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ACTION

- Revised Policy
- Superseding Policy Number: _____
- Repealing Policy Number: _____


POLICY:

1. Johns Hopkins Health Plans' credentialing criteria defines the criteria practitioners/ organizational practitioners must meet to be considered for inclusion into the Johns Hopkins Health Plans participating network.
2. The Johns Hopkins Health Plans credentialing process defines the procedure for processing an application, and for conducting verifications to ensure all the credentialing standards are met prior to presentation of the applicant to the Special Credentials Review Committee (SCRC).
3. The individual/organizational practitioner may send applications via email, fax, or hard copy. Upon receipt of an initial application, Johns Hopkins Health Plans' credentialing department will notify all individual practitioners of the intent to process the application according to the following timeframes:

For Incomplete Applications: When Johns Hopkins Health Plans receives an incomplete application from a practitioner, Johns Hopkins Health Plans will send the practitioner a 10-day letter. This letter goes to the practitioner within 10 calendar days of the receipt date of the incomplete application. It includes what information is missing from the credentialing application and the timeframes in which all completed information must be received by Johns Hopkins Health Plans in order to continue the application process. Once all necessary information is submitted, Johns Hopkins Health Plans has 30 days in which to inform the practitioner that the application will be processed.

For Complete Applications: When Johns Hopkins Health Plans receives a complete application from a practitioner, Johns Hopkins Health Plans will send the practitioner a 30-day letter. This letter goes to the practitioner within 30 days of the receipt date of the completed application. It notifies the provider that the application is complete and whether or not Johns Hopkins Health Plans will be processing the application or not.

4. Applications that have been submitted via the Council for Affordable Quality Healthcare (CAQH) are deemed by the Maryland Insurance Administration to be complete.
5. All initial applications will be processed within 120 days from the date the notification of intent to process the application (30-day letter) was sent to the practitioner.

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6. Johns Hopkins Health Plans will notify all practitioners/organizational practitioners of the outcome of their credentialing event within 60 days from the date of the SCRC decision.

7. Every individual/organizational practitioner will be re-credentialed at least every three (3) years. However, the SCRC may require that an individual/organizational practitioner be re-credentialed more frequently.

8. The Johns Hopkins Health Plans re-credentialing process includes the careful evaluation of the applicable information obtained through member complaints, quality improvement activities and other information, as appropriate, in order to determine if an individual/organizational practitioner should be granted continued participation.

9. All credentialing elements that require primary source verification must be collected within the 120 days prior to the SCRC review of the application.

10. The credentialing application must be signed and dated no more than 180 days prior to the SCRC review of the application.

11. Decisions that adversely affect a participating individual/organizational practitioner's status will be sent to the individual/organizational practitioner within 60 days of the decision, and may be appealed upon receipt of written request from the individual/organizational practitioner as set forth in the Johns Hopkins Health Plans Provider Discipline and Appeals Policy and Procedure (PCR.005).

12. Johns Hopkins Health Plans monitors participating individual/organizational practitioner's continued compliance with credentialing criteria between credentialing cycles.


SCOPE:

This policy applies to all individual/organizational practitioners applying for network participation as defined in Johns Hopkins Health Plans Policy PCR.001.

RESPONSIBILITIES:

Practitioners:

1. It is the responsibility of the individual/organizational practitioner to provide a complete application. Johns Hopkins Health Plans accepts the Maryland Uniform Credentialing Form (MUCF) as its credentialing application for individual practitioners. Individual practitioners may submit the MUCF through the Council for Affordable Quality Healthcare (CAQH) website, or submit a hard copy version of the MUCF. Individual practitioners in states other than Maryland may submit the standard CAQH credentialing application via either the web or hard-copy form. Organizational practitioners are required to submit the Johns Hopkins Health Plans facility credentialing application via hard-copy, fax or email.

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2. Each participating individual practitioner will be responsible for ensuring that a complete credentialing application is available via CAQH or submitted for re-credentialing. Failure to comply within the timeframe designated in the practitioner re-credentialing notification letter shall invoke the termination process as defined in PCR.004. An individual / organizational practitioner, whose participation status has been terminated for any reason, may re-apply to the network as an initial applicant in accordance with the initial credentialing procedures. However, the individual/organizational practitioner must wait one year from the termination to reapply to the network.

Network Managers:


1. Solicit new applicants for participation based upon individual/organizational practitioner specialty and network need in specific geographic regions; and,
2. Review unsolicited individual/organizational practitioner applications to determine if applicant's specialty is currently needed in that area; and,
3. When there is no network need, send written notification to the applicant and return the application with the notification/letter.

Provider Maintenance Department:

1. Enter new applicant information into the appropriate practitioner databases; and,
2. Update practitioner demographic and contractual information in the appropriate practitioner databases during the re-credentialing cycle; and
3. Terminate practitioners in the appropriate practitioner databases at the request of either the Provider Relations Department or the Credentialing Department.

Provider Relations Department:

1. Execute new individual/organizational practitioner contracts, as applicable, at the conclusion of a successful initial credentialing cycle.
2. Notify new individual/organizational practitioners of their successful completion of the contracting process. This notification must be within 60 days of the date of approval by SCRC or Johns Hopkins Health Plans Medical Directors.
3. Investigate individual/organizational practitioner relationships with Johns Hopkins Health Plans when an individual/organizational practitioner fails to comply with re-credentialing requests, and to submit requests for termination if it is determined that an individual/organizational practitioner no longer has a valid contractual relationship with Johns Hopkins Health Plans.


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Credentialing Department:

1. Ensure that the credentialing processes described in this policy are completed in a timely and efficient manner for all practitioners.
2. Notify the Senior Director of Provider Relations promptly, in writing, of the adverse actions taken by the SCRC.
3. It is the responsibility of the Credentialing Manager to ensure that all individual/organizational practitioners being presented to the SCRC for approval meet the criteria in this policy.
4. The Credentialing Manager ensures that all reporting agencies are reviewed for adverse information and disciplinary activities against participating practitioners within the Johns Hopkins Health Plans network. The designated credentialing staff person presents to the SCRC any practitioner who is deemed to pose a significant risk regarding patient safety or substandard medical care.
5. Notify new individual/organizational practitioners of their successful completion of the credentialing process, and forward appropriate materials including information for accessing the practitioner manual. This notification must be within 60 days of the date of approval by SCRC or Johns Hopkins Health Plans Medical Directors.

Credentialing Application and Criteria Review for Individual Practitioners – Initial and Re-credentialled Applicants:


1. All applications for initial participation are forwarded to the Provider Relations department for review of network need and contractual relationship between the individual practitioner and Johns Hopkins Health Plans. All re-credentialing applications are obtained by the Credentialing Department.
2. The Provider Relations Department forwards all initial individual practitioner applications to the Provider Maintenance Department to enter demographic information into the appropriate practitioner databases. Provider Maintenance forwards the application to the Credentialing Department for processing.
3. Upon receipt of an applicant's initial or re-credentialing application and supporting documentation, a credentialing staff person reviews the application for completeness and appropriateness of supporting documentation. An application shall be deemed complete if:
 - a.) material demographic information is provided (e.g., service location, phone numbers, NPI, name, mailing address(es), etc.); and
 - b.) material credentialing information is provided (e.g., license(s), education and training, professional and/or medical certifications, etc.); and,
 - c.) responses to all disclosure questions are provided (e.g., adverse actions on license, hospital privileges, Medicare/Medicaid participation, professional liability claims history, etc.); and,
 - d.) work history for past five (5) years is included on initial applications, and provided via an up-to-date CV, including explanations for any gaps greater than 6 months in duration; and
 - e.) application attestation is signed by the applicant and dated; and

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- f.) includes a photocopy of Professional Liability Insurance certificate
4. If the application is incomplete, written notification is sent within 10 days of receipt of the application to the individual practitioner that explains what information is missing or is incomplete from the application, and how the applicant can remedy the situation.
 5. If the application is complete, written notification is sent within 30 days that the application has been accepted and a final decision will be rendered within 120 days.
 6. The credentialing staff person conducts a criteria review to determine if the applicant minimally meets the criteria for acceptance as described in this policy.
 7. If the applicant meets the criteria, the application is accepted and the credentialing process is initiated.
 8. If the applicant does not meet the criteria, the credentialing specialist reviews the applicant's information to determine if either alternate or exception criteria may be met.
 9. If the applicant meets the alternate criteria or exception criteria, then the application is accepted and the credentialing process is initiated.
 10. The Credentialing Manager may administratively deny the applicant for participation in the Johns Hopkins Health Plans network if any of the following adverse actions is in place at the time of application: a.)The applicant's license to practice has been revoked by the State or federal agency; or, b.)The applicant's license to practice has been restricted (may not be on probation, surrendered, or suspended) by the State or federal agency; or, c.)The applicant's DEA or CDS certificate has been revoked or suspended; or, d.) The applicant's Medicare/Medicaid participation has been terminated or limited.
 11. The Credentialing Manager may administratively deny the applicant for participation in the Johns Hopkins Health Plans network if the applicant does not meet criteria (standard, alternate or exception) including but not limited to:
 - a.) License is not appropriate for independent practice; or
 - b.) Insufficient amounts of professional liability coverage; or
 - c.) No collaborative agreement (for Nurse Practitioners and Physician Assistants) with a participating physician
 12. If the Credentialing Manager administratively denies the applicant, notification is sent by First Class Certified U.S. Postal Service to the applicant within 30 days of receipt of the completed application.

Credentialing Application and Criteria Review for Organizational Practitioners- Initial and Re-credentialed Applicants:


1. When an organizational practitioner is identified by the Provider Relations Department for participation with Johns Hopkins Health Plans the following will be obtained for each servicing location from the administrator or other authorized representative of the organization:
 - a.) A complete, signed and dated Johns Hopkins Health Plans Facility Application, and;
 - b.) Evidence of current licensure to operate in the state in which the organization is located, and;

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- c.) Evidence of accreditation by a recognized accrediting body (e.g., JCAHO, CARF, AAAHC), or;
 - d.) Copy of CMS or state review, and;
 - e.) Evidence of Medicare and Medicaid Certification as applicable (for participation with the Medicare Advantage line of business) as verified via the CMS participation agreement , and;
 - f.) Evidence of Medicaid certification as applicable (for participation with the Priority Partners line of business), and;
 - g.) Evidence of adequate professional liability insurance coverage of at least \$1 million per incident and \$3 million aggregate
2. Hospitals and skilled nursing facilities applying for initial participation must have a hospital/ SNF quality rating of a 3 or higher as verified through CMS. Quality ratings below a level 3 are considered a risk and shall be subject to review and decision by the SCRC.
 3. The Provider Relations Department will forward the organizational practitioner application to the Provider Maintenance Department to enter demographic information into the appropriate practitioner databases. Provider Maintenance will forward the application to the Credentialing Department for processing.
 4. If the application is complete and acceptable, the Credentialing Department begins the credentialing cycle for the organizational practitioner.
 5. If the application is incomplete, notification is sent to the organizational practitioner informing them of the missing documents and/or information within 10 days of receipt of the application. The credentialing coordinator also notifies the network manager in the Provider Relations Department.

I. CRITERIA FOR INDIVIDUAL PRACTITIONER PARTICIPATION [(Clean File) Initial Credentialing event]:

- A. For all applicants:** All applicants must meet the following criteria:
1. The applicant must currently be engaged in active clinical practice.
 2. The applicant must possess a current, valid, unrestricted (may not be on probation, surrendered, or suspended) license to practice independently (vendor-eligible) in the state in which service is rendered.
 3. The applicant must possess current, adequate professional liability insurance coverage of at least \$1 million per incident and \$3 million aggregate; or is covered under the terms of the Federal Tort Claims Act (FTCA).
 4. The applicant must attest to the absence of present illegal drug use.
 5. The applicant must attest to the absence of adverse professional liability history.
 6. The applicant must attest to the absence of adverse criminal history. Minor traffic violations are exempted.
 7. The applicant must have valid, current, unrestricted (may not be on probation, surrendered, or suspended) participation in Medicare (for Medicare Advantage line of

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- business),and Medicaid (for Priority Partners line of business) programs as verified via the CMS participation agreement, or via online verification.
8. The applicant must attest to the absence of a history of professional disciplinary action, including revocation, suspension or restriction in any training or residency programs, state licensing board, professional societies, and clinical privileges at a hospital or facility.
 9. **Note:** EPSDT certification verification is done for all PCP practitioners treating patients under the age of 21 who are participating with the Priority Partners line of business. Although, EPSDT certification is not required for participation, a letter to those practitioners who are not EPSDT is required. See verification sources section of this policy.
 10. **NOTE:** A Medicare Opt Out list verification, Medicare Preclusion List verification, and CMS participation agreement verification, is performed for all practitioners participating with the Medicare Advantage line of business.
- B. For Medical Doctor (M.D.) / Doctor of Osteopathy (D.O.)/ Podiatrists (D.P.M.)/ Dentists/Oral Surgeons (D.D.S.):** All applicants must meet the criteria above (I.A) and the following additional criteria:
1. The applicant must have graduated from an accredited school of medicine, osteopathy, or dentistry as determined by their specialty, or successful completion of examination given by the Educational Commission for Foreign Medical Graduates (ECFMG).
 2. The applicant must have completed an accredited clinical postgraduate training program/residency (DPM's and DDS/ DMD excluded).
 3. The applicant must be board certified or be an active candidate for the board for the specialty for which the applicant is seeking participation (e.g., American Board of Medical Specialties, the American Osteopathic Association Specialties, the American Board of foot and Ankle Surgery (ABFAS), the American Board of Podiatric Medicine (ABPM), the American Board of Oral and Maxillofacial Surgery (ABOMS).
 4. The applicant must have admitting privileges in good standing at a Johns Hopkins Health Plans participating hospital/facility. The admitting privilege requirement is waived if the physician is practicing at an urgent care center only, or practices under one of the following specialties.
 5.
 - a.)Allergy/Immunology; or
 - b.)Dermatology; or
 - c.)Medical Genetics; or
 - d.)Occupational Medicine; or
 - e.)Ophthalmology; or
 - f.)Physical Medicine & Rehabilitation; or
 - g.)Sleep Medicine; or
 - h.)Psychiatry
 - i.) Radiologists and Pathologists* (Radiologists and pathologists are credentialed for the Medicare Advantage line of business only. If the practitioner states on the application

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they have current privileges at a par hospital, the privileges must be verified. If the practitioner does not attest to having privileges, nothing is verified , and the file is considered to meet standard criteria.)

Applicants who are required to but do not meet the criteria above for admitting privileges at par facility may be accepted for participation if the applicant meets the following additional criteria:

- a.)The applicant has clinical privileges in good standing at a Johns Hopkins Health Plans participating hospital or;
 - b.)Provides evidence of how patients are referred to inpatient treatment service at a participating facility and;
 - c.)When risk indicators related to work history are present on the application: Has two letters of reference attesting to the applicant’s clinical competence completed by peers of equal or higher level. **Note:** For recent graduates, letters of reference may be obtained from the residency program director, and any other physician with whom the practitioner worked during their residency. References must be performed by peers with at least one year’s knowledge of the applicant’s clinical performance.
6. The applicant must possess a current and valid DEA certificate authorizing a full schedule (2, 2N, 3, 3N, 4, 5). Radiologists and pathologists are exempted from this requirement. If a radiology or pathology practitioner holds DEA licensure, it must be verified. If they do not have DEA licensure, or do not have a full drug schedule, they are still considered as meeting standard criteria.
 7. The applicant must possess a current and valid CDS certificate. Radiologists and pathologists are exempted from this requirement. If a radiology practitioner holds CDS licensure, it must be verified. If they do not have CDS licensure, they are still considered as meeting standard criteria.
 8. For a physician to be listed as a **Primary Care Provider (PCP)** in the Johns Hopkins Health Plans directory, the applicant must hold current medical board certification in one of the following specialties: Family Medicine, Family Practice, Internal Medicine, Gynecology, Geriatrics, or Pediatrics. Practitioners with the designated specialty of General Practice may also be listed as a PCP.
 9. For a physician to be listed as a **Specialist** in the Johns Hopkins Health Plans directory, the applicant must be board certified in a specialty through the, American Board of Medical Specialties (ABMS) and its member boards, or the American Osteopathic Association (AOA).
- C. For All Nurse Specialties (NP-C, APRN, ARNP, ACNPC, CNP, CPNP, CRNP, CNM):** All applicants must meet the criteria above (I.A) and the following additional criteria:
1. The applicant must have a Master’s degree in nursing from an accredited postgraduate school with certification in a field of primary care. For midwives- The applicant must be a graduate of a nurse midwifery program accredited by the American Midwifery Certification Board (formerly known as the American College of Nurse Midwives Certification Council.)

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2. The applicant must be board certified for the board for the specialty for which the applicant is seeking participation (e.g., American Nurses Credentialing Center, American Academy of Nurse Practitioners, National Certification Corporation.).
 3. The applicant must possess a current and valid DEA certificate authorizing a full schedule (2, 2N, 3, 3N, 4, 5).
 4. The applicant must possess a current and valid CDS certificate.
 5. The applicant must demonstrate current experience and documented ability to provide patient care services at the level of quality and efficiency acceptable to Johns Hopkins Health Plans.
 6. The applicant must provide evidence of a collaborative agreement, if required by state law, with a Johns Hopkins Health Plans-participating practitioner specializing in the same or related field of practice in which the applicant is certified for each group in which they are affiliated with Johns Hopkins Health Plans. Note: The State of Maryland requires that all newly certified nurse practitioner licensees have a collaborating practitioner for the first 18 months of licensure. Johns Hopkins Health Plans requires evidence of this collaborating practitioner for all initial applicants who have been licensed for less than 18 months. The collaborating practitioner must be a Johns Hopkins Health Plans-participating physician specializing in the same or related field of practice in which the applicant is certified.
 The applicant must submit two letters of professional references attesting to the applicant's clinical competence when risk indicators related to work history are present in the application. Each of the letters of professional reference must be from a nurse practitioner of the same specialty, or from a physician. References must be performed by peers with at least one year's knowledge of the applicant's clinical performance. References are not required on the recertification cycle.
 - a. If the nurse has no admitting privileges or is not credentialed at a participating facility they must provide evidence of how patients are referred to inpatient treatment service at a participating facility.
 7. For a nurse practitioner to be listed as a **Primary Care Provider (PCP)** in the Johns Hopkins Health Plans directory, the applicant must hold certification in one of the following primary care areas: Acute care, adult health, college health, community health, family health, gerontology, maternal/child, obstetrics/gynecology, pediatrics, gerontology; or any other category recognized by the State of Maryland as an acceptable field of practice/specialty for a PCP.
- D. For Physician Assistants (PA-C):** All applicants must meet the criteria above (I.A) and the following additional criteria:
1. The applicant must have a baccalaureate or higher degree in any field from an accredited college or university.
 2. The applicant must be a graduate of an accredited Physician Assistant program.
 3. The applicant must be board certified by the National Commission on Certification of Physician Assistants.


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4. The applicant must possess a current and valid DEA certificate authorizing a full schedule (2, 2N, 3, 3N, 4, 5).
 5. The applicant must possess a current and valid CDS certificate.
 6. The applicant must demonstrate current experience and documented ability to provide patient care services at the level of quality and efficiency acceptable to Johns Hopkins Health Plans.
 7. The applicant must provide evidence of a collaborative agreement with a Johns Hopkins Health Plans-participating physician for each group in which they are affiliated with Johns Hopkins Health Plans.
 8. A physician assistant may be listed as a **Primary Care Provider (PCP)** in the Johns Hopkins Health Plans directory.
- E. **For Chiropractors (D.C.)/ Optometrists (O.D.)/ Clinical Psychologists (Ph.D., Psy.D., Ed.D.)/ Clinical Social Workers (LCSW-C)/ Professional Counselor in Mental Health/ Marriage and Family Therapist/ Physical Therapist, Audiologist, Speech Therapist, Occupational Therapist, Respiratory Therapist, Acupuncturist, Board Certified Behavior Analysts** : All applicants must meet the criteria above (I.A) and the following additional criteria:
1. The applicant must have graduated from an accredited college in their specialty.
 2. The applicant must have successfully passed the national examination for their specialty.
 3. The applicant must demonstrate current experience and documented ability to provide patient care services at the level of quality and efficiency acceptable to Johns Hopkins Health Plans, in their specialty.

II. CRITERIA FOR ORGANIZATIONAL PRACTITIONER PARTICIPATION [(Clean File) Initial Credentialing Event]:


A. Acute and Long-Term Care Hospitals, Psychiatric Hospitals, and Facility-Based Partial Hospitalization Psychiatric and Addictions Programs, Skilled Nursing Facilities, Free Standing or Ambulatory Surgical Centers, Ambulatory Mental Health and Addiction Disorder Centers/Programs, Home Health Agencies (HHA), Radiology Facilities, Birthing Centers, Dialysis, (and for Medicare Advantage only) Durable Medical Equipment, Laboratory Facilities, Rural Health Clinics, Federally Qualified Health Centers, Diabetes Self Management Facilities, Outpatient Speech Pathology Facilities, Outpatient Physical Therapy Facilities, Comprehensive Outpatient Rehabilitation Facilities, Portable X-ray Suppliers:

1. The organization must currently be engaged in active clinical practice.
2. The organization must possess a current, valid, unrestricted (may not be on probation, surrendered, or suspended) license to practice in the state in which service is rendered, if applicable.
3. The organization must possess current, adequate professional liability insurance coverage which meets the \$1 million per incident/\$3 million aggregate minimum coverage requirement or is covered under the terms of the Federal Tort Claims Act

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(FTCA). Mcare is also accepted for providers rendering services in the State of Pennsylvania.

4. The organization must have valid, current, unrestricted (may not be on probation, surrendered, or suspended) participation in Medicare and Medicaid programs as applicable, or be eligible to participate in such programs, as verified via the CMS participation agreement. *Medicare participation is required for the Medicare Advantage line of business. Medicaid participation is required for the Priority Partners line of business.*
5. The organization must attest to the absence of a history of disciplinary actions including revocation, suspension or restrictions by any accreditation entity, state licensing board, or Federal agency.
6. All applicants must be accredited by one of the following nationally recognized bodies:
 - a.) Joint Commission (JCAHO)
 - b.) American Association for Ambulatory Health Care (AAAHC)
 - c.) National Integrated Accreditation for Healthcare Organizations (NIAHO)
 - d.) Det norske Veritas (DNV)
 - e.) Commission of Accreditation of Rehabilitation Facilities (CARF)
 - f.) Community Health Accreditation Program (CHAPS)
 - g.) American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
 - h.) Accreditation Association for Hospitals and Health Systems (AAHHS)
 - i.) Center for Improvement in Healthcare Quality (CIHQ)
 - j.) National Dialysis Accreditation Commission (NDAC)
 - k.) The Compliance Team (TCT)
 - l.) Healthcare Facilities Accreditation Program (HFAP)
 - m.) Accreditation Commission for Health Care Inc (ACHC)
 - n.) American College of Radiology (ACR)
 - o.) American Board of Certification (ABC)
7. Hospitals and skilled nursing facilities applying for initial participation must have a hospital/ SNF quality rating of a 3 or higher as verified through CMS. Quality ratings below a level 3 are considered a risk and shall be subject to review and decision by the SCRC.
8. If the organization is not accredited, they must submit to a site visit conducted by Johns Hopkins Health Plans, or submit to Johns Hopkins Health Plans a copy of their CMS or state review. NOTE: This does not apply to some facility types. Radiology facilities must be accredited by the American College of Radiology, hospitals must be accredited by The Joint Commission, Durable Medical Equipment suppliers must be accredited by either Accreditation Commission for Healthcare (ACHC), Community Health Accreditation Program (CHAP), The Joint Commission, or the American Board of Certification; and Laboratory facilities must be accredited by either The Joint Commission or the College of American Pathologists.
9. The organization must maintain clinical records on all patients.

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10. The organization must have clinical oversight by a participating physician or Advanced Practice Nurse.

*Note: Radiology facilities offering x-ray services only are required to submit their Department of the Environment certificate only.

Laboratory facilities are required to submit a copy of the current CLIA certificate.

Note: A Medicare Opt Out list verification, and CMS participation agreement verification, is performed for organizational practitioners participating with the Medicare Advantage line of business.

III. CRITERIA FOR ONGOING INDIVIDUAL AND ORGANIZATIONAL PRACTITIONER PARTICIPATION (Re-Credentialing Event):

A. At least six (6) months prior to the expiration of the individual/ organizational practitioner’s current cycle, they will be notified to submit an application and required documentation, or the application is pulled from the CAQH website, or a MUCF/ Johns Hopkins Health Plans Facility Credentialing Application is obtained via email, fax or hard copy. The re-credentialing process follows the same as stated above in I. Credentialing Application and Criteria Review - Initial Applicants.

B. In addition, the individual/ organizational practitioner must meet acceptable quality assessment and utilization standards.

1. Credential: Quality of Care or Grievance Issues

a.) Criteria: No reportable activity related to patient safety

b.) Source: Credentialing database


c.) Process: Johns Hopkins Health Plans reviews all entries to verify no history of complaints

C. Individual/ organizational practitioners are required to have no quality of care issues, member complaints or off-site quality complaints, but may be accepted for ongoing participation if review of all complaints by the Johns Hopkins Health Plans Chief Medical Officer or designee determines that there is not a pattern of adverse behavior or clinical judgment. These individual/ organizational practitioners may be presented to SCRC for final determination.

D. Failure to comply with the re-credentialing process will result in termination of network participation.

IV. ALTERNATE CRITERIA FOR INDIVIDUAL PRACTITIONER PARTICIPATION (With Issues):

A. Applicants who do not meet the criteria above for absence of **Professional Liability History** may be accepted for participation if review of all liability cases by Legal Counsel and Johns Hopkins Health Plans Chief Medical Officer or designee determines that there is not a pattern of adverse behavior or clinical judgment.

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- B. Applicants who do not meet the criteria above for absence of **Adverse Criminal History** may be accepted for participation if review of all adverse criminal cases by Legal Counsel and Johns Hopkins Health Plans Chief Medical Officer or designee determines that:
1. The act was a misdemeanor which does not relate to the delivery of health care nor in which fraud, dishonesty, violence, or moral turpitude was involved; or,
 2. The act was a court-martial for actions not related to duties as a medical professional.

- C. Applicants who do not meet the criteria above for **DEA or CDS registration** may be accepted for participation if review by Johns Hopkins Health Plans Chief Medical Officer or designee determines that the applicant's lack of prescriptive authority does not restrict their ability to render appropriate services within the scope of their licensure.


- D. Applicants who do not meet the criteria above for the absence of **Adverse History of Professional Disciplinary Actions** may be accepted for participation if review of all adverse privilege and professional history by Legal Counsel and Johns Hopkins Health Plans Chief Medical Officer or designee determines that:
1. All license and clinical privilege disciplinary action was more than 5 years ago; or,
 2. Review of all disciplinary actions does not show patterns of adverse behavior or clinical judgment.

Note: An exception to this rule applies for the USFHP line of business only. USFHP practitioners identified as not having a full clinical practice level shall be immediately denied/terminated upon identification of the license action.

- E. Applicants who are required to but do not meet the criteria above for **Board Certification** may be accepted for participation if the applicant is located in a medically underserved geographic area, and meets one or more of the following criteria:
1. Has obtained board certification in the past, but that certification has subsequently expired, or has never been board certified, is in a re-credentialing cycle and;
 2. Holds admitting privileges in their specialty at a Johns Hopkins Health Plans participating facility;
 3. Has completed a residency and/or fellowship in the specialty for which he/she is applying to Johns Hopkins Health Plans
 4. Has no history of quality issues

Note: Re-credentialed providers with no admitting privileges, or that were required to obtain re-certification at the last credentialing cycle, but failed to do so, will be approved with the specialty of General Practice only. Re-credentialed providers that have never been board certified will be reviewed by the SCRC once, with that decision honored each subsequent credentialing cycle as long as they meet the same criteria statements listed in the initial risk assessment form.

- F. Applicants requiring consideration for alternate criteria are required to submit an up-to-date copy of their C.V.

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V. EXCEPTION CRITERIA FOR INDIVIDUAL PRACTITIONER PARTICIPATION (Requires SCRC Review):

- A. Applicants who do not meet the alternate criteria above for absence of **Adverse Criminal History** and do not meet the alternate criteria may be accepted for participation by exception if the SCRC determines that a review of all criminal history does not show patterns of adverse behavior or clinical judgment.
- B. Applicants who do not meet the alternate criteria above for the absence of **Adverse History of Professional Disciplinary Actions** and do not meet the alternate criteria may be accepted for participation by exception if the SCRC determines that a review of all privileging and disciplinary actions does not show patterns of adverse behavior or clinical judgment.


Note: An exception to this rule applies for the USFHP line of business only. USFHP practitioners identified as not having a full clinical practice level shall be immediately denied/ terminated upon identification of the license action

- C. Applicants who do not meet the alternate criteria above for **DEA or CDS registration** may be accepted for participation if review by the SCRC determines that the applicant’s lack of prescriptive authority does not restrict their ability to render appropriate services within the scope of their licensure.
- D. Applicants who do not meet the criteria for board certification may be accepted for participation on a case by case basis by the SCRC. Applicant participation will be granted based upon geographic need. Applicant specialty will be granted based upon education/ training and admitting privileges in the requested specialty. The SCRC may grant the designation of General Practice to practitioners, including but not limited to those requesting PCP specialties of Internal Medicine, Family Medicine, Geriatrics and Pediatrics.
- E. Any other applicants where Legal Counsel and Johns Hopkins Health Plans Chief Medical Officer determines there could be a significant risk. These will be reviewed and discussed by the SCRC on a case by case basis.
- F. Applicants requiring consideration for exception criteria are required to submit an up-to-date copy of their C.V.


VI. VERIFICATION SOURCES USED:

- A. **The Credentialing Department completes the following verifications for individual practitioners (Initial and Re-credentialed Applicants):**

- 1. Credential: State licensure

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- a.) Criteria: Current and unrestricted (may not be on probation, surrendered, or suspended) license in state(s) where practitioner will be rendering services.
 - b.) Source: Issuing Board/Office
 - c.) Process: Verifications are performed via internet website maintained by the licensing board or its agent, letter from issuing office, telephonic verification between Johns Hopkins Health Plans staff member and representative of issuing office, or printed/electronic rosters provided directly from the issuing office. Image of verification from issuing agency will be placed within database record.
2. Credential: State licensure disciplinary actions/sanctions
- a.) Criteria: History of licensing boards/agencies disciplinary actions against the practitioner in any state where the applicant has practiced within the past 5 years.
 - b.) Source: Issuing Board/Office; Federation of State Medical Boards (FSMB), HIPDB
 - c.) Process: Disciplinary Actions will be verified via internet website maintained by the licensing board or its agent, letter from issuing office, telephonic verification between Johns Hopkins Health Plans staff member and representative of issuing office, or printed/electronic rosters provided directly from the issuing office. Alternatively, an FSMB report may be used for physicians. A query against the Healthcare Integrity and Protection Data Bank (HIPDB) may be used for all other applicants in lieu of state licensing board reports. Image of verification will be placed within database record.
3. Credential: Drug Enforcement Administration (DEA) Certificate
- a.) Criteria: Current and unrestricted (may not be on probation, surrendered, or suspended) registration displaying full schedule (2, 2N, 3, 3N, 4, 5) for each state in which the applicant will be seeing members.
 - b.) Source: National Technical Information Service (NTIS) database query (internet) or copy of current registration certificate. In lieu of a DEA registration, the provider must submit a statement that explains why the provider does not have a full schedule registration or does not need a DEA registration.
 - c.) Process: Registration will be verified through NTIS website or submission of a copy of the applicant's current registration certification. Image of verification will be placed within the database.
4. Credential: Controlled Dangerous Substances (CDS) Certificate, where applicable
- a.) Criteria: Current and unrestricted (may not be on probation, surrendered, or suspended) registration from each state where applicable and where applicant will be seeing members.
 - b.) Source: Copy of current registration certificate or review/query of state-issued reports. In lieu of a CDS registration, the provider must submit a statement that explains why the practitioner does not need a CDS registration.
 - c.) Process: A copy of the applicant's current registration certification. Image of verification will be placed within the database. Alternatively, a review of periodic roster reports from State


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issuing agencies (such as the Department of Health and Mental Hygiene/Division of Drug Control for the State of Maryland) listing all CDS registrants may be used. Confirmation of the review will be noted in the database by the staff person who conducted the verification.

5. Credential: Specialty Board Certification
 - a.) Criteria: Current medical board specialty certification is required, or applicant must be active candidate for the board examination.
 - b.) Source: American Board of Medical Specialties (ABMS), American Osteopathic Agency (AOA), American Board of Podiatric Surgeons (ABPS), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM), American Board of Oral and Maxillofacial Surgery (ABOMS), American Board of Foot and Ankle Surgery (ABFAS), American Nurses Credentialing Center, American Academy of Nurse Practitioners, National Certification Corporation, National Commission on Certification of Physician Assistants (as applicable), or its agent
 - c.) Process: Verifications are performed via internet website maintained by the issuing agency or its agent, a letter from issuing agency, a telephonic verification between Johns Hopkins Health Plans staff member and representative of issuing agency, or printed/ electronic rosters provided directly from the issuing agency. Image of verification from issuing agency will be placed within the database record. *Note: If a chiropractor lists on their application that they are board certification, that certification must be verified.

6. Credential: Medical or Professional Education and Training
 - a.) Criteria: Highest degree awarded to meet the requirements of state licensure. Successful completion of an accredited residency and/or fellowship program when applicable. Successful completion of post-graduate clinical experience for allied health professionals.
 - b.) Source: Practitioner application, board certification verification, and/ or license verification.
 - c.) Process: Verifications are performed via internet website maintained by the institution or its agent, a letter from institution, a sealed transcript from the institution, or a telephonic verification between Johns Hopkins Health Plans staff member and representative of institution. Image of verification from issuing agency will be placed within the practitioner database.
 Note: May use Medical Board Certification, State licensing agencies, or professional certification associations (such as the American Psychology Association for clinical psychologists) verification to meet this credential if the issuing agency/board/ association primary source verifies the education and training as part of its certification or licensing process.

7. Credential: Malpractice History
 - a.) Criteria: Absence of malpractice settlements.
 - b.) Source: National Practitioner Data Bank (NPDB) or report from insurer.
 - c.) Process: A review of the disclosure questions regarding malpractice history on the credentialing application will be reviewed. Any voluntary disclosure of malpractice suits,

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whether or not monies were paid, will be considered. Additional documentation to support legal activity may be requested from the practitioner, the practitioner’s attorney, or the practitioner’s liability insurer. Verification of absence of malpractice claims (in which monies were paid) will be conducted by querying the NPDB. An image of report will be placed within the database record.

8. Credential: Medicare/Medicaid Sanctions
 - a.) Criteria: Absence of restrictions or disbarment for participation in Medicare or Medicaid programs.
 - b.) Source: National Practitioner Data Bank (NPDB) and Office of the Inspector General (OIG) List of Excluded Individual/Entities (LEIE).
 - c.) Process: Verification of absence of Medicare/Medicaid disbarment/disciplinary actions will be conducted by querying the NPDB. Additionally, an internet query against the OIG LEIE will be conducted. An image of the NPDB report and LEIE result report will be placed within the database record.

9. Credential: Professional Disciplinary History
 - a.)Criteria: Absence of professional disciplinary actions such as restrictions on clinical privileges by hospitals or facilities, reprimands or exclusions by professional societies, reprimands by educational and training entities.
 - b.)Source: National Practitioner Data Bank (NPDB), and Healthcare Integrity and Protection Data Bank (HIPDB)
 - c.)Process: A review of the disclosure questions regarding professional history on the credentialing application will be reviewed. Any voluntary disclosure of adverse actions will be considered. Additional documentation to support the findings of these actions may be requested from the practitioner, the practitioner’s attorney, or the entity that took the disciplinary action against the practitioner. An image of report will be placed within the database record.

10. Credential: Criminal History/National Sex Offender Registry
 - a.)Criteria: No activity reported on the National Criminal search or the National Sex Offender Registry. Minor traffic violations excluded.
 - b.)Source: HireRight ©
 - c.)Process: Verification of absence of criminal history via internet query to reputable reporting source. An image of the report will be placed within the database record.
 - d.)Applies to: USFHP applicants who will be treating patients under the age of 21

11. Credential: Admitting Privileges
 - a.) Criteria: Admitting privileges in good standing at a participating facility. Alternately, attestation of how patients are referred to participating facilities for inpatient care.
 - b.) Source: Facility’s Medical Staff Office or its equivalent.

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c.) Process: Verification of admitting privileges in good standing including specialty in writing from the facility, or via internet-query against the facility’s website, or internet query to the facility’s proxy, or telephonic confirmation from the facility. An image of the verification will be placed within the database record.

Note: If the provider does not have admitting privileges, then the practitioner must demonstrate the means of obtaining inpatient care at a participation facility for his/her patients.

12. Credential: Professional Liability Insurance Coverage

a.) Criteria: Practitioner must have current and adequate professional liability/malpractice insurance coverage with limits of at least \$1 million per incident and \$3 million aggregate, or demonstrate coverage under the Federal Tort Claims Act (FTCA).

b.) Source: Copy of insurance certificate required to list the applicant as the insured or evidence that the applicant is covered under a group policy.

c.) Process: An image of the certificate will be placed within the database record.

13. Credential: Work History

a.) Criteria: Uninterrupted relevant clinical experience for past 5 years, or if less than 5 years, from the time of initial licensure for this profession.

b.) Source: Credentialing Application

c.) Process: Review of practitioner’s application, curriculum vitae or resume to determine 5 years of clinical experience without gaps. Any gap greater than 6 months requires explanation. Explanation may be submitted verbally or in writing. Any gap greater than 1 year requires written explanation. For applicants with less than 5 years of experience, review must include time period from issuance of licensure to current. An image of the verification will be placed within the database record. Gaps less than 6 months do not require explanation, and do not constitute a risk.

14. Credential: Professional References

a.) Criteria: If the practitioner has a gap in work history six months or greater, then two “Letters of Reference” (LOR) from peer clinicians attesting to the clinical competence of the applicant must be obtained.


b.) Source: Johns Hopkins Health Plans Reference form or written letter completed by the reference.

c.) Process: Send letter of reference forms directly to the applicant to have his/her peers complete. Review LOR submitted to ensure that peer reference attests to the clinical competence of the applicant. An image of the verification will be placed within the database record.

15. Credential: Collaborative Agreement

a.) Criteria: Evidence of Collaborative Agreement for Advance Practice Nurses and Physician Assistants with a participating physician.

b.) Source: Self-attestation

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c.) Process: The applicant must provide evidence of a collaborative agreement, if required by state law, with a Johns Hopkins Health Plans-participating practitioner specializing in the same or related field of practice in which the applicant is certified for each group in which they are affiliated with Johns Hopkins Health Plans. Note: The State of Maryland requires that all newly certified nurse practitioner licensees have a collaborating practitioner for the first 18 months of licensure. Johns Hopkins Health Plans requires evidence of this collaborating practitioner for all initial applicants who have been licensed for less than 18 months. The collaborating practitioner must be a Johns Hopkins Health Plans-participating physician specializing in the same or related field of practice in which the applicant is certified.

16. Credential: Directed Inpatient Referral Form

a.) Criteria: Evidence from applicant of how inpatient care is obtained for patients when practitioner has no admitting privileges at a Johns Hopkins Health Plans participating facility.

b.) Source: Practitioner application or Directed Inpatient Referral Form

c.) Process: Review of application, verbal confirmation or Directed Inpatient Referral Form that demonstrates the means by which the applicant refers patients to inpatient levels of care.

17. Credential: EPSDT Certification

a.) Criteria: Evidence of EPSDT certification is obtained for all PCP practitioners treating patients under the age of 21 participating with the Priority Partners line of business.

b.) Source: EPSDT Verification Spreadsheet

c.) Process: Review of spreadsheet for practitioner name. If practitioner is not on the log, the practitioner's name is recorded on the weekly EPSDT verification log, and an EPSDT letter is sent to the practitioner asking them to obtain the EPSDT certification. If the practitioner's name appears on the spreadsheet, they are already EPSDT certified and no letter is necessary. The verification is captured in the credentialing database.


18. Credential: Medicare Eligibility

a.) Criteria: Evidence provider is eligible to participate with Medicare programs.

b.) Source: Online Medicare Opt Out listing, online Medicare Preclusion list, and Office of Inspector General (OIG) list of Excluded Individuals (LEIE)

c.) Process: Review spreadsheet for practitioner name. The verification is captured and data entered in the database. Data entry is performed under Medicare/ Medicaid sanctions in the database. If provider appears on the Medicare Opt Out list, Medicare preclusion list, or LEIE, they may not participate with the Medicare Advantage line of business.

19. Credential: Medicare Participation

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- a.) Criteria: Evidence provider holds an active participation agreement with Medicare programs.
- b.) Source: Online or hard copy of CMS participation agreement
- c.) Process: Search the Medicare website for practitioner name. Image verification to database record and perform data entry. If not found on Medicare website, request a hard copy of the CMS participation agreement from the practitioner, image to the database record, and perform data entry. If unable to verify that a CMS participation agreement exists, the practitioner may not participate with the Medicare Advantage line of business.

20. Credential: Medicaid Participation

- a.) Criteria: Evidence provider holds an active participation agreement with Medicaid programs.
- b.) Source: Online
- c.) Process: Search the Medicaid website for practitioner name. Image verification to database record and perform data entry. If not found on Medicaid website, practitioner may not participate in Priority Partners line of business.

B. The credentialing department completes the following verifications for organizational practitioners:


1. Credential: State facility licensure

- a.) Criteria: Current and unrestricted (may not be on probation, surrendered, or suspended) license in state where organization is to operate
- b.) Source: Issuing Board/Office
- c.) Process: Photocopy of license is acceptable for verification.


2. Credential: Accreditation

- a.) Criteria: Current accreditation by a recognized accrediting body specific to the health care delivery organization, if applicable
- b.) Source: Appropriate accrediting body
- c.) Process: Photocopy of accreditation certificate and verification through accrediting body website.
- d.) Exception: If the Organization does not or is not required to have accreditation, the Organization may submit evidence of good standing with state and federal agencies (such as CMS, GSA, OIG, etc.). If the Organization does not have a state or federal agency report, the Credentialing Department will request that a site visit be performed by the Provider Relations Department in accordance with its site visit policy. (PNM.016 On Site Office Evaluation and Medical Record Keeping Practices)

3. Credential: Professional liability coverage

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- a.) Criteria: Current professional liability insurance coverage of at least \$1 million per incident and \$3 million aggregate.
 - b.) Source: Current certificate of insurance
 - c.) Process: Photocopy of insurance certificate; or letter demonstrating coverage under the Federal Tort Claim Act (FTCA).
4. Credential: Medicare/Medicaid Sanctions
- a.) Criteria: No reportable activity
 - b.) Source: Office of Inspector General List of Excluded Individuals/Entities Search (OIG LEIE)
 - c.) Process: LEIE is queried via internet.
5. Credential: Medicare Participation
- b.) Criteria: Evidence provider holds an active participation agreement with Medicare programs.
 - b.) Source: Online or hard copy of CMS participation agreement
 - c.) Process: Search the Medicare website for practitioner name. Image verification to database record and perform data entry. If not found on Medicare website, request a hard copy of the CMS participation agreement from the practitioner, image to the database record, and perform data entry. If unable to verify that a CMS participation agreement exists, the practitioner may not participate with the Medicare Advantage line of business.
6. Credential: Medicaid Participation
- a.) Criteria: Evidence provider holds an active participation agreement with Medicaid programs.
 - b.) Source: Hard copy from facility.
 - c.) Process: Obtain a hard copy of the Medicaid participation agreement, or CMS letter showing participation with Medicaid. If unable to provide, facility may not participate in Priority Partners line of business.
7. Credential: Professional Disciplinary Actions
- a.) Criteria: No reportable activity
 - b.) Source: Disclosure Questions on Application
 - c.) Process: Johns Hopkins Health Plans reviews responses to disclosure questions on Organization's application.
8. Credential: Hospital/ SNF Quality Rating
- a.) Criteria: Hospitals and skilled nursing facilities must have a quality rating of a level 3 or higher.

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- b.) Source: website verifying star rating
- c.) Process: Search for facility on the website and image a copy of the star rating to the database record. If the rating is a 3 or higher, the file is considered to be clean. If the star rating is below a level 3, the file is processed as a risk and provider relations staff is notified to discuss the file at the next SCRC meeting.

- C. All verifications must be less than 120 days from the receipt of the application to review by the Special Credentials Review Committee or its designee.
- D. Johns Hopkins Health Plans reserves the right to require a site visit during the credentialing process or at any time thereafter.


VII. Individual/ Organizational Practitioner Decision Process (Initial and Recred):

Individual/ organizational practitioners that meet standard criteria:


- A. For applicants who meet the standard criteria for participation as described above and for whom no adverse information was discovered during the verification process, the individual/ organizational practitioner’s credentialing file is added to the “Clean List” report.
- B. The Clean List Report Approval: On a bi-weekly basis, all new delegated practitioners, all individual/ organizational practitioners who meet the standard criteria for participation and who have no adverse information within their credentialing file are added to a report. This is the “Clean List”
- C. The “Clean List” is circulated by email to the Chief Medical Officer (CMO) of Johns Hopkins Health Plans for review and approval. The CMO reviews all the names on the “Clean List”, and responds to the credentialing manager or designee that either all practitioners are accepted; or recommend removal of one or more individual/ organizational practitioners from the clean list. The credentialing manager or designee removes the name of any excluded individual/organizational practitioner from the “Clean List”, and forwards the credentialing file of the excluded individual/ organizational practitioner to the SCRC for review and approval at its monthly meeting.
- D. CMO decision is provided by wet ink signature of a clean list decision form.

For Individual/ Organizational Practitioners that do not meet standard criteria:

- A. For applicants who do not meet the standard criteria for participation, or for whom adverse information was discovered during the credentialing verification process: The practitioner’s credentialing file is marked as “Risk” and is forwarded to the designated credentialing staff person for a risk assessment. The following issues are considered risk:

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- d.) History of malpractice claims
 - e.) History of license sanctions
 - f.) Adverse responses to any of the disclosure questions found in the credentialing application
 - g.) Lack of DEA and/ or CDS license
 - h.) Having less than a full DEA drug schedule (2, 2N, 3, 3N, 4 and 5)
 - i.) Lack of or expired board certification
 - j.) Quality of Care issues related to patient safety
 - k.) History of Medicare/ Medicaid sanctions
 - l.) Inadequate professional liability insurance coverage
- B. The credentialing staff person reviews the credentialing file for adverse information and criterion that is not met at the standard credentialing criteria. A risk assessment form is generated; and the credentialing staff person indicates any risk “categories” (e.g., adverse malpractice history, adverse professional history, prior license actions, etc.) that apply to the individual/ organizational practitioner’s credentialing file. The credentialing staff person determines if any additional documentation (e.g., legal documents) or explanations are needed to provide a full assessment of the risk potential. Any additional documents or explanations are added to the individual/ organizational practitioner’s credentialing file and risk assessment.
- C. The credentialing staff person forwards the Risk Assessment form and pertinent documents to the Johns Hopkins Health Plans Legal Counsel (legal review) and Johns Hopkins Health Plans Medical Director (clinical review). Both review the risk assessment file and determine if there is minimal or significant clinical and legal risk.
- D. The Legal Counsel and the Medical Director have the following recommendation options:
- a) Approved without Reservation – practitioner is deemed to pose no significant legal or clinical risk.
 - b) Approved with Reservation – the practitioner is deemed to pose a potential clinical or legal risk and must be reviewed by the SCRC.
 - c) Deny – the practitioner is deemed to pose significant clinical or legal risk and must be reviewed by the SCRC.
 - d) Other- the credentialing file doesn’t contain sufficient information to render a recommendation. The additional information needed is indicated on the Risk Assessment Form. The file must be reviewed by the SCRC.
- E. If both the Legal Counsel and the Medical Director Approve without Reservation, the individual/ organizational practitioner’s credentialing file is added to the “With Issues” report.

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- F. The “With Issues” Report : On a monthly basis, all individual/ organizational practitioners who have adverse information within their credentialing file, but are deemed as having minimal clinical or legal risk are added to a report. This is the “With Issues” report. A meeting agenda outlining the risk issues for consideration is created. The “With Issues” report and agenda is sent via email to the CMO and selected sub-committee of Johns Hopkins Health Plans medical directors for review and decision. Sub-committee decision is provided by wet ink signature of a meeting minutes approval form.
- G. If either the Legal Counsel or the Medical Director Approve with Reservation or Deny, the individual/ organizational practitioner’s credentialing file is forwarded for SCRC review and decision at its monthly meeting.
- H. The designated credentialing staff person prepares the agenda for the monthly SCRC meeting to include any individual/ organizational practitioner who did not meet standard criteria, and that was deemed a significant risk by Legal Counsel and the Johns Hopkins Health Plans medical Director.
- I. The agenda and risk assessment documents are sent to the SCRC members for review and decision.
- J. The SCRC shall have the right to require the individual/ organizational practitioner to meet with the SCRC to discuss any aspect of the individual/ organizational practitioner’s credentialing or re-credentialing application, qualifications, or quality issues identified.
- K. The SCRC may use the expertise of the Johns Hopkins Health Plans Chief Medical Officer, Medical Director, or any member of the Network, an outside consultant, or legal counsel if additional review and recommendation is required regarding the individual/ organizational practitioner’s qualifications for participation. Such persons shall be considered to be agents of the SCRC for all purposes, including but not limited to protection from discovery and immunity for participating in credentialing process.
- L. The SCRC or any authorized individual or committee member may request an interview with the individual/ organizational practitioner as part of the evaluation process.
- M. All SCRC decisions shall be documented in the meeting minutes. Except as provided in the Johns Hopkins Health Plans Appeals process (PCR.005), decisions of the SCRC are final and are not subject to appeal.

VIII. ONGOING MONITORING:

- A. Ongoing monitoring activity takes place monthly. The agencies monitored for adverse actions are:


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- a.) State licensing board and medical boards in Maryland, Delaware, District of Columbia and Virginia, and any other state where Johns Hopkins Health Plans credentialed practitioners are rendering service to Johns Hopkins Health Plans members; and
- b.) Office of Inspector General (OIG); and
- c.) State of Maryland Department of Health and Mental Hygiene (DHMH) transmittals; and
- d.) American Board of Physicians Publications; and
- e.) TRICARE Management Activity, Department of Health and Human Services (DHHS) list of Sanctioned Providers provided by the Office of the Assistant Secretary of Defense, Health Affairs
- f.) Medicare Opt Out List of practitioners
- g.) Medicare Preclusion List of practitioners

B. All other issues involving quality of care, deficiencies in services rendered, or professional reprimands will be investigated by the Credentialing Department through its risk assessment process.

C. Procedures


- 2. The designated credentialing staff person maintains a listing of all the reporting agencies that are used for monitoring purposes, and on an ongoing basis, updates the listing to ensure that the most recent information regarding period of reporting (time frames), dates of release, method of reporting, and source of reporting is on file. If an agency does not have a regular release date, the designated credentialing staff person notes that the report from the agency is not routinely published and that the agency's source must be queried/retrieved at least once every six (6) months.
- 3. The designated credentialing staff person queries, retrieves or receives periodic reports from each of the listed agencies and reviews each report within 30 calendar days of the release of the report by the agency. The designated credentialing staff person maintains a log of each report obtained. The log includes:
 - a.)The name of the report
 - b.)The release date of the report, or the query date if the report is not regularly scheduled.
 - c.)The date of review
 - d.)Any findings related to participating providers
 - e.)The name of the individual reviewing the report
- 4. If an adverse action is identified through the credentialing ongoing monitoring process, the designated credentialing staff person initiates one of the following processes:

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- a.) If the individual/ organizational practitioner is more than one year from the credentialing expiration date, a risk assessment form is completed and follows the risk decision process.
 - b.) If the individual/ organizational practitioner is less than one year from the credentialing expiration date, the provider is forwarded to the credentialing administrative coordinator to pull a new application, and assign the individual/ organizational practitioner to a credentialing coordinator for re-credentialing.
 - c.) The Credentialing Manager will present to the Special Credentials Review Committee (SCRC) any individual/ organizational practitioner with professional violations identified between credentialing cycles.
 - d.) If the individual/organizational practitioner is identified as having a Medicare sanction or appears on the Medicare Opt Out report or Medicare Preclusion list, immediate action is taken in the credentialing department to include termination for cause procedures as outlined in PCR.004. Such actions are taken immediately and are not subject to appeal rights.
5. Other ongoing monitoring activities are performed in conjunction with the Compliance Department and Quality Improvement Department. When notified by the Compliance or Quality Improvement Department of serious quality of care issues, or license actions including, surrender, revocation etc... , where the provider is deemed a threat to the patient population, immediate action is taken in the credentialing department to include termination for cause procedures as outlined in PCR.004. Such actions are taken immediately and are not subject to appeal rights.

REFERENCE:

NCQA Credentialing Standards
 JHHC PCR.004 Termination of Network Participation
 JHHC PCR.005 Provider Discipline and Appeals
 COMAR
 Addendum: State of Maryland Department of Health and Mental Hygiene Office of Health Care Quality (OHCQ) Criteria for Certification
 HCQIS, IX
 32 CFR 199.6
 Definition Policy
 CMS Guidelines

 JOHNS HOPKINS HEALTH PLANS	JOHNS HOPKINS HEALTH PLANS	Policy Number: PCR.002 Effective Date: 12/1/09 Revision Date : 2/23/21 Review Date : 6/23/20
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SIGNATURES:

Approval Signature: _____ Date: _____
 Credentialing Manager

Approval Signature: _____ Date: _____
 Senior Director of Operations Support

Approval Signature: _____ Date: _____
 Associate Vice President of Provider Relations

Review/Revision Date: 12/1/2009; 10/18/2010; 11/21/2011; 3/19/2012, 9/1/13, 10/13/14, 9/1/15, 7/12/16, 7/25/17; 2/19/18; 6/26/18, 6/25/19, 6/23/20