality assurance, or utilization management, solely or in combination. At all times, HMO shall maintain full responsibility for the provision of health care services to its members HMO has established, operates, and maintains a health care delivery system, quality assurance system, provider credentialing system and other systems and programs meeting State Department of Insurance ("DOI") standards, if applicable, and is directly accountable for compliance with such standards. HMO may take whatever action it deems necessary to assure that all its systems and functions are in full compliance with the regulatory requirements of the DOI. Through the Oversight Program as described in this document, HMO shall assure that delegated services meet HMO standards for care and service, as well as the standards of the DOI and applicable accrediting agencies such as the National Committee for Quality Assurance ("NCQA").

HMO's Board of Directors has responsibility for the Oversight Program. It delegates implementation of the Program to HMO's Quality Improvement Committee. The Quality Improvement Committee shall review initial oversight assessments and approve delegated status; review delegation reports, quarterly evaluations and annual assessments; approve and monitor corrective action plans; and recommend changes to the Oversight Policy. The Quality Management Director, or designee, shall be responsible for initiating and monitoring the Oversight Program.

The contractual language between HMO and the Provider shall specify the delegated activities, the Provider's accountability for these activities, the frequency of reporting to HMO and the process by which the delegation shall be evaluated.

The Oversight of Delegated Services Policy shall be evaluated yearly as part of the annual Quality Management Program appraisal. Modifications shall be presented to HMO's Quality Improvement Committee for approval. In addition, interim modifications, consistent with changes in regulatory requirements or other business requirements, may be required. At all times, the most current revision of this Policy shall direct the oversight activity for each Provider.

II. Initial Evaluation

Prior to executing a delegation agreement, HMO shall determine the capacity of the Provider's delivery organization to assume responsibility for delegated activity(s) and to maintain HMO standards. This includes both a document review and on-site visit. Documents reviewed may include but are not limited to program descriptions, annual work plans, statements of effectiveness, committee minutes and applicable policies and procedures.

III. Annual Evaluation

Annually, there will be a comprehensive on-site review of the Provider's ability to provide care and service according to the standards of HMO, DOI and NCQA. The evaluation shall include, but is not limited to, review of the Provider's program descriptions, work plans, annual evaluations, committee minutes, policies and procedures and as applicable, random sample file reviews to include credentialing and re-credentialing files. If the audit findings identify noncompliance with the designated standards, a plan of corrective action must be developed. Provider shall provide a copy of its policies and procedures and other documents related to performance of its delegated responsibilities to HMO on an annual basis upon request.

IV. Ongoing Monitoring Plan

HMO will monitor the Provider on an ongoing basis to identify opportunities for improvement. For delegation agreements that have been in effect for more than 12 months, HMO will work collaboratively with the Provider to identify and follow up on at least one opportunity for improvement annually, if applicable. Sources for identifying areas for improvement may include but are not limited to: pre-delegation evaluation, annual evaluation or ongoing reports.

Provider shall submit monthly/quarterly reports (as defined in the exhibits to this agreement) to HMO's Quality Management Director or designee.

Each Provider shall have a quarterly oversight meeting with the HMO. The meeting may be in person or telephonic. Quarterly oversight activities will be comprehensive in nature. In addition to the monthly oversight reports, special focus will be placed upon observed trends, the results of actions initiated by the Provider, and the result of corrective actions taken. The Provider

shall be required to submit a quarterly report summarizing the activities completed during the quarter. More frequent reports may be required from the Provider if the Provider is placed on a Corrective Action Plan ("CAP") as outlined by the HMO.

V. Corrective Action Plans

If HMO receives information through its monitoring plan and/or audit processes that Provider or its subcontractors are not operating in accordance with this Agreement, federal or State requirements and is operating in a condition that renders the continuance of its business hazardous to the Covered Persons, HMO shall request a written and signed CAP from Provider. Each CAP shall include, but not be limited to, the following:

1. Expected, measurable results indicating completion of the CAP.
2. Detailed action plan to complete activities required by the CAP.
3. Due date for completion of CAP.

A. Submission of the proposed CAP shall be made by Provider to HMO within two (2) weeks of the notification from HMO, with a written explanation by Provider of:

   1. the Provider's noncompliance that necessitated the CAP written agreement; or
   2. the existence of the condition that renders the continuance of Provider's business hazardous to Covered Persons.

B. Implementation of the CAP shall be completed within thirty (30) days of Provider's receipt of written approval of the proposed CAP by HMO, unless an alternative completion period is approved by HMO in writing. If the noncompliance has not been cured before the expiration of such period, HMO may, at its discretion, assess a penalty of up to one percent (1%) of the total capitation or compensation amount paid to Provider for the preceding calendar month. The amount of the penalty shall be deducted from the capitation or compensation payment(s) owed to Provider for the month following notice of the non-compliance or the expiration of the cure period, whichever is later. Such penalty shall continue to be assessed for subsequent months until such time as (1) the noncompliance is cured, or (2) either HMO or Provider notifies the other in writing of its intent that this Agreement be terminated or that the delegation of any of the activities be rescinded. The amount of such penalty shall be recalculated on a monthly basis to be equal to one percent (1%) of the capitation or compensation paid to Provider for the preceding month. The CAP shall accomplish the written expected results and such results must be validated by a HMO audit within the stated time frame. Failure of the Provider or any of its subcontractors to comply with this provision may result at HMO's discretion, the suspension or revocation of delegation.

C. HMO shall cooperate with Provider or its subcontractors to correct any failure by Provider to comply with the State Department of Insurance's regulatory requirements relating to any matters:

   1. delegated to Provider by HMO; or
   2. Necessary for HMO to ensure compliance with statutory and regulatory requirements.

D. HMO shall notify the State Department of Insurance and request intervention if:

   1. HMO does not receive a timely response from Provider as required above; or
   2. HMO receives a timely response from Provider as required above, but HMO and Provider are unable to reach an agreement as to whether Provider:
      a) is complying with the CAP; or
      b) has corrected any problem regarding a practice that is hazardous to Covered Persons of HMO.

When deficiencies are severe or unable to be resolved HMO reserves the right to withdraw the opportunity for or revoke the delegation arrangement.