DELEGATED CREDENTIALING ATTACHMENT
TO
PARTICIPATING PROVIDER AGREEMENT

This Delegated Credentialing Attachment ("Delegation Attachment") sets forth the terms and conditions under which Health Plan shall delegate to Provider specific credentialing and recredentialing activities. This Delegation Attachment will be coterminous with the provider agreement (the "Agreement"), unless sooner terminated as provided in Section 2.3 of this Attachment, and is contingent upon the successful completion and approval of the delegation audit as designated by the Health Plan; otherwise, if such delegation audit fails the Health Plan cannot proceed with the delegation to Provider and this Delegation Attachment is null and void.

ARTICLE I
CREDENTIALING SERVICES

1.1 Delegated Credentialing Services. Pursuant to this Delegation Attachment, Provider agrees to accept assignment of responsibility for the credentialing and recredentialing of those professional and/or organizational/facility providers described herein and on Exhibit 1 attached hereto, whom Provider is authorized to credential (collectively "Credentialed Providers") and agrees that such responsibility is enforced for all products and services covered under the Agreement without exceptions. Provider agrees to undertake all responsibilities for credentialing and recredentialing as set forth in this Delegation Attachment, and as updated from time to time by Company or Payor. Provider represents and warrants that all Credentialed Providers who are credentialed and recredentialed by Provider will comply with Health Plan's credentialing and recredentialing requirements.

Physicians and Other Practitioners. Provider shall perform all credentialing and recredentialing functions as delegated by Health Plan with respect to those Credentialed Providers who (i) are physicians or other practitioners, (ii) are employees or independent contractors of Provider or have entered into a written participation agreement with Provider, and (iii) will provide Covered Services to Covered Persons as set forth in the Agreement. Such Credentialed Providers may include, but are not limited to, the following:

A. MD, DO, DPM, DC, DDS, and DMD practitioners who perform medical services;
B. OD practitioners who perform ophthalmologic services;
C. Allied health professionals ("AHP") who are health care professionals with formal education and clinical training who are certified through certification, registration and/or licensure. AHP professionals include, but are not limited to: dental hygienist, medical assistant, medical technologist, occupational therapist, speech therapist, physical therapist, etc.; and
D. Mid-level practitioners, which includes physician assistants, nurse practitioners and certified nurse-midwifes.

Notwithstanding the above, Provider shall not be required under this Delegation Attachment to credential or recredential the following types of physicians or other practitioners who: (i) are physicians and practitioners who practice exclusively within the inpatient setting and who provide care for Covered Persons only as a result of Covered Persons being directed to the hospital or another inpatient setting, (ii) are physicians and practitioners who practice exclusively within free-standing facilities and who provide care for Covered Persons only as a result of Covered Persons being directed to the facility, (iii) are dentists who provide primary dental care only under a dental plan or rider, (iv) are covering physician and practitioners (e.g., locum tenens), and (v) are physicians and practitioners who do not provide care for Covered Persons in a treatment setting (e.g., board-certified consultants).

Provider agrees that physicians and practitioners must be at least provisionally credentialed by the Provider prior to providing services to Covered Persons. Those practitioners with provisional credentialing must complete the full credentialing process within 60 days of provisional credentialing. A physician or practitioner may only be provisionally credentialed once.

Organizational/Facility Providers. Provider shall perform all credentialing and recredentialing functions as delegated by Health Plan with respect to those Credentialed Providers that: (i) are organizational/facility providers, (ii) are independent contractors of Provider, have entered into a written participation agreement with Provider, or have some other written contract of affiliation in place with Provider, and (iii) will provide Covered Services to Covered Persons as set forth in the Agreement. Such Credentialed Providers may include, but are not limited to, the following:

A. Hospitals
B. Home health agencies
C. Skilled nursing facilities
D. Free-standing surgical centers
E. Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory setting.

1.2 Complaints about a Credentialed Provider. Provider agrees to assist Health Plan with investigation of complaints received about one of its Credentialed Provider sites, including site visit as indicated, and in accordance with Health Plan policies and procedures. Health Plan monitors member complaints about Credentialed Provider sites on an ongoing basis. Health Plan will request office site visits for those Credentialed Providers who meet Health Plan complaint thresholds for concerns about physical accessibility, appearance, adequacy of exam room/waiting room space, office procedures, etc. per National Committee for Quality Assurance ("NCQA") requirements. When a member complaint is received about the site of a Credentialed Provider, Health Plan will forward the complaint and a request for an onsite visit to Provider within two business days of receipt of the complaint by Health Plan. Provider will have 30 calendar days from receipt of the notification to conduct a site visit at involved Credentialed Provider site and report findings to Health Plan. If office does not receive score of at least 80%, Provider must initiate a corrective action plan ("CAP") and perform a follow-up site visit within three months to evaluate whether the deficiencies in the CAP are resolved. Failure to comply with the terms of the CAP may result in probation, suspension or immediate termination of involved Credentialed Provider. Office site visits may be required in additional circumstances per State contract. Provider shall comply with all or both, whichever is stricter. The Health Plan's timeframe for resolution shall not exceed 60 days from receipt of the complaint. The Health Plan monitors complaints and adverse events on an ongoing basis and at recredentialing.

1.3 Compliance with Standards. Provider agrees to conduct credentialing and recredentialing activities as may be required by law, regulatory agencies, and NCQA for all Credentialed Providers. All programs, work plans, and policies and procedures shall be in accordance with the most current NCQA Health Plan (HP) Standards & Guidelines, including CR 1, Element C, Factor 4 and CR 8, Element C, Factor 5 (System Controls), and shall comply with all applicable Medicare laws, regulations, and CMS instructions as well as State's department of insurance and other State legal and regulatory requirements. It is the responsibility of the Provider to be aware of and comply with all laws, rules and regulations, including updates as they may become effective.

1.3.1. Future Elements. NCQA and/or state or federal authorities may modify credentialing or recredentialing requirements during the term of this contract. Provider agrees to adhere to the most current State and federal laws, regulations and instructions and NCQA credentialing or recredentialing criteria at all times during the term of this Delegation Attachment.

1.4 Oversight of Delegated Services. Provider hereby agrees to accept all responsibilities associated with such delegation and specifically agrees to abide by the policies and procedures set forth in Health Plan's "Oversight of Delegated Services Policy and Monitoring Plan" (the "Policy") attached hereto as Exhibit 2 to this Delegation Attachment and any and all procedures set forth herein. Provider's material deviations from the Policy and/or procedures set forth herein may result in review and action by Health Plan, including rescission of this Delegation Attachment or any delegated activity herein and/or the assessment of penalties as described in the Agreement. Nothing in this Delegation Attachment shall be construed in any way to limit Health Plan's authority or responsibility to comply with all regulatory requirements of the State including, but not limited to, requirements of the Department of Managed Care, Department of Health Care Services, and/or Department of

Insurance or the State Medicaid Agency. Health Plan may take whatever action is deemed necessary by it and the Department of Managed Care, Department of Health Care Services and/or State's Department of Insurance to assure that Provider shall comply with all statutory and regulatory requirements relating to any function, duty, responsibility or delegation assumed by or carried out by the Provider.

1.4.1 Reports. Provider shall produce the reports set forth in Exhibits 3, 3-A and 3-B of this Delegation Attachment and submit such reports to Health Plan on or before the due dates and at the frequency set forth in such exhibits. These exhibits are subject to modification.

1.4.2 File Reviews. Annually, or as needed, Provider shall give Health Plan access, upon request, to credentialing and recredentialing files for remote review, excluding any confidential peer review files. Provider agrees to obtain from each Credentialed Provider the appropriate consent and authorization for the release of credentialing and recredentialing information to Health Plan. All credentialing and recredentialing files will contain appropriate consent and authorization for the release of credentialing and recredentialing information not more than six months old at the time of Provider credentialing committee approval. At least annually, or more frequently, and by type (e.g., desk audit, on-site visit) as deemed necessary by Health Plan representatives, Provider will permit Health Plan to perform performance compliance review, including without limitation review of any credentialing and recredentialing files, upon not less than 10 days written notification by Health Plan. Upon request from NCQA to Health Plan and Health Plan's subsequent notification of the NCQA request to the Provider, Provider shall provide copies of requested files in accordance with the NCQA's designated time frame.

1.4.3 Policy Notifications. Health Plan retains the right to recommend modifications to Provider policies and procedures, as necessary, to assure compliance with NCQA and applicable statute regulations. Provider shall have 30 calendar days following written notification from Health Plan to propose alternatives to Health Plan's modifications of Provider policies and procedures. In the event Provider accepts Health Plan's modifications or upon resolution of any issues related to the proposed modifications, Provider shall provide Health Plan with an implementation plan with timelines for compliance to required modifications within 10 business days. Provider shall have 60 calendar days to demonstrate compliance with modification requirements unless State or federal law, rule or regulation or accreditation requirement requires a lesser timeframe.

1.4.4 Corrective Action Plans. Provider agrees to comply with (a) Health Plan's specific recommendations regarding deficiencies in Provider's delegated services identified by Health Plan; (b) reasonable time frames for resolution of any such deficiencies; and (c) any re-reviews of Provider's programs. In the event that Provider's performance of delegated activities is considered unsatisfactory by Health Plan, Health Plan shall initiate the CAP process as set forth in Exhibit 2 to this Delegation Attachment.

1.4.5 Health Plan's Decisions. Health Plan retains the right, based on its sole judgment, to approve, suspend, or terminate any Credentialed Provider from participation in Health Plan's provider network system. Health Plan agrees to notify Provider of its decision and Provider shall have 14 calendar days from such notice to request reconsideration of such decision by Health Plan. However, Provider agrees that Health Plan shall have final decision on the matter as it relates to Health Plan Covered Persons.

1.5 Sub-delegation. If another entity performs any of the functions delegated by Health Plan for the Provider, Health Plan considers this sub-delegation of the delegated responsibilities. Provider may not sub-delegate its responsibilities under this Delegation Attachment to another entity without prior advance approval from Health Plan. Requests to sub-delegate responsibilities must be presented to Health Plan in writing at least 60 days in advance of such proposed sub-delegation. The written request must include an objective evaluation of the sub-delegate's ability to perform the functions and comply with applicable state and federal statutes and rules, and accreditation requirements. Health Plan reserves the right to perform an independent evaluation of the proposed sub-delegate's capability to perform the functions in compliance with all requirements before rendering a decision about whether to approve the sub-delegation. The decision about whether to approve or deny the sub-delegation request is at the Health Plan's sole discretion. If the Health Plan denies the request, the sub-delegate

may not be brought forward for consideration as a potential sub-delegate until nine months after the denial decision is rendered.

If Health Plan approves sub-delegation of a portion of these responsibilities to another entity, Provider is responsible for conducting oversight of the sub-delegate's performance to comply with the terms of this Delegation Attachment, including at least annual evaluation of policies and procedures and audits and review of reports described herein. Provider must report results of its oversight activities to Health Plan within 30 days of completion. Health Plan reserves the right to perform an independent evaluation of sub-delegate's capability to perform the functions in its sole discretion. Provider shall provide documentation and demonstrate oversight of the sub-delegate by Provider to include:

A. An executed agreement, that defines the delegated responsibilities of the Provider and sub-delegate, reporting requirements consistent with those set forth in this Delegation Attachment, the process by which the Provider evaluates the sub-delegate's compliance with performance requirements in this Delegation Attachment at least every 12 months, and the remedies, including revocation of the sub-delegation, available to the Provider if the sub-delegate does not fulfill its obligations

B. Evaluation of the sub-delegate's capacity to perform the delegated activities prior to the execution of the contract

C. Annual evaluation of performance in accordance with Health Plan's, accreditation, regulatory and statutory standards

The role of Provider and any sub-delegate in contracting with Health Plan is limited to performing certain delegated functions of Health Plan, using standards approved by Health Plan and which are in compliance with applicable statues and rules, and are subject to Health Plan's oversight and monitoring of Provider's performance.

Health Plan retains the right to modify, rescind or terminate at any time any one or all delegated activities under this Delegation Attachment, regardless of any sub-delegation that may be approved.

ARTICLE II
GENERAL

2.1 Material Changes. Provider shall provide written notice to Health Plan at least 30 days prior to making any and all material changes to delegate's credentialing and recredentialing procedures and processes relevant to the services delegated to Provider under this Delegation Attachment.

2.2 Compensation. No compensation shall be paid under the terms of this Delegation Attachment.

2.3 Termination. Either party may terminate this Delegation Attachment without cause upon 120 days prior written notice to the other party. Health Plan reserves the right, upon written notice to Provider, to terminate this Delegation Attachment or rescind any of the activities delegated to Provider herein for Provider's material deviations from the functions delegated from the Policy or for business reasons as deemed necessary by Health Plan.

Notwithstanding the foregoing, unless otherwise agreed to by the parties, this Delegation Attachment shall automatically terminate upon termination of the Agreement. Termination of this Delegation Attachment shall not affect the rights and obligations of the parties under the Agreement.

2.3.1 In the event that this Delegation Attachment terminates, but the Agreement remains in force, the Credentialed Provider, credentialed and/or recredentialed by Provider, will remain credentialed in Health Plan's network until such time the recredentialing is due, at which time the Health Plan shall assume this function. In the event that a Credentialed Provider record is requested for an audit by any

regulatory entity before recredentialing is taken over by the Health Plan, Provider shall cooperate with such request and submit original or quality copies of Credentialed Provider credentialing and recredentialing files, excluding confidential peer review documentation to Health Plan in order to comply with audit requirements.

2.4 Performance Standards. Provider's performance of the delegated activities described in this Delegation Attachment shall be subject to the performance measures set forth in subsection 2.4.1 below. Health Plan will provide feedback to Delegate on regular reports submitted in accordance with reporting requirements outlined in this Delegation Attachment.

2.4.1 Provider must attain 95% compliance on the following critical elements:

A. Timeliness to committee – No more than 90 days from date of receipt of application to committee approval for initial credentialing and within 36 months of the previous credentialing date for recredentialing
B. Regulatory Requirements – National Practitioner Data Bank (NPDB) query and Medicare/Medicaid Office of Inspector General ("OIG") Sanction Report. Exclusion lists screening requirements are also applicable as noted above
C. Reporting to Health Plan markets – all reports in Exhibit 3, 3-A and 3-B to this Delegation Attachment must be submitted on due date or date pre-determined by Health Plan

All other elements require a minimum of 90% compliance. Failure to meet compliance requirements will result in a CAP. Failure to comply with the terms of the CAP may result in probation, suspension or immediate termination of any one or all delegation activities under this Delegation Attachment. Any sanction Health Plan receives from the State that is a result of Provider's omissions or non-performance will be the responsibility of the Provider. Provider shall reimburse Health Plan within 30 days after notification by Health Plan of such sanction.

2.5 Penalties and Sanctions Notification. Provider shall notify Health Plan of any sanctions incurred or issued to Provider following review by a federal, State, or voluntary accreditation agency.

2.6 Reporting Compliance. Provider shall comply with the same credentialing and recredentialing reporting requirements as Health Plan must comply with under the Government Contract.

2.7 Limitation on Liability; Indemnification. Provider agrees to indemnify and hold Health Plan and its agents, employees, officers and affiliates harmless from any and all claims, losses, liabilities, lawsuits and expenses arising out of or in relation to the delegated functions and activities pursuant to this Delegation Attachment.

2.8 Confidentiality. Provider must comply with the Health Insurance Portability and Accountability Act ("HIPAA") regulations as described in the Agreement. This delegation arrangement will not include the transfer of protected health information (PHI) by either party.

2.9 Agreement Conflict. In the event of a conflict with the Agreement, the terms of this Delegation Attachment shall govern as to delegated responsibilities.

2.10 Compliance with Legal and Regulatory Requirements. Provider agrees to carry out all responsibilities under this Delegation Attachment in compliance with all applicable requirements of state and federal law and regulation, accreditation agencies, and the Government Contract.

2.11 Plan Responsibility. Provider acknowledges that Health Plan is ultimately responsible for ensuring compliance with requirements and Provider agrees to cooperate with Health Plan in overseeing its responsibilities.

EXHIBIT 1
TO
DELEGATED CREDENTIALING ATTACHMENT

ENTITIES COVERED UNDER DELEGATION

This Exhibit 1 to the Delegated Credentialing Attachment is the initial list of the entities covered under delegation pursuant to the Delegation Attachment. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list containing the names, office telephone numbers, addresses, tax identification numbers, hospital affiliations, specialties and board status (if applicable), State license number, and National Provider Identifier (NPI) of entities covered under delegation and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least 30 days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

Provider may add new providers to this Delegation Attachment as entities covered under delegation. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s) and shall use best efforts to provide such notice at least 30 days in advance of such addition, pursuant to notice provisions set forth in the Agreement.

ENTITY/GROUP/CLINIC/FACILITY NAME	TAX ID #	NPI #

EXHIBIT 2
TO
DELEGATED CREDENTIALING ATTACHMENT

OVERSIGHT OF DELEGATED SERVICES POLICY AND MONITORING PLAN

I. Introduction

Health Plan may delegate certain activities that relate to credentialing and recredentialing of a Credentialed Provider contracted with Provider. At all times, Health Plan shall maintain full responsibility for the provision of health care services to its members. Health Plan has established, operates, and maintains a health care delivery system, quality assurance system, provider credentialing system and other systems and programs meeting standards and requirements of accreditation agencies, applicable State agency (Department of Managed Health Care, Department of Insurance, Department of Health Care Services, DOM, OIC) and is directly accountable for compliance with such standards. Health Plan 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 applicable State's Department of Managed Health Care, Department of Health Care Services, Department of Insurance, DOM or OIC. Through the oversight program as described in this document, Health Plan shall assure that delegated services meet Health Plan standards for care and service, as well as the standards of the applicable State's Department of Managed Health Care, Department of Health Care Services, Department of Insurance, DOM or OIC and applicable accrediting agencies such as NCQA.

Health Plan's Board of Directors has responsibility for the oversight program. It delegates implementation of the Program to Health Plan'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 Health Plan and the Provider shall specify the credentialing and recredentialing delegated activities, the Provider's accountability for these activities, the frequency of reporting to Health Plan and the process by which the delegation shall be evaluated.

The Oversight of Delegated Services Policy and Monitoring Plan shall be evaluated yearly as part of the annual quality management program appraisal. Modifications shall be presented to Health Plan'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 the Policy shall direct the oversight activity for each Provider.

II. Credentialing Delegated Responsibilities

Credentialing delegated responsibilities for the Health Plan and Provider are set forth below in Table 1, "Credentialing Delegated Responsibilities Matrix," to this Exhibit 2. All Provider's programs, work plans, and policies and procedures shall be in accordance with the most current Health Plan standards and guidelines, as applicable, and shall comply with all Regulatory Requirements.

III. Initial Evaluation

Health Plan shall determine the capacity of the Provider's delivery organization to assume responsibility for delegated activity(s) and to maintain Health Plan standards by completing an assessment of the Provider's credentialing activities ("Delegated Credentialing Assessment"), which shall be completed prior to the Provider assuming credentialing responsibilities described in the Delegation Attachment. This includes a desk audit review and/or an on-site visit as determined appropriate by the Health Plan. Documents reviewed may include, but are not limited to, program descriptions, annual work plans, statements of effectiveness, committee minutes and applicable policies and procedures.

IV. Annual Evaluation

Upon 30 days advance written notice, there will be an annual comprehensive review of the Provider's ability to provide care and service according to the standards of Health Plan, applicable State's Department of Managed Health Care, Department of Health Care Services, Department of Insurance, DOM or OIC and NCQA. The annual evaluation will be either through a desk audit review and/or an on-site visit as determined appropriate by the Health Plan and 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 recredentialing files. If the audit findings identify noncompliance with the designated standards, a CAP must be developed. Provider shall provide a copy of its policies and procedures and other documents related to performance of its delegated responsibilities to Health Plan on an annual basis upon request.

V. Ongoing Monitoring Plan

Provider shall submit regular reports as defined in the exhibits to this Delegation Attachment, to Health Plan's Quality Management Director or designee.

The Health Plan shall review the quarterly credentialing activity summary report submitted by the Provider to observe trends, and monitor the results of corrective actions taken, as appropriate. More frequent reports may be required from the Provider if the Provider is placed on a CAP as outlined by the Health Plan.

VI. Corrective Action Plans

If Health Plan receives information through its monitoring plan and/or audit processes that Provider or its subcontractors are not operating in accordance with this Delegation Attachment, federal or State requirements and is operating in a condition that renders the continuance of its business hazardous to the Covered Persons, Health Plan 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 Health Plan within two weeks of the notification from Health Plan, 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 30 days of Provider's receipt of written approval of the proposed CAP by Health Plan, unless an alternative completion period is approved by Health Plan in writing. The CAP shall accomplish the written expected results and such results must be validated by a Health Plan audit within the stated time frame. Failure of the Provider or any of its subcontractors to comply with this provision may result in, at Health Plan's discretion, the suspension or revocation of delegation.

C. Health Plan shall cooperate with Provider or its subcontractors to correct any failure by Provider to comply with the applicable State's Department of Managed Health Care, Department of Health Care Services, Department of Insurance, DOM, or Office of the Insurance Commissioner's regulatory requirements relating to any matters:

   1. Delegated to Provider by Health Plan; or
   2. Necessary for Health Plan to ensure compliance with statutory and regulatory requirements.

D. Health Plan will monitor the Provider on an ongoing basis to identify opportunities for improvement. For Delegation Attachments that have been in effect for more than 12 months, the Health Plan 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.

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

IN WITNESS WHEREOF, the Parties hereto have executed and delivered with Amendment as of the date first set forth below.

HEALTH PLAN:

Sunshine State Health Plan, Inc.

Authorized Signature

William M. Kruegel
Chief Operating Officer

PROVIDER/DELEGATED ENTITY:

Authorized Signature

Printed Name

Title

Effective Date: _____

RESET

EXHIBIT 1

TO

DELEGATION CREDENTIALING AGREEMENT

Type of Credentialed Providers

_____ accepts assignment of responsibility for the credentialing and recredentialing of the following types of Credentialed Providers (place a "check" in one box):

☐ Physicians and other practitioners only	☐ Physician and other practitioners and organizational/facility providers

Table 1. **Credentialing Delegated Responsibilities Matrix**

	Responsible Party		
Activity	**Health Plan**	**Credentialing Delegate**	**Comments**
The organization adopts credentialing policies and procedures that outline the process used to credential and recredential practitioners. Policies and procedures must comply with NCQA CR 1A requirements.	X	X	Shared responsibility. Both parties must comply.
The organization's policies and procedures outline the rights of practitioners and comply with NCQA CR 1B requirements.	X	X	Shared responsibility. Both parties must comply.
Develops and implements policies and procedures that define the system controls essential to ensuring that data about the credentialing process accurately reflects what happened and meet CR 1C requirements.		X	
Performs audits of credentialing system data integrity which meet CR 1D requirements no less than annually and submits reports to the health plan. If audit shows inappropriate modifications of credentialing data, implements corrective action to address root causes and conducts quarterly monitoring until findings demonstrate improvement for at least three consecutive quarters.		X	
The organization's credentialing committee includes representation from a range of participating practitioners (CR 2A).		X	
The organization's credentialing committee must review at least the qualifications of any practitioner who does not meet established criteria (CR 2A).		X	
The organization's medical director or designated physician may review and approve the qualifications of practitioners who meet established criteria (CR 2A).		X	

	Responsible Party		
Activity	**Health Plan**	**Credentialing Delegate**	**Comments**
The organization conducts primary source verification of the following credentials at initial credentialing and recredentialing for all contracted practitioners using sources accepted by NCQA: • License to practice (CR 3A) • DEA and CDS certificate, when applicable (CR 3A) • Education and training, (CR 3A) at initial credentialing • Board certification (CR 3A) • Work history for the last 5 years at initial credentialing only (CR 3A) • History of professional liability claims (CR 3A) • State sanctions or restrictions on licensure (CR 3B) • Medicare and Medicaid sanctions (CR 3B)		X	
The organization requires all practitioner applicants to complete an application at initial credentialing and recredentialing which includes: • Reasons for inability to perform the essential functions of the position, with or without accommodation; • Lack of present illegal drug use; • History of loss of license and felony convictions; • History of loss or limitation of privileges or disciplinary actions; • Current malpractice insurance coverage; and • Attestation to the correctness and completeness of the application (CR 3C).		X	
The organization makes initial credentialing decisions before the practitioner begins delivering care to members (CR 3).		X	
The organization conducts recredentialing and makes a decision about recredentialing status no more than 36 months after the previous decision (CR 3).		X	
The organization conducts ongoing monitoring of the status of license sanctions and Medicare and Medicaid sanctions on a monthly basis, or within 30 days of issuance of the sanction report for all contracted practitioners (CR 5A).		X	
The organization conducts an evaluation of the pattern of complaints and sentinel/adverse events involving practitioners it credentials no less than every six months and determines if any practitioner requires further review based on analysis of patterns of this data over time (CR 5A).		X	

	Responsible Party		
Activity	**Health Plan**	**Credentialing Delegate**	**Comments**
The organization takes appropriate action for individual practitioners based on ongoing monitoring of license and Medicare and Medicaid sanctions and patterns of complaints and sentinel/adverse events (CR %A).		X	
The organization executes a written agreement with any credentialing sub-delegate that meets the requirements in CR 8A which are applicable to the scope of delegated responsibilities.		X	
The organization conducts oversight of any credentialing sub-delegates at least annually, in compliance with NCQA requirements (CR 8C and D).		X	
The organization documents review of credentialing sub-delegate reports within 30 days of receipt of such reports from the sub-delegate (CR8C).		X	
Health Plan retains accountability for any NCQA requirements not identified above as delegated responsibilities.			

EXHIBIT 3
TO
DELEGATED CREDENTIALING ATTACHMENT

REPORTS TO BE PREPARED BY PROVIDER

Provider shall prepare and deliver to Health Plan, if applicable, all reports required under the State contract held by Health Plan according to the report matrix developed by the State or as otherwise required by Health Plan, including, but not limited to, the reports and requirements in this Exhibit 3.

Process for report submission:

Credentialing reports to be submitted via email to the Credentialing Department, for reporting, and the Provider and Contracting Department, for enrollment into systems. Instructions for secure and/or FTP access must be included in the email notification. *This content is needed to meet delegation agreement requirements for Factor 3.

Credentialing Reports	Frequency	Format	Submission Schedule
Credentialed Providers Roster	Monthly Updates	Microsoft Excel, See Exhibit 3-A	Concurrent requirements are due to Health Plan within 15 calendar days, including all initially credentialed, de-credentialed and denied recredentialed Credentialed Providers, with the exception of providers who are suspended or de-credentialed with cause, in which case Provider shall notify Health Plan within three business days of rendering the decision.
Comprehensive Credentialed Providers Roster	Quarterly	Microsoft Excel, See Exhibit 3-A	Quarterly requirements are due to Plan 15 calendar days after the end of the quarter.
Credentialing Activity Summary	Quarterly	Microsoft Excel, See Exhibit 3-B	Quarterly requirements are due to Plan 15 calendar days after the end of the quarter.

Credentialing Reports	Frequency	Format	Submission Schedule
Credentialing System Control Audit Report	Results of audit to assess integrity of data about credentialing process and when data is modified, that organizational procedures are followed	• Audit results, including method for selecting cases, identification of staff who completed audit, number of cases audited in reporting process, audit results for each individual audit criterion, and analysis of whether audit results met a quantitative performance goal, root cause analysis for any findings of inappropriate modifications and action plans to prevent future inappropriate modifications.	Annually, no later than March 1 for the prior calendar year
IT Security Controls Report	Evidence of internal review to ensure unauthorized access to information systems used to manage credentialing process does not occur	• Examples of acceptable reporting include annual review of individuals authorized to access information system used to manage credentialing process • Information security audit of delegate's process to maintain confidentiality and security of data stored in information system used to manage credentialing process	Annually, no later than March 1 for the prior calendar year

EXHIBIT 3-A
TO
DELEGATED CREDENTIALING ATTACHMENT

CREDENTIALING DEMOGRAPHIC INFORMATION

Credentialing demographic information comes in a Microsoft Excel text format with the following elements, as set forth below. Provider shall provide such lists to the Health Plan monthly and following the format specified below.

Provider File Layout

Line	Required	Field Name	Values	Comments
1	Yes	**TIN**	Numeric, 9 characters	Tax Identification Number – IRS #
2	Yes	**Provider NPI**	Numeric, 10 characters	National Provider Identifier (NPI)
3	Yes	**Provider Taxonomy**	Alphanumeric, 10 characters	Provider's medical taxonomy that corresponds to their specialty. List of valid taxonomies can be found on www.nucc.org.
4	Yes	**Provider Specialty**	Characters	Provider's medical specialty that corresponds to their taxonomy. List of valid specialties can be found on www.nucc.org.
5	Yes	**Business Entity Name**	Up to 100 characters are allowed	This should be the name registered on W-9
6	Yes	**Business Entity Address Line 1**		Needed to ensure accurate payment in claims systems
7	No	**Business Entity Address Line 2**		Needed to ensure accurate payment in claims systems
8	Yes	**Business Entity City**		Needed to ensure accurate payment in claims systems
9	Yes	**Business Entity Zip**	Numeric, 5 characters	Needed to ensure accurate payment in claims systems
10	Yes	**Business Entity Phone**	Numeric, 10 characters, no dashes	Needed to ensure accurate payment in claims systems
11	No	**Business Entity Fax**	Numeric, 10 characters, no dashes	Needed to ensure accurate payment in claims systems
12	No	**Provider Medicaid Number**	Numeric	
13	No	**Provider Medicaid State**	2 Letter State Code (CAPS)	
14	No	**Office Manager Email**		Email address of the location's office manager.
15	No	**Provider Email**		Email address of the provider or provider representative.
16	Yes	**Provider Primary Location**	Y/N	Mark Y if this location is the Provider's primary location. If listing multiple locations for the provider, designate only one as the primary location.
17	Yes	**Provider Name**	Up to 100 characters are allowed	This is the name of the provider (facility or organization).

Line	Required	Field Name	Values	Comments
18	Yes	**Location Name**	Up to 100 characters are allowed	This is the location name that will display in the provider directory. Recommend using the name that patients are familiar with and will likely search for on the provider directory for this address.
19	Yes	**Location Address Line 1**	Service address only, **No** PO Box address allowed	This is the first line of the address that will display in the provider directory
20	Yes	**Location Address Line 2**	Service address only, **No** PO Box address allowed	This is the second line of the address that will display in the provider directory
21	Yes	**Location City**	Service address only, **No** PO Box address allowed	
22	Yes	**Location Zip**	Numeric, 5 characters	
23	Yes	**Location Phone Number**	Numeric, 10 characters, no dashes	Appears on the provider directory. This is the main, general office phone number for the location that members and other practitioners will call. Provide only one phone number for each location. Including multiple phone numbers in the directory will make it unclear to members and other practitioners which phone number they should call.
24	Yes	**Location Fax Number**	Numeric, 10 characters, no dashes	Include actual, working fax number only
25	Yes	**Do Not Display Provider Location in Directory**	Y/N	Default is N (displays location in directory).
26	Yes	**Handicap Accessibility?**	Y/N	Appears on the provider directory. Default is N (not handicap accessible).
27	Yes	**Provider Office Hours - Sunday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
28	Yes	**Provider Office Hours - Monday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)

Line	Required	Field Name	Values	Comments
29	Yes	**Provider Office Hours - Tuesday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
30	Yes	**Provider Office Hours - Wednesday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
31	Yes	**Provider Office Hours - Thursday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
32	Yes	**Provider Office Hours - Friday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
33	Yes	**Provider Office Hours - Saturday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
34	Yes	**Provider Insurance Carrier**		Provider's malpractice insurance provider
35	No	**Provider Insurance Expiration Date**	MM/DD/YYYY	Insurance expiration date
36	Yes	**Provider Coverage Amount**	No special characters	Insurance amount
37	No	**Provider License Number**		
38	No	**Provider License State**	2 Letter State Code (CAPS)	
39	No	**Provider License Expiration Date**	MM/DD/YYYY	
40	Yes	**Do Not Display Provider Location in Directory**	Y/N	Indicates if practitioner should be listed in the directory ***at this location***. Default is N (No), indicating the practitioner ***should*** appear in the directory. (N = Show in directory; Y = DO NOT show in directory)
41	Yes	**Delegated Agency Name**	Delegated Entity Name	This is the delegated entity name. Must be the same legal entity name as it appears on the Agreement.

Line	Required	Field Name	Values	Comments
42	Required for Medicare & Duals Products Only	**ADA - Parking**	Y/N	Indicate if location meets American Disabilities Act (ADA) requirements for accessible parking spaces, curb ramps, or loading zones at building entrance
43	Required for Medicare & Duals Products Only	**ADA – Interior Building**	Y/N	Indicate if location meets ADA requirements for doorways wide enough to ensure safe and accessible passage by individuals using mobility aids
44	Required for Medicare & Duals Products Only	**ADA – Restroom**	Y/N	Indicate if location meets ADA requirements for wheelchair accessible restrooms with grab bars and accessible lavatories
45	Required for Medicare & Duals Products Only	**ADA – American Sign Language Signage**	Y/N	Indicate if location meets ADA requirements for signage with braille and raised tactile text characters at office, elevator, and restroom doors
46	Required for Medicare & Duals Products Only	**ADA – Medical Equipment**	Y/N	Indicate if location meets ADA requirements for medical equipment accessible to patients using mobility aids
47	Required for Medicare & Duals Products Only	**ADA – Exam Room**	Y/N	Indicate if location meets ADA requirements for exam rooms accessible to patients using mobility aids
48	Required for Medicare & Duals Products Only	**Translation Services for Written Materials**	Y/N	Indicate if translation services for written materials are available at the location.
49	Required for Medicare & Duals Products Only	**Languages Offered On Site by Interpreters**	Characters	List languages offered at this location by qualified healthcare interpreters.

Line	Required	Field Name	Values	Comments
50	Required for Medicare & Duals Products Only	**Location Accessible by Train**	Y/N	Indicate if provider's location is on an accessible public transportation train route
51	Required for Medicare & Duals Products Only	**Location Accessible by Bus**	Y/N	Indicate if provider's location is on an accessible public transportation bus route
52	Required for Medicare & Duals Products Only	**Patient Populations Serviced**	Characters	Indicate whether the location specializes in treating certain patient populations.
53	No	**Facility Accreditations**	Characters	List the organizations by which this provider or the location has been accredited. (Example: NCQA, CLIA, JCAHO)

Practitioner File Layout

Line	Required	Field Name	Acceptable Values	Comments
1	Yes	**Last Name**	Characters	Practitioner's last name. Proper capitalization should be used. Appears on the provider directory.
2	Yes	**First Name**	Characters	Practitioner's first name. Proper capitalization should be used. Appears on the provider directory.
3	No	**Middle Initial**	1 Character	Practitioner's middle initial. Appears on the provider directory.
4	No	**Suffix**	Jr, Sr, II, III, IV	Practitioner's suffix (examples: Jr, III). Appears on the provider directory.
5	Yes	**Title/ Degree**	Characters	Practitioner's degree and/or credential. Usually the practitioner's academic degree, but sometimes how the practitioner is licensed and addressed in correspondence (e.g., MD, CNP, PT, LPCC, etc.). Appears on the provider directory.
6	Yes	**Practitioner NPI**	Numeric, 10 characters	Practitioner's National Provider Identifier (NPI). Note this should be different than the provider's NPI
7	No	**SSN**	xxx-xx-xxxx Numeric	Used for sanctions/license monitoring checks and other checks where NPI is not used.
8	Yes	**Date of Birth**	MM/DD/YYYY numeric	Practitioner's date of birth. Used for sanctions/license monitoring checks, or to eliminate duplicate providers with common names
9	Yes	**Gender**	F/M	Practitioner's gender. Appears on the provider directory.
10	Yes	**Practitioner E-mail**		Practitioner's email
11	Yes	**Practitioner participates as a primary care provider, or a Specialist, or both**	"PC" for primary care, "SP" for specialist, or "PS" for both.	"PC" indicates that the practitioner is willing to accept membership assignment as a Primary Care Provider (PCP). "SP" indicates that the practitioner is a specialist and not a PCP, and "PS" indicates he/she is willing to participate as both.
12	No	**Language1**	Characters	A language ***other than English*** spoken by the practitioner. Appears on the provider directory.
13	No	**Language2**	Characters	Allows for adding additional languages spoken by the practitioner. Appears on the provider directory.
14	No	**Language3**	Characters	Allows for adding additional languages spoken by the practitioner. Appears on the provider directory.
15	Yes	**Practitioner DEA Number**	Numeric	Drug Enforcement Administration (DEA) Number for state
16	Yes	**Practitioner DEA State**	2 Letter State Code (CAPS)	

Line	Required	Field Name	Acceptable Values	Comments
17	Yes	**Practitioner DEA Expiration Date**	MM/DD/YYYY	DEA expiration date
18	Yes	**Practitioner Medical License Number**		Practitioner's license number
19	Yes	**Practitioner Medical License State**	2 Letter State Code (CAPS)	
20	Yes	**Practitioner Medical License Expiration Date**	MM/DD/YYYY	License expiration date
21	Yes, if required by your state	**Practitioner Medicaid Number**		Practitioner's Medicaid ID
22	Required w/ Practitioner Medicaid Number	**Practitioner Medicaid Number State**	2 Letter State Code (CAPS)	
23	Yes	**Practitioner Medicaid Expiration Date**	MM/DD/YYYY	Medicaid expiration date
24	Yes	**Practitioner Primary Taxonomy**	Alphanumeric, 10 characters	Practitioner’s medical taxonomy that corresponds to their specialty. List of valid taxonomies can be found on www.nucc.org.
25	Yes	**Practitioner Primary Specialty**	Characters	Practitioner’s medical specialty that corresponds to their taxonomy. List of valid specialties can be found on www.nucc.org.
26	Required if practitioner is mid-level	**Supervising Physician's Name**	Characters	Supervising physician may be required if practitioner is mid-level (i.e. Nurse Practitioner) in certain states.
27	Required if practitioner is mid-level	**Supervising Physician's Specialty**	Characters	Practitioner’s medical specialty that corresponds to their taxonomy. List of valid specialties can be found on www.nucc.org.
28	Yes	**Practitioner Primary Specialty Board Status**	Board Certified, Board Eligible, Not Certified, Not Applicable, or Unknown	Indicates if practitioner is board certified in the indicated primary specialty/taxonomy. Appears on the provider directory. Default is "Not Certified"
29	Required if practitioner is Board Certified	**Practitioner Primary Specialty Original Certification Date**	MM/DD/YYYY	This is the date that the practitioner was originally board certified.

Line	Required	Field Name	Acceptable Values	Comments
30	Yes	**Practitioner Primary Specialty Certification Expiration Date**	MM/DD/YYYY	This is the date that the practitioner's board certification expires. Required only if the practitioner is Board Certified. Appears on the provider directory.
31	Yes	**Primary Specialty Board Certificate Issuer**	Select from dropdown	The organization that provided board certification for the practitioner in this specialty. Appears on provider directory.
32	No	**Practitioner Taxonomy 2**	Alphanumeric, 10 characters	Practitioner's medical taxonomy that corresponds to their specialty. List of valid taxonomies can be found on www.nucc.org.
33	No	**Practitioner Specialty 2**	Characters	Practitioner's medical specialty that corresponds to their taxonomy. List of valid specialties can be found on www.nucc.org.
34	No	**Practitioner Specialty 2 Board Status**	Board Certified, Board Eligible, Not Certified, Not Applicable, or Unknown	Indicates if practitioner is board certified in the indicated primary specialty/taxonomy. Appears on the provider directory. Default is "Not Certified"
35	No	**Practitioner Specialty 2 Original Certification Date**	MM/DD/YYYY	This is the date that the practitioner was originally board certified. Required only if the practitioner is Board Certified.
36	No	**Practitioner Specialty 2 Certification Expiration Date**	MM/DD/YYYY	This is the date that the practitioner's board certification expires. Required only if the practitioner is Board Certified. Appears on the provider directory.
37	No	**Practitioner Specialty 2 Board Certificate Issuer**	Select from dropdown	The organization that provided board certification for the practitioner in this specialty. Appears on provider directory.
38	No	**Practitioner Taxonomy 3**	Alphanumeric, 10 characters	Practitioner's medical taxonomy that corresponds to their specialty. List of valid taxonomies can be found on www.nucc.org.
39	No	**Practitioner Specialty 3**	Characters	Practitioner's medical specialty that corresponds to their taxonomy. List of valid specialties can be found on www.nucc.org.
40	No	**Practitioner Specialty 3 Board Status**	Board Certified, Board Eligible, Not Certified, Not Applicable, or Unknown	Indicates if practitioner is board certified in the indicated primary specialty/taxonomy. Appears on the provider directory. Default is "Not Certified"
41	No	**Practitioner Specialty 3 Original Certification Date**	MM/DD/YYYY	This is the date that the practitioner was originally board certified. Required only if the practitioner is Board Certified.

Line	Required	Field Name	Acceptable Values	Comments
42	No	**Practitioner Specialty 3 Certification Expiration Date**	MM/DD/YYYY	This is the date that the practitioner's board certification expires. Required only if the practitioner is Board Certified. Appears on the provider directory.
43	No	**Practitioner Specialty 3 Board Certificate Issuer**	Select from dropdown	The organization that provided board certification for the practitioner in this specialty. Appears on provider directory.
44	Yes	**Practitioner Primary Location?**	Y/N	If practitioner has multiple locations contracted with health plan, indicate one location to act as the practitioner's main/primary location.
45	Yes	**Provider Name**	Up to 100 characters are allowed	This is the name of the provider (facility or organization). Appears on the provider directory.
46	Yes	**TIN**	99-9999999 or 999999999	Tax Identification Number – IRS #
47	Yes	**Provider NPI**	Numeric, 10 characters	National Provider Identifier (NPI)
48	Yes	**Location Name**	Up to 100 characters are allowed	This is the ***location name*** that will display in the provider directory. We recommend using the name that patients are familiar with and will likely search for on the provider directory.
49	Yes	**Location Address Line 1**	Service address; **No** PO Box address allowed	This is the first line of the address that will display in the provider directory
50	Yes	**Location Address Line 2**	Service address; **No** PO Box address allowed	This is the second line of the address that will display in the provider directory
51	Yes	**Location City**	Service address; **No** PO Box address allowed	
52	Yes	**Location Zip**	Numeric, 5 characters	
53	Yes	**Location Phone Number**	Numeric, 10 characters	
54	Yes	**Location Fax Number**	Numeric, 10 characters	
55	Yes	**Do Not Display Practitioner Location in Directory?**	Y/N	Indicates if practitioner should be listed in the directory at this location. Default is N (No), indicating the practitioner ***should*** appear in the directory.
56	Yes	**Handicap Accessibility?**	Y/N	
57	Yes	**Practitioner Office Hours - Sunday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)

Line	Required	Field Name	Acceptable Values	Comments
58	Yes	**Practitioner Office Hours - Monday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
59	Yes	**Practitioner Office Hours - Tuesday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
60	Yes	**Practitioner Office Hours - Wednesday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
61	Yes	**Practitioner Office Hours - Thursday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
62	Yes	**Practitioner Office Hours - Friday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
63	Yes	**Practitioner Office Hours - Saturday**	Indicate either "24 hrs", "Closed", or a span of time in "hh:mmAM-hh:mmPM" format	Appears on the provider directory. Example for hour format (08:00AM-05:00PM)
64	Yes	**Practitioner Panel Status**	"Open Panel" New and Existing patients allowed or "Closed Panel" if Only Existing Patients are allowed.	Appears on the provider directory. Default is Open Panel (excepting new patients)
65	Yes	**Gender Limitations**	Female only, Male only, None	Appears on the provider directory.
66	No	**Practitioner Panel Lowest Age**	Numeric	Appears on the provider directory. Default is blank (no patient age restrictions).
67	No	**Practitioner Panel Highest Age**	Numeric	Appears on the provider directory. Default is blank (no patient age restrictions).
68	Yes	**Practitioner Insurance Carrier**	Character	Practitioner's malpractice insurance provider
69	Yes	**Practitioner Insurance Coverage Amount**	(1.0M/3.0M)	Insurance coverage amount that covers the practitioner

Line	Required	Field Name	Acceptable Values	Comments
70	Yes	**Practitioner Insurance Expiration Date**	MM/DD/YYYY	Insurance expiration date
71	No	**Practitioner Primary Hospital**	Character	Name of hospital that practitioner has privileges with.
72	No	**Practitioner Primary Hospital Privilege Type**	Active, Provisional, Temporary	Indicates the type of privileges the practitioner has at the hospital.
73	No	**Practitioner Hospital 2**	Character	Name of hospital that practitioner has privileges with.
74	No	**Practitioner Hospital 2 Privilege Type**	Active, Provisional, Temporary	Indicates the type of privileges the practitioner has at the hospital.
75	No	**Practitioner Hospital 3**	Character	Name of hospital that practitioner has privileges with.
76	No	**Practitioner Hospital 3 Privilege Type**	Active, Provisional, Temporary	Indicates the type of privileges the practitioner has at the hospital.
77	Yes	**Delegated Agency Name**	Delegated Entity Name	This is the delegated entity name. Must be the same legal entity name as it appears on the delegated agreement.
78	Yes	**Credentialing Committee Date**	MM/DD/YYYY	The ***initial/original*** committee approval date.
79	Required for Medicare & Duals Products Only	**Cultural Competence Training – African American**	Y/N	Indicate if practitioner has completed cultural competence training specific to African American culture.
80	Required for Medicare & Duals Products Only	**Cultural Competence Training – Alaskan Native**	Y/N	Indicate if practitioner has completed cultural competence training specific to Alaskan Native culture.
81	Required for Medicare & Duals Products Only	**Cultural Competence Training – American Indian**	Y/N	Indicate if practitioner has completed cultural competence training specific to American Indian culture.
82	Required for Medicare & Duals Products Only	**Cultural Competence Training - Asian**	Y/N	Indicate if practitioner has completed cultural competence training specific to Asian culture.

Line	Required	Field Name	Acceptable Values	Comments
83	Required for Medicare & Duals Products Only	**Cultural Competence Training – Hispanic/Latino**	Y/N	Indicate if practitioner has completed cultural competence training specific to Hispanic/Latino culture.
84	Required for Medicare & Duals Products Only	**Cultural Competence Training – Pacific Islander**	Y/N	Indicate if practitioner has completed cultural competence training specific to Pacific Islander culture.
85	Required for Medicare & Duals Products Only	**Patient Populations Serviced**	Characters	Indicate the patient populations that the practitioner has specialized training and experience in treating.
86	Required for Medicare & Duals Products Only	**Patient Disorders**	Characters	Indicate the patient disorders that the practitioner has specialized training and experience in treating.

EXHIBIT 3-B
TO
DELEGATED CREDENTIALING ATTACHMENT

QUARTERLY - CREDENTIALING ACTIVITY SUMMARY REPORT REQUIREMENTS

☐ Initial Credentialing
☐ Number of practitioners credentialed
☐ Recredentialing
☐ Number of practitioners recredentialed timely
☐ Number of practitioners non-timely
☐ Terminated/Rejected/Suspended/Denied/Resigned
☐ Number with cause
☐ Number with administrative reason
☐ Number resigned
☐ Facility/Organizational Credentialing, if applicable
☐ Number of facilities in network
☐ Number of facilities newly credentialed
☐ Number of facilities recredentialed within 36-month timeline
☐ Number of facilities recredentialed outside of 36-month timeline
☐ Ongoing Monitoring
☐ Date license sanction report was received by licensing entity
☐ Date and staff member reviewing license sanction report by licensing entity
☐ Date and staff member reviewing Medicare and Medicaid sanction information
☐ Number of practitioners in network identified as having new sanctions for State license and Medicare/Medicaid in reporting period