CREDENTIALING PROGRAM DESCRIPTION

This Program Description represents a summary of the Plan's core Credentialing and Recredentialing related Policies and Procedures. This Program Description is not intended as a substitute for the detailed processes and/or state specific requirements described in the Plan's policies and procedures.

TABLE OF CONTENTS

SECTION	SUBJECT	PAGE
I.	Credentialing Program Purpose, Scope and Objectives	3
II.	Policies and Procedures	3
III.	Scope for Credentialing and Recredentialing: Practitioners	4
IV.	Authority and Responsibility for the Credentialing Program	6
V.	Credentialing Committee Structure and Activities	7
VI.	Credentialing and Recredentialing Standards of Participation	9
VII.	Primary Source Verifications	11
VIII.	Credentialing and Recredentialing Process and Sources: Practitioners	12
IX.	Recredentialing	20
X.	Termination and Reinstatement	21
XI.	Practitioner Office Site Visits	21
XII.	Confidentiality	22
XIII.	Non-Discriminatory Credentialing and Recredentialing	23
XIV.	Application Status	23
XV.	Practitioner Rights	24
XVI.	Assessment and Reassessment Process and Sources: Organizational Providers	25
XVII.	File Retention	32
XVIII.	Ongoing Monitoring	32
XIX.	Notification to Authorities	36
XX.	Provisional Credentialing	36
XXI.	Credentialing Appeal Process	37
XXII.	Credentialing Information Integrity	38
XXIII.	Delegated Credentialing	39

I. CREDENTIALING PROGRAM PURPOSE, SCOPE AND OBJECTIVES

A. Purpose

Sentara Health Plans ("Plan") Credentialing Program ("Program") is comprehensive and ensures practitioners and organizational providers meet and continue to meet professional standards assuring the competency and quality of the Plan's participating Network delivering care to Plan members. The Program includes credentialing, recredentialing, ongoing monitoring and delegated credentialing oversight activities. The Plan does not make credentialing or recredentialing participation decisions based on a practitioner's race, ethnic or national identity, gender, age, sexual orientation or the types of procedures or patients in which the practitioner or organizational provider renders care to.

B. Scope

The Plan follows credentialing guidelines issued by the National Committee for Quality Assurance (NCQA), the Centers for Medicare and Medicaid Services (CMS), governing state regulatory agencies and Plan policies. The Program emphasizes and supports practitioner and organizational provider abilities to manage health care of Plan members. The Plan shall not prohibit or otherwise restrict any practitioner or organizational provider, acting within the lawful scope of practice, from advising, or from advocating on behalf of a Plan member who is a patient about any of the following:

The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among treatment options. This includes the risks, benefits and consequences of treatment or non-treatment and the opportunity for the patient to refuse treatment and/or express preferences about future treatment decisions.

C. Goals/Objectives

- Ensure the Credentialing Program adheres to all applicable federal, state and accreditation requirements;
- Initially credential practitioners and organizational providers (facilities) before they provide care to members;
- Conduct initial credentialing within all regulatory and/or accreditation processing timeframes;
- Recredential practitioners and reassess organizational providers at least every 36-months;
- Perform Ongoing Monitoring for quality, sanction and disciplinary issues in-between credentialing cycles;
- Perform oversight of entities the Plan contractual delegates Credentialing activities to.

II. POLICIES AND PROCEDURES

The Plan maintains well defined documented policies and procedures for initial credentialing, recredentialing, on-going monitoring and delegated credentialing oversight processes for the purpose of evaluating, selecting and retaining qualified practitioners and organizational providers to provide care to Plan members. The Credentialing Department designee, on an annual basis, reviews all credentialing policies and procedures, makes any necessary updates and submits them for approval by the Quality and Accreditation Department. Approved Policies and Procedures are electronically stored in the Plan's Policy management system.

III. SCOPE FOR CREDENTIALING & RECREDENTIALING: PRACTITIONERS

A. Practitioners who are within the Plan's scope to be credentialed and recredentialed

The Plan defines the types of practitioners who are credentialed and recredentialed as those listed below:

Medical Health Practitioners:

- Practitioners are licensed, certified or registered by the state to practice independently;
- Practitioners who have an independent relationship with the Plan. An independent relationship exists when the Plan directs its members to see a specific practitioner or group of practitioners, including all practitioners whom members can select as Primary Care Practitioners (PCPs). An independent relationship is not synonymous with an independent contract;
- Practitioners may seek approval from the Plan to participate as a Primary Care Practitioner and a Specialist providing they meet the Plan's participation criteria for all scopes of practice being requested;
- Practitioners who see members outside inpatient hospital/outside freestanding ambulatory facility settings;
- Practitioners who are hospital based but who also see the Plan members as a result of an independent relationship with the Plan;
- Pain Medicine practitioners;
- Oral Surgeons and Dentists who provide care to Plan members under their medical benefits;
- Non-physician practitioners who have an independent relationship with the Plan and who provide care to members under the Plan's medical benefits;
- Telemedicine Practitioners;
- Rental Network practitioners that are part of the Plan's primary network and the Plan has members who reside in the rental area;
- Rental Network practitioners that are part of the Plan's out-of-area care and members may see only those practitioners or are given an incentive to see the rental network practitioners;
- PPO Network practitioners if information about the Network is included in member materials or on a member ID Card that directs members to use the Network or there are incentives for members to see the PPO Network practitioners.

Behavioral Health Practitioners:

- Addiction Medicine practitioners
- Psychiatrists and other physicians
- Doctoral or Master's level Psychologists
- Master's level Clinical Social Workers
- Master's level Clinical Nurse Specialists
- Psychiatric Nurse Practitioners
- Psychiatric Physician Assistants
- Behavioral Analysts and Assistant Behavioral Analysts

The following list identifies by discipline the practitioner types that fall under the Plan's scope of credentialing and recredentialing. These lists are not all inclusive.

Doctorate Level Practitioners

- Medical Doctors (MD)
- Osteopathic Doctors (DO)
- Chiropractors (DC)
- Optometrists (OD)
- Podiatrists (DPM)
- Oral Surgeons (DDS/DMD)
- Psychologists (PsyD/PhD)
- Pharmacists (PharmD)

Dental Practitioners

- Dentists (DDS/DMD)

Allied Health Professionals

- Acupuncturists
- Audiologists
- Diabetes Educators
- Dieticians and Nutritionists
- Physical, Occupational, Massage and Speech Therapists
- Psychologists
- Clinical Social Workers
- Mental Health Counselors and Professional Counselors
- Behavior Analysts and Assistant Behavior Analysts
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives

B. Practitioners who are <u>not</u> within the Plan's scope to be credentialed and recredentialed:

The Plan defines the types of practitioners who are not credentialed or recredentialed, as those practitioners who do not have an independent relationship with the Plan, and meet any of the following criteria:

- Practitioners who practice exclusively within the inpatient setting, and who provide care for Plan members only as a result of members being directed to the hospital or other inpatient setting;
- Practitioners who practice exclusively within free standing facilities and who provide care to Plan members only as a result of members being directed to the facility;
- Pharmacists who work in conjunction with a pharmacy benefit management organization to which the Plan delegates utilization management functions;
- Covering practitioners (e.g., Locum Tenens);
- Practitioners who do not provide care for Plan members (e.g., Board Certified Consultants who may provide a professional opinion to the treating practitioner);
- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

Hospital Based Practitioners may include, but are not limited to:

- Anesthesiologists & Certified Registered Nurse Anesthetists
- Emergency Medicine
- Hospitalists & Hospital Medicine

- Pathologists
- Radiologists
- Neo-Natal / Peri-Natal
- Critical Care Medicine
- Trauma Medicine
- Any other practitioner specialty practicing exclusively in an inpatient setting

Non-inpatient facilities in which practitioners may practice exclusively and provide care for members only as a result of members being directed to the facility may include, but are not limited to:

- Mammography Centers & Free-Standing Radiology Centers
- Urgent Care Centers
- Surgery Centers
- Ambulatory Behavioral Health Facilities
- Psychiatric and Addiction Disorder Clinics

School Based Clinics

- School Based Practitioners
- School Nurses

IV. AUTHORITY AND RESPONSIBILITY FOR THE CREDENTIALING PROGRAM

The Plan's Board of Directors has ultimate authority, accountability, and responsibility for the Credentialing Program and has delegated full oversight of the Credentialing Program to the Credentialing Committee. The Credentialing Committee accepts the responsibility of administering the Credentialing Program and having oversight of operational activities, which include making the final decision, (i.e., approve, pend, or deny) for all practitioners and organizational providers (facilities) regarding network participation. At least annually, the Credentialing Program Description will be reviewed/updated and presented to the Credentialing Committee, and/or the Quality Improvement Committee (QIC).

Chief Medical Officer (CMO): The CMO provides direction for the development and implementation of the Credentialing, Quality Improvement, Utilization Management and other Medical Management Programs.

Plan Medical Director: The Plan Medical Director has oversight responsibilities for clinical and peer review aspects of the Credentialing Program. They or their designee acts as the Chairperson for the Credentialing Committee.

Enterprise Credentialing Director: The Plan's Enterprise Credentialing Director has oversight responsibilities for the day-to-day operations of the Credentialing Department and management of the Plan's Credentialing System.

Credentialing Committee: The designated review body of the Plan used to make Network participation decisions for credentialing, recredentialing, ongoing monitoring and delegated credentialing activities. The Credentialing Committee is a heterogeneous, clinical peer-review body of participating Plan practitioners who span a range of medical health care professions, including primary care and specialty care as well as behavioral health specialists.

V. CREDENTIALING COMMITTEE STRUCTURE & ACTIVITIES

A. Credentialing Committee Membership with Voting Privileges

The Credentialing Committee is a heterogeneous, clinical peer-review body comprised of participating Plan practitioners who span a range of medical and behavioral health care professions including primary care, specialty care and behavioral health specialists. These Committee Members:

- Represent a varying span of medical professions which represent the Plan's participating Network;
- Are external to the Plan (not employed), and must hold a Plan contract for Network participation;
- Are not excluded from the Plan's credentialing, recredentialing and ongoing monitoring requirements;
- Provide advice and expertise while engaging in meaningful peer review discussions before rendering decisions on which practitioners and facilities meet criteria and expectations for Plan Network participation;
- Understand membership on the Credentialing Committee is voluntary and they may resign their Committee duties at any time without retaliation by the Plan;
- May be appointed, rotated or removed from the Committee at the sole discretion of the Plan Medical Director.

B. Confidentiality, Non-Discrimination & Conflict of Interest

Clinical voting members are required to sign Confidentiality, Non-Discrimination and Conflict of Interest Statements annually. No person may participate in the review and evaluation of any professional practitioner or facility with whom they have been in a group practice, professional corporation, partnership, corporation, limited liability company or similar entity whose primary activity is the practice of medicine or where judgment may be compromised or deemed a potential for Conflict of Interest. The Plan Medical Director and/or Chairperson of the Credentialing Committee shall have the authority to excuse a voting member from the Credentialing Committee in the presence of a conflict of interest. A Credentialing Committee member may also recuse themselves. Such actions will be documented in the meeting Minutes.

C. Credentialing Committee Membership with Non-Voting Privileges

Representatives from various Plan Departments are included in Credentialing Committee membership as non-voting members. They provide relevant administrative support to the Medical Director and Committee Members for Plan policy clarifications and ease of Credentialing Program facilitation. Department personnel represented may include: Credentialing, Quality Improvement, Provider Operations and Network Development. Plan employees shall sign a Confidentiality Statement upon employment and prior to being granted access to any Credentialing related data or documentation.

D. Meeting Frequency & Quorum

The Credentialing Committee shall meet at least monthly. However, additional or more frequent meetings will be scheduled as deemed necessary by the Plan Medical Director. A quorum attendance of 51% of voting membership must be present at each meeting for all items and cases requiring a vote, in order for the proceedings to be considered valid.

E. Credentialing Committee Duties

The Committee is responsible for oversight of the credentialing, recredentialing, ongoing monitoring and delegated credentialing oversight processes. Duties include but may not be limited to the following activities:

- Ensure the Credentialing Program is administered in accordance with and applied consistently for all governing State, Federal, Plan and Accreditation regulations;
- Establish, revise and monitor Credentialing Program at least annually;

- Report Credentialing Program activities to the Plan's Quality Improvement Committee (or any other Plan Committee requiring or requesting a report from the Program), at least annually;
- Adhere to required Confidentiality, Non-Discrimination and Conflict of Interest requirements during all aspects of their tenure serving on the Credentialing Committee;
- Review completed Minutes from the prior meetings to ensure discussion and decisions were captured and documented accurately. They may vote to fully approve the Minutes as submitted or approve the Minutes with specific requested changes;
- During each meeting, receive, review and discuss the credentials and file information of all practitioners and facilities being credentialed, recredentialed or monitored who do not meet the Plan's established Network participation criteria and/or professional and ethical standards for their position. This review includes evaluating files identified as "Issue" files or those files with problematic or concerning trends in their history (e.g., malpractice cases, licensure issues, quality concerns, missing documentation, etc.);

Committee review of Issue files we be handled thoughtfully with robust discussion among all Committee Members giving consideration to all elements applicable to each case before rendering Plan Network participation decisions and the practitioners or facilities ability to deliver appropriate care, services and quality to Plan Members.

The Committee may vote to administer any of the following actions regarding Network participation:

- Approve for a full 3-Year Cycle;
- Approve for a limited Cycle (6 months, 1-Year or 2-Years);
- Pend the case file for further information;
- Deny participation.

F. Review of Files that Meet Established Criteria

The Plan Medical Director or his/her designee may review and approve "Clean" files on a continual basis before, in-between and after each Credentialing Committee meeting. Clean files are those deemed to meet the Plan's established Network participation criteria.

The Medical Director or his/her designee review and approve Clean files within a secure area of the Plan's Credentialing System that only Medical Directors can access. They electronically sign and date each decision issued. The approval date issued for Clean files by the Medical Director is considered the official and final decision approval date. Full 3-year cycles are issued/approved for all Clean files. The Credentialing Committee shall be presented with a listing of the practitioners and facilities approved as "Clean" by the Medical Director or his/her designee during this timeframe. These participation decisions are recorded in the meeting Minutes.

G. Credentialing Committee Meeting Minutes

Complete and accurate Minutes will be maintained for each meeting. The Committee will review minutes for accuracy and vote to approve them. The Minutes shall be securely stored electronically only accessible to authorized personnel.

H. Communication of Committee Decisions

All Clean files approved by the Medical Director outside of the Credentialing Committee will have a written approval notification sent to each practitioner and facility within 30-calendar days of the decision date. All Issue file decisions rendered by the Credentialing Committee will have written notifications sent to each practitioner and facility within 30-calendar days of the decision date. Denial decisions will also be communicated in writing within 30-calendar days of the decision and any applicable appeal rights and corresponding time frames will be listed in the letter.

VI. CREDENTIALING AND RECRECENTIALING STANDARDS OF PARTICIPATION

The Plan accepts practitioners into its network at its sole discretion based on the need for practitioners in certain specialties, geographic areas, or similar considerations. Each practitioner must meet minimum standards for participation in the Plan's Network. Acceptable participation criteria will comply with the Plan, CMS, applicable state regulators, NCQA, or any other applicable regulatory and/or accreditation entity regulations. The Plan credentials practitioners before they provide care to members.

A. Exclusion Credentialing and Recredentialing Criteria:

The Plan shall, upon obtaining information or receiving information from a verifiable, approved and reliable sources, exclude from participation practitioners or persons meeting certain criteria including that which falls into categories referenced in the Social Security Act. Entities, which could be excluded under § 1128(b)(8), as amended of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity and has been convicted of the following crimes:

- Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);
- Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended); or
- Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary.

Practitioners verified to have any of the following are also excluded from Plan Network participation:

- Who appear on the OIG LEIE or System for Award Management Exclusions report;
- Who appear on a State Medicaid Exclusion report;
- Who appear on the Social Security Administration Death Master File;
- With a current suspended or terminated license to practice.

B. Minimum Credentialing and Recredentialing Criteria:

- Practitioner must hold active unrestricted (no limitations), current and valid professional licensure(s) to practice in any state the practitioner is providing care to Plan membership;
- As applicable, practitioner must hold a current and valid Federal Drug Administration Certificate with authority to write prescriptions for their scope of practice;
- As applicable, practitioner must hold a current and valid State Controlled Substance Registration Certificate (CSR/CDS) in any state with this Certificate requirement for practitioners prescribing controlled substances, if those states are states in which the practitioner will render care to Plan membership;
- As applicable, Board Certification by an approved certifying Board, in a recognized practice specialty;
- In lieu of Board Certification, the practitioner must have completed education and training in his/her practicing specialty and this training must be able to be primary source verified by the Plan;
- Sentara Health Plans requires all physicians (MD/DO) to be board certified. Sentara Health Plans may, at its sole discretion, waive the specialty board certification requirement for applicants that meet a certain criteria, such as: The practitioner is within 6-years of graduation from their practicing specialty training program; They practice in an underserved geographic area classified Rural by the most recent U.S. Census located at www.census.gov. The practitioner practices in a specialty required to fill a geo-access gap for the Plan as determined by Network Management; The practitioner has been previously board certified by an acceptable

certified board in their practicing specialty for 30-years, has no quality issues and/or malpractice claims (pending or settled) in the last 10 years and has chosen to not renew their accepted board certification.

- Practitioner must carry active professional malpractice liability coverage (as required by state law), meeting the regulatory monetary coverage amounts required by the state(s) they are providing care to Plan members;
- Practitioner must have absence of a history of denial or cancellation of professional malpractice liability insurance, and evidence that any history of malpractice suits, arbitrations or settlements do not suggest an ongoing substandard professional competence or conduct as determined by the Credentialing Committee;
- Practitioner must have absence of health problems including drug or alcohol abuse, which may interfere with judgment or competence, substantially impeding their ability to perform the essential functions of his/her scope of practice as determined by the Credentialing Committee;
- Practitioner must have absence of a history of criminal felony convictions and/or, indictments, or evidence this history does not suggest an effect on professional competence or conduct. A conviction within the meaning of this section includes a plea or verdict of guilt or a conviction following a plea of nolo contendere;
- Be and continue to be eligible for participation in Medicare and/or Medicaid programs with no evidence of an active investigation with Medicare or any state Medicaid entity;
- Not have active sanctions listed with the OIG LEIE, SAM or and State Medicaid Exclusion Report;
- Medicare Requirement: Not have opted-out of Medicare participation.

C. Quality Criteria:

In the event a site visit is conducted to a practitioners office, it must meet site visit and medical record keeping practice guidelines as per Plan, CMS, State regulatory and/or NCQA regulations.

- Practitioner practice patterns must reflect a general adherence to established practice standards and protocols as adopted by the Plan;
- Practitioner must maintain satisfactory performance in practice quality indicators established by the Plan (i.e., clinical outcomes, performance measure outcomes, member satisfaction, etc.).

The Plan retains the right to approve or deny new practitioners for participation based on quality issues, and to terminate individual practitioners for the same. Termination of individual practitioners for quality-of-care considerations shall be supported by documented records of noncompliance with specific expectations and requirements for practitioners. The Plan has a prescribed system of appeals available, which must be followed.

D. Business Administrative Criteria:

Practitioner must maintain the Plan's access standard requirements at the majority of the ambulatory service sites where a member may be seen. Unless prohibited by state law, the practitioner's area of specialty must fill a network need as determined by the Plan. The Plan reserves the right to deny participation, case-by-case if a need does not exist for a particular specialty and if such action is deemed in the best interest of the Plan's network.

E. Credentialing or Recredentialing "Clean" File Management:

Practitioners who meet the Plan's established "Clean" file criteria may be reviewed and approved by the Medical Director. Medical Director approval of Clean files is final. Clean files are those practitioner's:

- With Prior historical "issues" in their file that were previously reviewed by the Credentialing Committee and approved during a prior review cycle;
- With Work history gaps that have an acceptable explanation provided by the Practitioner (i.e.. having a baby, searching for employment, caring for a family member, home schooling children, travel, retirement etc..);
- Who should have an active DEA or CDS/CSR Certificate, however, they do not and they have an appropriate

covering practitioner who agrees to write prescriptions for their Plan members;
- Required to have hospital privileges who do not, however, they do have appropriate admitting coverage in place for their Plan members;
- Who do not provide 24/7 call coverage themselves, however, they do have appropriate 24/7 call coverage arrangement in place for Plan members;
- With settled malpractice cases of less than $100,000.00 each;
- With settled malpractice cases of more than $100,000.00 each that are over 10-years old;
- With settled malpractice cases involving a patient death over 10-years ago.

F. Credentialing or Recredentialing "Issue" File Management:
Files that do not meet the definition of a "Clean" file per the Plan's established Clean file criteria are considered an "Issue" file. These completed case files are reviewed in detail by the Credentialing Committee members for peer review discussion and Plan Network participation determinations. Issue files are practitioner's with:

- Malpractice cases involving the death of a patient within the past 10-years, not previously reviewed;
- Settled malpractice cases of more than $100,000.00 each within the past 10-years, not previously reviewed;
- License Sanction or License Limitation, not previously reviewed;
- Hospital Sanction, Discipline or Revocation of privileges, not previously reviewed;
- Any specialties requiring hospital privileges that do not have any hospital privileges and do not have adequate admitting coverage available for Plan members;
- No 24/7 call coverage available for Plan members;
- Active enrollment in a drug, alcohol or other addiction monitoring program;
- Inability to perform limitations or practice restrictions (mental, physical or addiction related limitations);
- Any cumulative current and historical adverse information suggestive of a negative trend or poor outcomes, regardless of if some of the information may have been previously reviewed;
- Unacceptable Quality of Service and/or Quality of Care issue(s) on file with the Plan during recredentialing.

VII. PRIMARY SOURCE VERIFICATIONS

Primary source verification is an official, documented verification by an entity that they conferred or issued a credential, indicating that an individual's statement of possession of said credential is true and valid. Primary source verifications are obtained by the Plan from approved NCQA institutions such as, but not limited to: a medical/professional school, a board certification entity, or a state licensing board. A contracted Agent or Display Agent utilized by a primary source to provide legitimate primary source verifications are acceptable.
Primary source verifications may be accomplished by mail, fax, email, verbally or electronically through the source website. The means by which primary source verifications are obtained shall be documented in the Plan's credentialing system. The intent is to ensure that no interference from outside parties occurs during obtaining or transmission of the verified information.

Appropriate Methods of Performing and Documenting Primary Source Verifications
The Plan Credentialing staff will conduct primary source verifications as required by our regulatory agencies and NCQA. The Plan may accept letters, emails, fax's, telephone calls, internet verifications and/or electronic verifications received through our Credentialing system as acceptable sources of primary source verification. All primary source verifications received shall be reviewed and validated by a Credentialing staff member and be valid and current at the time of the participation determination. Verifications will be documented in the Plan's credentialing system as follows:

- Name of the person/source entity supplying the verification including source address/website;
- Name & identifying information of the practitioner the verification applies to;
- The date the verification was completed;
- The type of verification completed (License, Education, Board Certification etc..);
- Relevant date range time periods, as required, for the verification such as dates of education attendance or completion, effective and expiration dates of licenses and board certification etc..;
- The name of the Credentialing staff that completed the verification;
- Information verified must be accurate and current/valid at the time of the Credentialing Committee decision.

VIII. CREDENTIALING AND RECREDENTIALING PROCESS AND SOURCES: PRACTITIONERS

A. Complete Application

Practitioners are required to complete an application for initial credentialing and recredentialing. The Plan uses the Council for Affordable Quality Health Care's (CAQH) Universal Provider Data Source Application found at https://proview.caqh.org. If a state mandates use of their specific state application for credentialing and recredentialing, CAQH utilizes the state specific application templates in lieu of the standard CAQH application.
In order to begin the credentialing or recredentialing process, a complete application must be received with a signed attestation confirming the correctness and completeness of the application. An application is complete when:

- The application has been fully completed with all questions answered and required fields populated;
- Full 5-year work history must be provided within the application or a current Curriculum Vitae must be provided (initial credentialing only);
- Application is signed and dated by the applicant;
- Solo practitioner's must have provided covering practitioner information;
- Hospital or Surgery Center privileges are provided, as applicable;
- PCPs without hospital privileges must provide their admitting arrangements;
- Explanations for any "yes" response within the application Questionnaire Disclosure are required;
- SSN, NPI, DEA, CDS, License, Medicare and/or Medicaid ID Numbers must be provided, as applicable;
- Malpractice liability insurance coverage information must be provided within the application or included as a separate document;
- The following application disclosure questions must be answered:
    - Reasons for inability to perform the essential functions of the position;
    - Lack of present illegal drug use;
    - History of loss of license and/or felony convictions;
    - History of loss or limitation of privileges or disciplinary actions;
    - Current malpractice insurance coverage;
    - Current and signed, Attestation confirming the correctness and completeness of the application.

B. Credentialing and Recredentialing Application Verification

Verification time limit: Attestation is 180-calendar days from the credentialing or recredentialing decision
Required: During initial credentialing and recredentialing

Primary source verification of the application itself is not required. The Plan uses information provided on a complete application to verify related information directly from primary sources. Verification of the application includes:

- Review of the full application to ensure it is fully completed;

- Required supplemental documents have been included with the application;
- A signed and dated Authorization and Release was included;
- The application has been appropriately signed, dated and the correctness and completeness has been attested to within the time limit.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The application Attestation Date;
- The date the application was reviewed;
- The Plan Representative who reviewed the application.

C. Current Valid State License Verification

Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing, recredentialing and between cycle monitoring

License must be in effect at the time of all credentialing or recredentialing decisions and will be verified for all states where the practitioner provides care to Plan members. Primary source verifications will be completed as follows:

- Dated electronic verification performed automatically through the Plan's Credentialing System (web crawler) with the state licensure agency;
- By a dated verification obtained by a Plan staff member directly from the state licensure website.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- Expiration Date of the License;
- The Plan Representative who performed the verification.

D. Current Valid DEA/CDS/CSR (if applicable)

Verification time limit: Prior to the credentialing or recredentialing decision
Required: During initial credentialing and recredentialing

Certificate(s) must be in effect at the time of credentialing or recredentialing decisions and are required for all states where the practitioner provides care to Plan members.

Verifications may be obtained through any of the following methods:

- Copy of the Certificate(s);
- Electronic verification performed automatically through the Credentialing System with the approved DEA primary source verifier;
- American Medical Association Physician Master File primary source verification for DEA only;
- American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File for DEA only;
- Confirmation from the state pharmaceutical licensing agency, where applicable for CDS/CSR's.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;

- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Expiration Date of the DEA, CDS/CSR Certificate;
- The Plan Representative who performed the verification.

E. Education and Training

Verification Time Limit: Prior to the credentialing decision (or recredentialing decision if training completed is new since last review cycle)

The Plan verifies the highest levels of education and training obtained by the practitioner as appropriate:

- Board Certification in their practicing specialty(ies);
- Residency in their practicing specialty(ies);
- Graduation from Medical or Professional School.

NCQA approved board certification organizations primary source verify the practitioner's education and training prior to issuing board certification credentials. Therefore, verification of board certification through these organizations fully meets the requirement for verification of education and training for applicable practitioners. The Plan only recognizes Residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) in the United States, the American Osteopathic Association in the United States, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.

Verification of Fellowship completion does not meet the requirement for verification of education and training. Future dates of program completion do not meet the requirement for verification of education and training.
If a program is completed earlier than the issue date of the certificate of graduation or residency program, the organization may provide a letter from the primary source (e.g., program director) that the practitioner completed all program requirements, per NCQA standards and guidelines.

The Plan may use any of the following methods to primary source verify education and training:

For Physicians:

- Verify graduation directly from the Medical School, Podiatry School, Dental School or Chiropractic School who issued the practitioner's credential;
- Through the state licensing agency if the agency confirms they verify training prior to issuing licensure;
- NCQA approved board certification through the American Board of Medical Specialties (ABMS) or the official ABMS verification Display Agent, where a dated certificate of primary source authenticity is provided. This verification is obtained automatically electronically through the Plan's Credentialing System at https://dcs.abms.org/verifycertification.asmx;
- Through the American Medical Association Physician Masterfile at https://www.ama-assn.org/topics/ama-physician-professional-data;
- Through the American Osteopathic Association Physician Profile Report or the AOA Physician Master File at https://aoaprofiles.org;
- Through the Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986 at https://www.ecfmg.org;
- Through the Federal Credentials Verification Service (FCVS), for closed Residency programs through the FSMB at https://www.fsmb.org.

For Non-Physician allied and behavioral health professionals:

- The Plan must primary source verify the practitioners education and training directly with the institution who issued the practitioners credential or their official Display Agent. The National Student Clearinghouse (NSC)

is an approved Display Agent for many training and education institutions in the United States. Verifications may be obtained for participating NSC institutions at: https://www.studentclearinghouse.org.

Remainder of the page was intentionally left blank.

- Board Certification Verification from the Registry that performs primary source verification of board certification status may be used as acceptable verification if the Plan obtains annual written confirmation that the Registry performs primary source verification of completion of education and training. If the Registry does not verify completion of professional education and training, the Plan must primary source verify the practitioners education and training directly with the institution who issued the practitioners credential or their official Display Agent.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The dates of the education or training;
- The Plan Representative who performed the verification.

F. Board Certification Status

Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision

The Plan verifies board certification status of practitioners who disclose they are board certified on their application during initial credentialing and recredentialing. The Plan may use any of the following sources to verify NCQA approved board certification:

For all practitioner types:

- Directly from the appropriate specialty board or their official Display Agent;
- Through the state licensing agency, if they primary source verify board certification and the Plan has written confirmation of this directly from the licensing agency.

For Physicians (MD/DO):

- Through the American Board of Medical Specialties (ABMS) or the official ABMS verification Display Agent, where a dated certificate of primary source authenticity is provided. This verification is obtained automatically electronically through the Plan's Credentialing System at https://dcs.abms.org/verifycertification.asmx;
- Through the American Medical Association Physician Masterfile at https://www.ama-assn.org/topics/ama-physician-professional-data;
- Through the American Osteopathic Association Physician Profile Report or the AOA Physician Master File at https://aoaprofiles.org.
- The Plan does not accept boards in the United States that are not members of the ABMS or AOA.

For Oral Surgeons (DMD/DDS):

- Through the American Board of Oral and Maxillofacial Surgery at https://www.aaoms.org.

For Podiatrists (DPM):

- Through the American Board of Foot & Ankle Surgery at https://www.abfas.org;
- Through the American Board of Podiatric Medicine at https://podiatryboard.org.
- The Plan does not accept boards in the United States that are not members of ABFAS or Podiatry Board.

Note: Verification of board certification is not required for Nurse Practitioners, Physician Assistants or other Non-Physician health care professionals unless the Plan communicates these board certifications to Plan members.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The expiration date for the board certification or indication of lifetime status;
- The Plan Representative who performed the verification.

G. Work History

Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing

Primary source verification of work history is not required. However, verification by the Plan must include:

- A minimum of the most recent 5-years relevant work history as a health professional, which may be contained in the practitioner's application or provided in a supplemental Curriculum Vitae document;
- If the practitioner has practiced fewer than 5-years from the date of verification of work history, the work history start date begins at the time of initial licensure;
- Prior work experience for physicians (before they became physicians), practicing in a non-physician health professional role within the most recent 5-year period are included;
- The beginning and ending month and year for each position of employment are required unless the practitioner has had continuous employment for the most recent 5-years or more with no gap.

Work History Gaps

Any gap(s) exceeding 6-months are clarified by the Plan with the practitioner verbally or in writing.

- The Plan will document their review of the work history and the gap explanation in the practitioner's record in the Credentialing System;
- Any gap(s) exceeding 1-year must be explained by the practitioner in writing.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- Copy of the practitioner's Work History details will be stored on their application, Curriculum Vitae or a supplemental gap explanation document;
- The date the verification was obtained;
- The source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

H. Malpractice History

Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing and recredentialing

The Plan obtains a minimum of the past 5-years of malpractice settlement information that resulted in settlement or judgement paid on behalf of the practitioner. The required 5-year look back period may include residency and fellowship training years. The following primary sources may be used as verification:

- Directly from the practitioner's malpractice carrier(s);
- Through a query from the National Practitioner Data Bank (NPDB) at https://www.npdb.hrsa.gov.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;

- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

I. National Practitioner Data Bank (NPDB)
Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing and recredentialing

The Plan has a contractual agreement with the NPDB with Authorized Agent(s). The Plan's Credentialing System automatically electronically connects to the NPDB at https://www.npdb.hrsa.gov using our authorized account and retrieves individual practitioner verification reports. The reports are securely stored in each practitioner's record within the Credentialing System. The NPDB report can be used as evidence of verification for any or all of the following:

- 5-Year Malpractice History;
- Medicare and/or Medicaid Sanction History;
- State License Sanctions or Limitations.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:
- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

J. Hospital / Surgery Center Privileges
Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing and recredentialing

Verification may be obtained through any of the following:
- From the practitioners credentialing or recredentialing application if the name of the facility, dates of affiliation are active and type of privileges held are listed completely. The practitioners application attestation shall suffice as verification of hospital privileges;
- A copy of a letter issued by the hospital/surgery center may be provided by the practitioner which contains their current hospital privilege information;
- A verification from the hospital/surgery center website showing the practitioner's privilege status;
- Confirmation received directly from the hospital/surgery center confirming the practitioners privilege status.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:
- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

K. National Provider Identification (NPI)
Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing, recredentialing and between cycle monitoring

Confirmation the practitioner has an active NPI for their practicing specialty taxonomy is required. Practitioners with a deactivated NPI will be denied or terminated from Plan participation. Verification may be evidenced by:

- Through a website verification obtained directly from the National Plan & Provider Enumeration System (NPPES) at https://www.nppes.cms.hhs.gov/; or
- Through an automatic, electronic verification obtained through the Plan's Credentialing System, which connects directly to the NPPES at https://cs.veritystream.cloud/asp/NPI_RegistrySearch.aspx and returns a status verification directly into the practitioner's record in the Credentialing system.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

L. Social Security Death Master (SSDMF)

Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing, recredentialing and between cycle monitoring

Practitioners found on the SSDMF will be prohibited from participating or continuing their participation in the Plan's Network. These practitioners will be denied Plan Network participation or terminated accordingly. These practitioners may be reported to the Plan's Special Investigation Unit for fraud review. Verification will be evidenced by:

- Through an automatic, electronic verification obtained through the Plan's Credentialing System, which connects directly to https://ladmf.ntis.gov/ and returns a status verification directly into the practitioner's record in the Credentialing system.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

M. License Sanction or Limitation on Scope of Practice

Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing, recredentialing and between cycle monitoring

The Plan verifies state sanctions, restrictions on licensure and/or limitations on scope of practice in all states where the practitioner provides or has provided care to members for the most recent 5-year period available. If practitioners were licensed in more than one state in the most recent 5-year period, the verification(s) must include all states in which they provided care. Practitioner must have a valid, active and unrestricted license in the state(s) where they will provide care to Plan members. Practitioners found to have an active license sanction or limitation may be prohibited from participating or continuing their participation in the Plan's network and will be reviewed by the Plan's Credentialing Committee. Verifications may be obtained through any of the following sources:

Physicians

- Appropriate State License Agency(ies);
- Disclosure report response from the NPDB https://www.npdb.hrsa.gov;
- Disclosure report response from the FSMB https://www.fsmb.org.

Chiropractors & Dentists

- Appropriate State License Agency(ies);
- Disclosure report response from the NPDB https://www.npdb.hrsa.gov.

Podiatrists

- Appropriate State License Agency(ies);
- Disclosure report response from the Federation of Podiatric Medical Boards (FPMB) https://www.fpmb.org.

Non-Physician Behavioral Health & Allied Health Professionals

- Appropriate State License Agency(ies).

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

N. Sanction Information – Medicare & Medicaid

Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing, recredentialing and between cycle monitoring

The Plan verifies Medicare and Medicaid Sanctions in all states where the practitioner provides or has provided care to members for the most recent 5-year period available. If practitioners were licensed in more than one state in the most recent 5-year period, the verification(s) must include all states in which they provided care. Practitioners found to have an active Medicare or Medicaid sanction are prohibited from participating or continuing their participation in the Plan's network. Verifications may be obtained through any of the following sources, as applicable:

- Specific State Medicaid Agency or Intermediary;
- Medicare Intermediary or Medicare Exclusion Database;
- List of Excluded Individuals and Entities (LEIE) maintained by the Office of the Inspector General (OIG) at https://exclusions.oig.hhs.gov;
- Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General at secure OPM Debar Webpage or available to the public through the General Services Administration's Government-wide list of exclusions known as the System for Award Management or SAM (www.sam.gov), formerly the Excluded Parties List System (EPLS).
- American Medical Association Physician Master File at https://www.ama-assn.org/topics/ama-physician-professional-data;
- Federation of State Medical Boards (FSMB) at https://www.fsmb.org;
- National Practitioner Data Bank (NPDB) at https://www.npdb.hrsa.gov.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

O. Medicare Opt-Out Listing

Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing, recredentialing and between cycle monitoring

Practitioners that sign and new or hold an existing contract with the Plan for the provision of Medicare services to Plan members will be reviewed against the State Carrier's listing of Medicare Opt-Out practitioners. Practitioners who appear on this listing as having Opted-Out are not eligible to become or to remain as participating providers for the Plan's Medicare program(s) and will be terminated accordingly. Verifications may be obtained through any of the following sources:

- Medicare Opt-Out Status: Through an automatic, electronic verification obtained through the Plan's Credentialing System at https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits.
- Medicare Opt-Out Status Revalidation: Through an automatic, electronic verification obtained through the Plan's Credentialing System at https://data.cms.gov/tools/medicare-revalidation-list.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

P. SAM - System for Award Management

Verification time limit: 120 calendar days of the Medical Director or Credentialing Committee Decision
Required: During initial credentialing, recredentialing and between cycle monitoring

Primary Source Verification of Medicare & Medicaid Sanctions must also be obtained through the System for Award Management (SAM) formerly the Excluded Party List System (EPLS). Practitioners or Facilities found to have an active SAM Exclusion will be prohibited from participating or continuing participation with the Plan. Verifications may be obtained through either of the following sources:

- Through a website verification obtained directly from: https://sam.gov/;
- Through an automatic, electronic verification obtained through the Plan's Credentialing System, which connects directly to https://sam.gov/ and returns a status verification directly into the practitioner's record in the Credentialing system.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

IX. RECREDENTIALING

The Plan recredentials all practitioners at least every 36-months. Information and documents are obtained and verified according to the standards stated in Sections III-VIII. above. The recredentialing process shall also include performance-monitoring information on each practitioner from the following areas:

- Member Grievances and/or Complaints;
- Adverse Events, quality deficiencies, and/or quality issue trend patterns;
- Site Assessment and/or Medical Record Keeping Practice/Treatment Assessment Issues.

X. TERMINATION AND REINSTATEMENT

A. Termination & Reinstatement due to Non-Response to Recredentialing

If the Plan terminates a practitioner for administrative reasons (e.g., the practitioner failed to provide complete recredentialing information) and not for quality reasons, it may reinstate the practitioner within 30-calendar days of their termination date if all required information is received and without initially credentialing, as long as the practitioner's recredentialing cycle has not expired. However, the Plan is required to perform initial credentialing if the practitioner's reinstatement date is more than 30-calendar days after their termination date or if their recredentialing cycle has expired.

B. Termination & Reinstatement of a Practitioner the Plan Directly Credentialed or Recredentialed

If a practitioner was credentialed with the Plan and terminated from the Network voluntarily and not for quality reasons or any other adverse or egregious event, the practitioner may re-enter the network within 30-calendar days without having to be initially credentialed. However, the Plan shall initially credential a practitioner again if the break in network participation is more than 30-calendar days.

- The Plan re-verifies credentials that are no longer within verification time limits;
- The Plan re-verifies credentials that will not be in effect when the Credentialing Committee or medical director makes the credentialing decision.

C. Termination of a Delegated Credentialing Entity

NCQA requires an unbroken string of recredentialing at least every 3-years. If the Plan can obtain files from the delegate, it is not required to start over with initial credentialing; it may continue the process begun by the delegate and recredential practitioners when they are due. If the Plan cannot obtain files from the delegate, it must perform initial credentialing within 6-months of the delegate's termination date.

XI. PRACTITIONER OFFICE SITE VISITS

The Plan's Network Management Department conducts a site visit, if the Appeals and Grievances Department receives a member grievance or complaint about the quality of a practitioner's office related to but not limited to these criteria:

- Physical Accessibility (handicapped accessible, well-lit exam rooms, posted office hours);
- Physical Appearance;
- Adequacy of Waiting- and Examining-Room Space.

If required, follow-up site visits will be conducted at least every six months until the compliance threshold is met with the office. The office-site criteria include standards and compliance thresholds for each category below:

- Physical Accessibility (handicapped accessible, well-lit exam rooms, posted office hours);
- Physical Appearance;
- Adequacy of Waiting Exam Room Space;
- Availability of Appointments (timeliness of routine office visits, urgent visits);
- Adequacy of Treatment Record Keeping.

XII. CONFIDENTIALITY

All information received during credentialing, recredentialing and on-going monitoring is considered proprietary and confidential, and therefore subject to certain restrictions and prohibitions. Employees shall sign a Confidentiality Statement upon employment and prior to accessing any practitioner or facility information. Credentialing Committee members are required to sign Confidentiality, Non-Discrimination and Conflict of Interest Statements annually before participating in meetings. Accordingly, all information received shall be stored in the Plan's Credentialing System and subject to access only by authorized personnel The Plan assigns access and user rights to the Credentialing System based on role based access permissions to control access to information and prevent unauthorized modification to data and information.

The Plan has established processes to educate staff and monitor the use and disclosure of practitioner and facility information received by employees and agents of the Credentialing Department or on behalf of the Plan, in the performance of their job duties and responsibilities to the extent that such information meets the definitions of individually identifiable health information (IIHI) or protected health information (PHI) as defined under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Employees are required to complete annual Compliance Training courses which incorporate confidentiality and system and data security responsibilities.

A. Plan Employees

- Employees shall sign a Confidentiality Statement upon employment and prior to being granted access to any Credentialing related data or documentation.
- New Credentialing employees shall be oriented to the Confidentiality policy and procedures.
- Credentialing Staff shall participate in an annual review of the Confidentiality policy and procedure.
- Credentialing Staff shall complete annual Compliance and Data Security Training (which includes affirmation of their Confidentiality responsibilities).
- Employees may be required to sign revised or new Confidentiality Statements periodically.

B. Governance

- Review and release of credentialing, recredentialing and on-going monitoring files shall be prohibited except to the extent permitted by the Privacy Rule of HIPAA or any other governing law.
- All credentialing, recredentialing and ongoing monitoring information shall be stored electronically. The Plan's Credentialing System User access is restricted. Authorized Users have access to view or update only information that is necessary during the performance of their job duties and responsibilities.
- In the event any credentialing related documents are received in paper hard copy form, they shall be scanned into the Plan's Credentialing System for electronic storage and the paper copies received shredded.
- The Plan Medical Directors have limited, secure access to a specific area within the Credentialing System to review case information for purposes of rendering Network participation decisions. The Medical Directors also have access to update these cases with approval or denial determinations and electronically sign each decision they issue.
- The Plan Credentialing Committee Members have access to review limited, redacted case file information during Credentialing Committee meetings for purposes of discussion and peer review in order to render Network participation decisions.
- Credentialing Committee meeting minutes are stored electronically on a secured drive with limited User access. The minutes can be made available to applicable Plan personnel upon receipt of an appropriate and approved written request.

XIII. NON-DISCRIMINATORY CREDENTIALING AND RECREDENTIALING

The Plan does not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional or facility, who is acting within the scope of their license or certification under state law, solely on the basis of the license or certification. The Plan does not make credentialing or recredentialing decisions solely on a practitioner's race, ethnic or national identity, gender, age, sexual orientation or the type of procedure(s) or patient (i.e., Medicaid and Medicare), in which the practitioner specializes. This does not preclude the Plan from including in its network practitioners or facilities who meet certain demographic or specialty needs, for example, cultural needs of Plan members. The Plan does not discriminate against practitioners or facilities that serve high-risk member populations or specialize in conditions that may require costly treatment.

To assure there is no discrimination in the making of credentialing or recredentialing decisions, the Plan maintains a heterogeneous Credentialing Committee membership and those responsible for making credentialing or recredentialing decisions affirm they will not discriminate when making recommendations and decisions. Credentialing Committee membership are held to the highest moral standards. Tangible evidence of nondiscrimination is demonstrated by:

- Confidentiality, Non-Discrimination and Conflict of Interest Statements signed by each Credentialing Committee Member are obtained confirming they agree to adhere to conducting their Network participation decisions in a non-discriminatory manner. The attestation statement also specifically states the Plan does not base credentialing and/or recredentialing decisions on race, ethnic/national identity, gender, age, sexual orientation, or patient type (e.g., Medicaid and Medicare) in which the practitioner or facility specializes.
- Issue case files being reviewed by the Credentialing Committee are "blinded" with practitioner personal identifying information redacted from the review materials.
- The Plan has established practitioner participation requirements and set criteria to assist the Credentialing Committee members when making their decisions.
- Credentialing Committee decisions are reviewed at least annually to ensure no trends are identified indicating potential discriminatory outcomes.
- Any practitioner grievance received alleging there was discriminatory action taken which impacted their Network participation status are investigated.
- If findings of discrimination by any Credentialing Committee Members are discovered, they will immediately be removed for the Plan's Credentialing Committee.

XIV. APPLICATION STATUS

Upon receipt of a written request, the Plan will provide the practitioner with information on the status of their credentialing or recredentialing application. The Plan will provide status information within 10-business days of receiving the practitioner's request. Practitioners will be advised of the date their application was received, the status of the processing of their application including any missing or outstanding information still needed for their file and the expected timeframe for Medical Director or Credentialing Committee review for participation determination. No peer-review information or details will be disclosed to the practitioner. Practitioners are informed of this process through the Credentialing Program Description which is posted publicly on the Plan's website. Practitioners are instructed on the Plan's website they may contact the Credentialing Department at SHPCredDept@Sentara.com to request the status of their application.

XV. PRACTITIONER RIGHTS

A. Right of Practitioner to review information submitted to support his/her credentialing or recredentialing application:

Practitioner's may review any documentation submitted by him/her in support of their application, together with any information received from outside sources such as: malpractice carriers, state licensing agencies or certification boards. Practitioner's may not review any peer review information obtained by the Plan. Practitioners are informed of this Right through the Credentialing Program Description which is posted publicly on the Plan's website. Practitioners may request to review such information, by sending a written request, to the Credentialing Department at:

Sentara Health Plans
Attn: Credentialing Department
1330 Sentara Park
Virginia Beach VA 23464

B. Right of Practitioner to correct erroneous information and receive notification of the process and time frame the Plan will follow:

In the event the credentialing or recredentialing verification process reveals information submitted by the practitioner that differs from the verification information obtained by the Plan, the practitioner has the right to review information the Plan received. The practitioner is allowed to submit corrections for erroneous information or an explanation for the variation. Practitioners are informed of this Right through the Credentialing Program Description which is posted publicly on the Plan's website.

C. The process the Plan will follow for notifying practitioner when information obtained during credentialing or recredentialing varies from information the practitioner provided to the Plan:

The Plan notifies the practitioner of discrepant information it received during the credentialing and recredentialing process within 30-days of receipt. The Plan informs the practitioner of the discrepancy and requests a written explanation be submitted within 10-days. Practitioners are informed of this process through the Credentialing Program Description which is posted publicly on the Plan's website.

The Plan's written notification to the practitioner includes the following:

- The nature of the discrepancy with a copy of the information the Plan received;
- The process the practitioner needs to follow to correct the erroneous information;
- The format the practitioner needs to follow for submitting the corrections;
- Informs the practitioner they have 10-days from receipt of the Plan's notification to submit their corrections;
- Informs the practitioner that failure to return corrected information may jeopardize their Network participation status with the Plan;
- Informs the practitioner of the process the Plan will follow once their corrections are received;
- The name and address of the Plan Representative to whom they need to submit their corrections.

Once the corrected information has been received from the practitioner, the Plan will do the following:

- Document receipt and retain images of the corrected information received from the practitioner in the credentialing system;
- Notify the practitioner they received their corrections;

- Resume credentialing or recredentialing processing of the practitioners file, following the Plan's normal file review process for Medical Director or Credentialing Committee participation determination;
- Notify the practitioner of the credentialing or recredentialing participation determination within 30-days of the decision date.

XVI. ASSESSMENT AND REASSESSMENT PROCESS AND SOURCES: ORGANIZATIONAL PROVIDERS

The Plan will assess an Organizational Provider's ability to provide quality care and/or services before the facility is approved to render care to Plan members and before the contracting process has been completed. Re-assessment shall be completed on each participating Plan Organizational Provider at least every 36-months thereafter. As per NCQA, an Organizational Provider is a facility that provides services to members and where members are directed for services rather than to a specific practitioner.

A. Organizational Provider Types

The lists below are not all inclusive, however, they represent the broad scope of Organizational Providers the Plan may assess, monitor and re-assess every 36-months. Organizational Providers include facilities providing medical, behavioral, long term, and home or community based health care services.

Medical

- Hospitals (Acute Care, Children's, Critical Access, Rehabilitation)
- Home Health Agencies
- Skilled Nursing Facilities
- Free-Standing Ambulatory Surgery Centers
- Long Term Acute Care Facility
- Hospices

Medical Ancillary

- Comprehensive Outpatient Rehab Facilities
- Rural Health Clinics and Federally Qualified Health Clinic's
- Health Departments
- Community Service Boards
- Early Intervention Centers
- Outpatient Clinics
- Diagnostic Imaging Centers & Mobile Imaging
- Infusion and/or Chemo Therapy Centers
- Physical Therapy, Occupational Therapy & Speech Therapy Clinics
- Durable Medical Equipment Suppliers
- Dialysis Centers
- Hearing Aid Suppliers
- Laboratories
- Orthotic and Prosthetic Suppliers
- Pharmacy's & Pharmacy Clinics
- Optical Suppliers
- Urgent Care Centers

Long Term Care, Home and Community Based

- Adult Companion Services
- Adult Day Care Services
- Adult Day Health
- Assisted Living Facilities
- Case Management Services
- Community Care Management Agency
- Community Care Foster Family Home
- Environmental Accessibility Adaptation Services
- Family Training Services
- Financial Assessment Risk Reduction Services
- Home Delivered Meals
- Home Maintenance
- Housekeeping and Chore Services
- Service Facilitation Services
- Personal Care and/or Respite Care
- Nutrition Assessment Risk Reduction Services
- Private Duty Nursing
- Social Day Care
- Medically Frail Day Care
- Mentally Challenged Day Care
- Mental Health Skills Building

Behavioral Health

- Hospitals (Psychiatric)
- Community Mental Health Centers
- Community Service Boards
- Residential Treatment Centers for Psychiatric or Addiction Disorders
- Addiction Disorder Treatment Centers
- Mental Health and Addiction Disorder Counseling Centers
- Opioid Treatment Centers

B. Participation Criteria

The Plan accepts organizational providers into its network at its sole discretion based on the need for facilities in certain types, geographic areas, or similar considerations. Each organizational provider must meet minimum standards for participation in the Plan's Network. Acceptable participation criteria will comply with the Plan, CMS, applicable state regulators, NCQA, or any other applicable regulatory and/or accreditation entity regulations. The Plan assesses organizational providers before they provide care to Plan members.

1. **Exclusion Criteria – Disclosure of Ownership Controlling Interest and Management:**

   The Plan shall, upon obtaining information or receiving information from a verifiable, approved and reliable sources, exclude from participation organizational providers or persons meeting certain criteria including that which falls into categories referenced in the Social Security Act. Entities, which could be excluded under § 1128(b)(8), as amended of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect

ownership or controlling interest of five (5) percent or more in the entity and has been convicted of the following crimes:

- Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);
- Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended);
- Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary.

2. Exclusion Criteria – State and Federal Regulations:

- Who appear on the OIG LEIE or System for Award Management Exclusions report;
- Who appear on a State Medicaid Exclusion report;
- With a current suspended or terminated license to practice.

3. Minimum Participation Criteria:

Organizational Providers must meet the following criteria in order to participate in the Plans Network:

- Submit a complete application at initial assessment and during reassessment;
- Hold a current, valid state license without restriction, as applicable for each state of practice;
- Hold current, valid Professional and General Liability coverage within the policy limits established by their governing state laws, as applicable;
- Be in good standing with state and federal regulatory bodies;
- Must hold a current NPI appropriate for their facility specialty type taxonomy;
- Have an acceptable Disclosure of Ownership, Controlling Interest and Management Statement required by 42 CFR Part §455;
- Non-Accredited facilities must provide their most recent state or CMS site survey or allow the Plan to conduct a quality assessment if they do not have a state or CMS site survey to provide.

4. Quality Criteria:

The Plan retains the right to approve, deny or terminate organizational providers based on quality issues which include Adverse Events and Member Complaints.

- In the event a site visit is conducted to an Organizational Provider's facility , it must meet site visit, quality and medical record keeping practice guidelines as per Plan, CMS, State regulatory and/or NCQA regulations;

- Organizational Provider must maintain satisfactory performance quality indicators established by the Plan (i.e., clinical outcomes, performance measure outcomes, member satisfaction, etc.).

5. Business Administrative Criteria:

Unless prohibited by state law, the organizational provider facility type must fill a network need as determined by the Plan. The Plan reserves the right to deny participation, case-by-case if a need does not exist for a particular facility type and if such action is deemed in the best interest of the Plan's network.

C. Current Valid State License

Verification Time Limit: 120 days of the Medical Director or Credentialing Committee Decision
Required: During assessment, reassessment and in between cycle monitoring

The Plan will primary source verify the Organizational Provider's state License. The License must be in effect at the time of the participation determination. Licenses will be verified for all states where the Organizational Provider provides care to Plan members. Organizational Providers found to have an active license sanction or limitation may be prohibited from participating or continuing their participation in the Plan's network and will be reviewed by the Plan's Credentialing Committee. Verifications may be obtained through either of the following methods:

- Dated electronic verification performed automatically through the Credentialing System directly with the state licensure agency;
- By a dated verification obtained by a Plan staff member directly from the state licensure website.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e., electronic, website, letter etc..);
- Expiration Date of the License;
- The Plan Representative who performed the verification.

D. National Provider Identification (NPI)

Verification Time Limit: 120 days of the Medical Director or Credentialing Committee Decision
Required: during assessment, assessment and in between cycle monitoring

Confirmation the Organizational Provider has an active NPI appropriate for their facility specialty type taxonomy is required. Organizational Providers verified to have a deactivated NPI will be denied or terminated from Plan Network participation. Verifications will be obtained through either of the following sources:

- Through a website verification obtained directly from the National Plan & Provider Enumeration System (NPPES) at : https://www.nppes.cms.hhs.gov/; or
- Through an automatic, electronic verification obtained through the Plan's Credentialing System, which connects directly to the NPPES at https://cs.veritystream.cloud/asp/NPI_RegistrySearch.aspx and returns a status verification directly into the practitioner's record in the Credentialing system.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e., electronic, website, letter etc..);
- The Plan Representative who performed the verification.

E. Medicare and Medicaid Sanction Information

Verification Time Limit: 120 days of the Medical Director or Credentialing Committee Decision
Required: during assessment, assessment and in between cycle monitoring

The Plan verifies Medicare and Medicaid Sanctions in all states where the Organizational Provider renders care to members. Organizational Providers found to have an active Medicare or Medicaid Exclusion sanction will be prohibited from participating or continuing their participation in the Plan's Network. Verifications will be obtained through the following sources:

Medicaid (as applicable)

- Through the State Medicaid Agency or Intermediary if the state publishes a Medicaid Exclusion Listing.

OIG List of Excluded Individuals and Entities (LEIE) maintained by the Office of the Inspector General (OIG) at:

- https://exclusions.oig.hhs.gov;

SAM System for Award Management (SAM) formerly the Excluded Party List System (EPLS) at:

- Through a website verification obtained directly from: https://sam.gov/; or
- Through an automatic, electronic verification obtained through the Plan's Credentialing System, which connects directly to https://sam.gov/ and returns a status verification directly into the Organizational Provider's record in the Credentialing system.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e., electronic, website, letter etc..);
- The Plan Representative who performed the verification.

F. Current Professional and General Liability Insurance Coverage

Verification time limit: Coverage must be effective at the time of the credentialing participation decision, as applicable
Required: During assessment and reassessment, as required by state law

Verification may be obtained through any of the following:

- From the Organizational Provider's assessment or reassessment application, if the application includes the name of the insurer(s), policy limits and dates of coverage; or
- A copy of the Organizational Providers Policy Face Sheet, Certificate of Insurance, Policy Declaration Page, Federal Tort coverage letter or documentation of private Employer Self Insurance.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

G. Accreditation

Verification time limit: 120 days of the Medical Director or Credentialing Committee Decision
Required: During the initial assessment and re-assessment

Organizational Providers who have achieved Accreditation will have their Accreditation status verified by the Plan. Verifications will be obtained through any of the following methods:

- Verification obtained from the Accrediting Bodies website;
- Written or verbal verification obtained from the Accrediting Body;
- In the event Accreditation status is not able to be primary source verified by the Plan, verification may be obtained from the organizational provider through a copy of their Accreditation Report, Accreditation Certificate, or Decision Letter.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

Note: NCQA does not accept an attestation from the Organizational Provider regarding their Accreditation status as acceptable verification.

H. Plan Site Review for Unaccredited Organizational Providers
Verification time limit: 120 days of the Medical Director or Credentialing Committee Decision
Required: During the initial assessment and re-assessment

When Organizational Providers are not Accredited, the Plan shall conduct a Quality Assessment of the Organization. This assessment is performed through either of the following approaches by a member of the Plan's Quality Department:

1. **Off-Site Document review of the following:**
   - Evidence of a current Quality Improvement Plan and a formal Quality Improvement process;
   - Policies and Procedures for responding to patient/ family complaints;
   - A formal credentialing process to ensure that practitioners who are granted clinical privileges meet minimum credentialing criteria;
   - Policies and Procedures for medical records maintenance.

2. **On-Site Review will include review of the following:**
   - Evidence of a current Quality Improvement Plan and a formal Quality Improvement process;
   - Policies and Procedures for responding to patient/ family complaints;
   - A formal credentialing process to ensure that practitioners who are granted clinical privileges meet minimum credentialing criteria;
   - Policies and Procedures for medical records maintenance;
   - Evidence of physical/functional safe environment;
   - Review of mechanisms for infection control;
   - Review of procedures for assessment of and preventative maintenance of emergency equipment.

The Plan shall provide feedback to the Organizational Provider concerning the results of their Quality Assessment, which may include suggestions for corrective action for any deficiencies noted during the review. The Plan may offer sample material or resources to assist them in correcting any noted deficiencies. Deficiencies falling below the Plan's passing threshold will be followed up on by the Quality Department at least every six months until they are resolved. If they are not resolved and/or the Organizational Provider is not making viable progress to resolve, the issue will be submitted to the Plan's Medical Director for review and determination. A copy of the Quality Assessment will be sent to the Organizational Provider and stored in the Organizational Providers record in the Plan's Credentialing System.

I. State or Federal Site Review in lieu of the Plan's Quality Assessment
The Plan may substitute a copy of a Centers for Medicare and Medicaid (CMS) or applicable State quality review in lieu of conducting their own quality assessment if the CMS or State assessment is no more than 3-years old. If the CMS or State assessment is older than 3-years, the Plan is required to perform its own Quality Assessment. Verification is evidenced by one of the following:

- The Plan obtains a copy of the CMS or State assessment, report or letter directly from CMS or the State;

- The Plan obtains a copy of the CMS or State assessment, report or letter, from the Organizational Provider;
- The Plan obtains all necessary documents to confirm the CMS or State assessment, report or letter indicates the Organizational Provider was reviewed and passed the assessment.

The Plan deems valid CMS or State assessments showing the Organizational Provider passed as meeting the Plan's Quality Assessment criteria and no further action is necessary.

Exception: The Plan is not required to conduct a Quality Assessment if the Organizational Provider is located in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/ruralhealth/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

I. Assessment and Reassessment Review Criteria

Clean File

Organizational Providers who meet the following during initial assessment and reassessment:

- Licensure is active and in good standing without restrictions;
- No Medicare or Medicaid sanction exclusions;
- Have a valid, active NPI;
- Have General and Professional Liability coverage, if required by state law;
- Have a satisfactory Ownership Disclosure;
- Be Accredited without restriction or In lieu of Accreditation, have a compliant Plan, CMS or State Quality Assessment

Issue File

Organizational Providers who meet the following during initial assessment and reassessment:

- Licensure is active with restrictions;
- Accreditation with restrictions or an open Corrective Action;
- Plan, CMS or State Quality Assessment with an open Corrective Action.

J. Assessment and Reassessment Decision Making Process

The Plan Medical Director has the authority to approve Clean files. All Issue files must be reviewed and determined by the Credentialing Committee.

Clean Files

The Medical Director reviews a listing of Clean Organizational Providers weekly. They review and provide electronic approval determinations back to the Credentialing Department. The approval date and copy of the Medical Director's electronic approval are stored in the Organizational Providers record in the Plan's Credentialing System. A list of all Clean files approved by the Medical Director is provided to the Credentialing Committee during the next meeting and is documented in the meeting Minutes.

Issue Files

All Issue case files are prepared for full Credentialing Committee member review by the Credentialing Department. Organizational Provider file issues are summarized, relevant documents are redacted and case packets are prepared for review during the next scheduled Credentialing Meeting. These meetings occur once per month. At the conclusion of the meeting the Plan updates the Credentialing System with the Committee's decision. All discussion and decisions are documented in the Credentialing Committee Minutes.

K. Notification of Assessment or Reassessment Decision

Organizational Providers approved or denied during the initial assessment or reassessment will be sent a written notification indicating their status within 30-calendar days of the decision. Any that are denied or terminated will also be advised of their Appeal Rights, if applicable.

XVII. FILE RETENTION

Credential files are considered protected and confidential information and must be retained for at least seven years. Each practitioner and organizational provider has an electronic file stored in the credentialing system.

XVIII. ONGOING MONITORING

The plan performs monthly ongoing monitoring of Practitioner and Organizational Provider facility sanctions, exclusions, complaints, licensure status, quality issues and adverse events between recredentialing cycles. The Plan will take appropriate action against practitioners or facilities when it identifies occurrences of poor quality, sanctions, exclusions, complaints, licensure status issues and/or other derogatory information deemed to jeopardize quality care and services provided to Plan members.

The Plan shall on a monthly basis monitor the participating Network of practitioners and facilities to ensure they continue to be complaint with all applicable licensure, Medicare/Medicaid sanctions or exclusions, complaints, quality and adverse events.

A. Medicare and Medicaid Sanctions or Exclusions

Sanctions and Exclusions will be completed within 30-calendar days of its release by the official reporting source entity. The Plan verifies Medicare and Medicaid Sanctions or exclusions in all states where the practitioner or facility provides care to Plan members. Verifications may be obtained through any of the following sources:

- Specific State Medicaid Agency or Intermediary;
- Medicare Intermediary or Medicare Exclusion Database;
- List of Excluded Individuals and Entities (LEIE) maintained by the Office of the Inspector General (OIG) at https://exclusions.oig.hhs.gov;
- Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General;
- American Medical Association Physician Master File at https://www.ama-assn.org/topics/ama-physician-professional-data;
- Federation of State Medical Boards (FSMB) at https://www.fsmb.org; or
- National Practitioner Data Bank (NPDB) at https://www.npdb.hrsa.gov.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

B. System for Award Management (SAM): Primary Source Verification of Medicare & Medicaid Sanctions must also be obtained through SAM, formerly the Excluded Party List System (EPLS). Verification may be evidenced by either of the following methods:

- Through a website verification obtained directly from: https://sam.gov/; or
- Through an automatic, electronic verification obtained through the Plan's Credentialing System, which connects directly to https://sam.gov/ and returns a verification directly into the practitioner or facility record.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

C. Medicare Opt-Out Listing

Practitioners that hold an existing contract with the Plan for the provision of Medicare services to Plan members will be reviewed against the State Carrier's listing of Medicare Opt-Out practitioners. Practitioners who appear on this listing as having Opted-Out of the federal Medicare program are not eligible to remain as participating providers for the Plan's Medicare program(s) and will be terminated accordingly. Medicare Opt-Out status will be verified monthly during ongoing monitoring. Primary source verification will be obtained from and evidenced by the following method:

- Medicare Opt-Out Status: Through an automatic, electronic verification obtained through the Plan's Credentialing System at https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits.
- Medicare Opt-Out Status Revalidation is verified monthly: Through an automatic, electronic verification obtained through the Plan's Credentialing System at https://data.cms.gov/tools/medicare-revalidation-list.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

D. Sanctions and Limitations on Licensure

Licensure Sanctions and Limitations will be completed within 30-calendar days of its release by the official reporting source entity. The Plan verifies state sanctions, restrictions on licensure and/or limitations on scope of practice in all states where the practitioner or facility provides care to members on a monthly basis during ongoing monitoring. These primary source verifications may be obtained through any of the following sources:

Physicians:

- Appropriate State License Agency(ies);
- Disclosure report response from the NPDB https://www.npdb.hrsa.gov;
- Disclosure report response from the FSMB https://www.fsmb.org.

Chiropractors & Dentists:

- Appropriate State License Agency(ies);
- Disclosure report response from the NPDB https://www.npdb.hrsa.gov.

Podiatrists:

- Appropriate State License Agency(ies);
- Disclosure report response from the Federation of Podiatric Medical Boards (FPMB) https://www.fpmb.org.

Non-Physician Behavioral Health & Allied Health Professionals:

- Appropriate State License Agency(ies).

Organizational Providers/Facilities:

- Appropriate State License Agency(ies)

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

E. Current Valid State License

Licenses will be verified for all state(s) where the practitioner or Organizational Provider render care to Plan members. Licenses must be active and valid during ongoing monitoring validation.

- License verifications will be primary source verified directly from the state licensure agency;
- License verifications will be verified through the following methods:
  - Through an automatic, electronic verification obtained through the Plan's Credentialing System directly from the appropriate state licensure agency website or database; or
  - By a dated verification obtained by a Plan staff member directly from the state licensure website;

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- Expiration Date of the License;
- The Plan Representative who performed the verification.

F. National Provider Identification (NPI)

Confirmation the practitioner or Organizational Provider has an active NPI for their practicing specialty or Organizational Provider facility type taxonomy is verified. Verification may be evidenced by:

- Through a website verification obtained by the Plan directly from the National Plan & Provider Enumeration System (NPPES) at : https://www.nppes.cms.hhs.gov/; or
- Through an automatic, electronic verification obtained through the Plan's Credentialing System, which connects directly to the NPPES at https://cs.veritystream.cloud/asp/NPI_RegistrySearch.aspx and returns a status verification directly into the practitioner's record in the Credentialing system.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

G. Social Security Death Master (SSDMF)

Confirmation that the practitioner does not exist on the SSDMF file is verified. Verification may be evidenced:

- Through an automatic, electronic verification obtained through the Plan's Credentialing System, which connects directly to https://ladmf.ntis.gov/ and returns a verification into the practitioner's record.

All verifications will be documented in the Plan's Credentialing System. The following information will be documented:

- The date the verification was obtained;
- The primary source the verification was obtained from;
- The method in which the verification was obtained (i.e.. electronic, website, letter etc..);
- The Plan Representative who performed the verification.

H. Investigation of Member Complaints

The Plan shall investigate all practitioner-specific member complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable. The Plan shall evaluate the history of all complaints for all practitioners at least every 6-months.

I. Investigation of Adverse Events

The Plan monitors for adverse events at least every 6-months. At minimum, the Plan monitors adverse events for primary care practitioners and high-volume behavioral healthcare practitioners.

J. Adverse Event Action

1. Medicare/Medicaid Sanction Exclusions

In the event a participating practitioner or facility is identified as having a Medicare or Medicaid Sanction Exclusion, they will be terminated from the Plan immediately. Written notice will be sent to the practitioner or facility by the Credentialing Department indicating they have been terminated immediately "With Cause." A copy of this notice will be retained electronically in the Plan's Credentialing System.

2. Medicare Opt-Out

In the event a Plan participating Medicare practitioner is identified as having opted-out of the federal Medicare program, they will be terminated immediately from Plan Medicare contracts. Written notice will be sent to the practitioner or facility by the Credentialing Department indicating they have been terminated from their Medicare contract immediately "With Cause." A copy of this notice will be retained electronically in the Plan's Credentialing System.

3. Loss of Licensure

In the event a participating practitioner or facility is identified as no longer having a valid active license in the state(s) they are providing care and services to Plan members in, they will be terminated immediately from Plan participation. Written notice will be sent to the practitioner or facility by the Credentialing Department indicating they have been terminated immediately "With Cause." A copy of this notice will be retained electronically in the Plan's Credentialing System.

4. Deactivated NPI

In the event a participating practitioner or facility is identified as no longer having a valid active NPI (Deactivated NPI Status), they will be terminated immediately from Plan participation. Written notice will be sent to the practitioner or facility by the Credentialing Department indicating they have been terminated immediately "With Cause." A copy of this notice will be retained electronically in the Plan's Credentialing System.

5. SSDMF

In the event a participating practitioner is identified as appearing on the SSDMF, they will be immediately terminated from Plan participation. Depending on the circumstances of the "death" notice verification, the Credentialing Department may report the case to the Plan's Special Investigations Unit for potential fraud activity. Written notice will be sent to the practitioner's address of record by the Credentialing Department indicating they have been terminated immediately "With Cause." A copy of this notice will be retained electronically in the Plan's Credentialing System.

K. The Range of Actions Available to the Plan

The Plan has a range of actions available when making the decision to take action against a practitioner or facility for quality reasons. The Credentialing Committee shall use objective evidence and patient-care considerations when deciding on a course of action for dealing with a practitioner or facility that fails to meet the Plan's quality standards. The Credentialing Committee will review all available case information and have the ability to suspend, reduce, or terminate Network participation.

Adverse Events, prior to termination, may have a range of actions offered by the Plan in an effort to improve performance of the practitioner or Organizational Provider (i.e., close panels to all new members, remove all members from their existing panel, restrict the specific duties or services they may provide, require oversight of surgical procedures by another Plan participating surgeon, mandate periodic reviews of their medical records, require continuing medical education course(s), require attendance at Plan in-service Training(s), etc.).

If the Credentialing Committee makes the decision to suspend, reduce, or terminate the practitioner or organizational provider (facility), written notice will be sent to the practitioner or facility by the Credentialing Department indicating the actions taken by the Credentialing Committee. Appeal Rights and timeframes will be stated in the letter if applicable. A copy of this notice will be retained electronically in the Plan's Credentialing System.

XIX. NOTIFICATION TO AUTHORITIES

In the event the Plan determines a practitioner or organizational provider (facility) participated in an action or conduct which adversely affected a Plan member's health or welfare, the Plan shall report the intervention they took against the practitioner or facility to the appropriate governing agencies. As a result, a Practitioner or Facility terminated from the Plan's Network due to competence and/or professional conduct related to the deliverance of quality health care services to Plan membership, will be reported to any of the following entities, as applicable, within 30-business days of the termination date:

- Appropriate Governing State Agency;
- National Practitioner Data Bank;
- Office of the Inspector General;
- Centers for Medicare and Medicaid Services;
- Other appropriate entities.

XX. PROVISIONAL CREDENTIALING

The Plan does not allow Provisional Credentialing.

XXI. CREDENTIALING APPEAL PROCESS

The Credentialing Committee shall use objective evidence and patient-care considerations to decide on the means of altering a Practitioner or Organizational Provider's participation status based on quality of care, quality of service, or lack thereof of required credentials. The assessment of information for Practitioner's and Organizational Provider's will occur during credentialing, recredentialing, ongoing monitoring or upon the Plan's notification or identification of potential quality issue. Practitioners and Organizational Providers will be notified in writing of the Plan's decision to suspend, reduce, or terminate their Network participation status. The Plan provides an Appeal Hearing process for Practitioners or Organizational Providers regarding actions by the Plan that relate to either their Network participation status or any action by the Plan related to their competency, professional conduct and/or quality issues.
Exception: Credentialing or recredentialing decisions made for business or administrative purposes have no Appeal Rights, except with respect to Practitioners or Organizational Providers contracted with the Plan for Medicare Advantage.

A. Notice of Proposed Adverse Action

Following the decision by the Credentialing Committee to suspend, reduce, or terminate a Practitioner's or Organizational Provider's Network participation for quality reasons, written notice will be sent to the Practitioner or Organizational Provider by the Credentialing Department indicating the action(s) to be taken within 30-days of the decision. Appeal Rights and timeframes will be stated in the letter and a copy will be retained electronically in the Plan's Credentialing System. Adverse Action for quality reasons include: quality of care, quality of service, member complaints, adverse events and lack thereof required credentials. The written notice shall inform the Practitioner or Organizational Provider an Adverse Action has been proposed to be taken against them.

B. Informal Meeting

Upon receipt of written notice of an Adverse Action, the Practitioner or Organizational Provider may request to meet on an informal basis with an Ad Hoc Committee concerning the Adverse Action recommended by the Credentialing Committee by submitting such request in writing to the Chair of the Credentialing Committee or designee within ten (10) business days. Upon their receipt of such request, the Credentialing Committee Chair or their designee shall appoint an Ad Hoc Committee to meet, on an informal basis, with the Practitioner or Organizational Provider to discuss the matter.

This informal meeting shall be confidential, non adversarial, shall not constitute an Appeal Hearing. Following the meeting, the Ad Hoc Committee shall notify the Credentialing Committee Chair or their designee and the Practitioner or Organizational Provider of its recommendation to accept, modify, or reject the Adverse Action.

When the Practitioner or Organizational Provider is given notice of the recommendation of the Ad Hoc Committee which remains an Adverse Action, they shall be entitled to request an Appeal Hearing before a Hearing Panel. The Credentialing Committee Chair or designee shall appoint Hearing Panel members. No Practitioner or Organizational Provider shall be entitled as a right to more than one appellate hearing before a Hearing Panel.

This notice shall include the following:

- The reason for the proposed Adverse Action.
- Their right to request an Appeal Hearing if the Practitioner or Organizational Provider submits such a request in writing to the Credentialing Committee Chair or designee within 30-days of receipt of the notice.
- Failure to request an Appeal Hearing in writing within such time shall be deemed a waiver of the Practitioner's or Organizational Provider's right to an Appeal Hearing.

- The Practitioner's or Organizational Provider's (or their designee's) failure to attend the Appeal Hearing without good cause will result in the forfeiture of the right to a Hearing.

C. Appeal Hearing

1. The Appeal Hearing shall be conducted before a Hearing Panel. Hearing Panel members shall:

- Be clinical Practitioners of the same professional discipline as the affected Practitioner and considered qualified peers to review the case;
- Not be in direct economic competition with the affected Practitioner or Organizational Provider;
- Not be a member of the Plan's Credentialing Committee.

2. Practitioner or Organizational Provider Rights for the Appeal Hearing:

- To be represented by an attorney or other person of their choice;
- To have a record made of the Appeal Hearing proceedings;
- To have a copy of the Appeal Hearing record available to them upon their payment of reasonable charges to the Plan for the preparation of such record;
- To present evidence deemed relevant by the Hearing Panel, regardless of its admissibility in a court of law;
- To call and examine or cross-examine witnesses;
- To submit a written statement at the completion of the Appeal Hearing.

D. Notice of Appeal Hearing Decision

Upon the completion of the Appeal Hearing, the Practitioner or Organizational Provider shall receive a written notice of the recommendation of the Hearing Panel, including a statement of the basis for the recommendation. They will also receive a written decision notice from the Plan, including a statement of the basis for the decision. Decisions made by the Hearing Panel are final.

E. Notification to Authorities

If a Practitioner's or Organizational Provider's contract or participation is denied or terminated as a result of an Adverse Action based on deficiencies in the quality of care and/or professional misconduct affecting Plan membership, or as otherwise required by applicable law, the Plan will notify licensing and/or other disciplinary bodies or appropriate authorities of such action.

XXII. CREDENTIALING INFORMATION INTEGRITY

A. The Plan maintains thorough policies and procedures documenting the following requirements for credentialing information integrity:

- How primary source verifications are received, dated and stored;
- How modified information is tracked and dated from its initial verification;
- The titles/roles of staff who are authorized to review, modify and delete credentialing system information and what circumstances when modification or deletion is appropriate;
- The security controls in place to protect credentialing information from unauthorized modification;
- How the Plan monitors its compliance with these elements.
- Annual Credentialing Information Integrity Training

B. The Plan maintains thorough policies and procedures documenting the following oversight elements are in place to ensure the Plan's credentialing system security and controls are maintained:

- Identify all modifications to credentialing and recredentialing information that did not meet the Plan's criteria for being appropriate modifications;
- Analyze all instances of modifications identified that did not meet the Plan's appropriate modification criteria;
- Act on all findings of non-compliance and implement quarterly monitoring of non-compliant items for a minimum of three consecutive quarters.
- Report to NCQA when fraud and misconduct is identified.

XXIII. DELEGATED CREDENTIALING

The Plan ensures accountability and oversight for credentialing and recredentialing activities of practitioners (to include behavioral health) when the Plan delegates all or part of the credentialing, recredentialing and on-going monitoring activities. Each delegate is required to follow Plan, NCQA, CMS, state and any other required regulatory or accreditation requirements. The Plan retains the right, including quality issues, to make the final decision to approve, deny, suspend, and terminate a practitioner who has been delegated for credentialing.

A. Delegated Credentialing Agreement

The Plan shall enter into a legally binding, dated Delegated Credentialing Agreement with each delegate. This agreement shall be mutually agreed upon before delegation begins. The agreement will at minimum, include the following areas:

- Describes the delegated activities for both the delegate and the Plan;
- Requires the delegate to submit reports to the Plan at least semi-annually;
- Describes the process by which the Plan evaluates the delegate's performance;
- Requires the delegate to have credentialing system security controls in place to protect data from unauthorized modification and to monitor these system controls at least annually;
- Requires the Plan to monitor the delegate's credentialing system security controls at least annually;
- Specifies the Plan retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the Plan delegates decision making to the delegated entity;
- Describes remedies available to the Plan is the delegate does not fulfill its obligations, including revocation of the delegation agreement.

B. Responsibilities

The responsibilities and delegated activities of the delegated entity and the Plan are evidenced by the following being included in the agreement:

- The specific functions and activities being performed by the delegate;
- The specific functions and activities being retained by the Plan;
- If the delegate subdelegates an activity, the agreement will specify which entity is responsible for oversight of the subdelegate.

C. Reporting

The Plan determines the method and content of reports required from the delegate. The delegated agreement shall:

- Require at least semi-annual reporting is submitted to the Plan by the delegate;
- Specify what information is required to be submitted by the delegate and acceptable formats for submitting their reports to the Plan;
- Instructions on how and where reports are to be submitted to the Plan.

The Plan will analyze the delegate's reports to evaluate whether the delegated entity is meeting reporting guidelines as set forth in the Delegation Credentialing Agreement. The Plan will not accept reports that are incomplete or that do not meet the specific requirements stated in the Delegated Credentialing Agreement.

D. Performance Monitoring

The Plan evaluates the delegated entities prior to initial contracting and annually thereafter. Performance is assessed by conducting file audits, policy and procedure audits and credentialing systems controls and oversight compliance. The purpose of these audits is to assess the delegate's compliance with Plan, CMS, State, and NCQA requirements. If deficiencies are identified during an annual audit, a corrective action plan is developed and issued to the delegate. Noncompliance shall be monitored every 6-months until the deficiencies are corrected. In the event the deficiencies are not corrected, the delegated credentialing compliance issue will be presented to the Plan's Chief Medical Officer, their designee and/or the Plan's Credentialing Committee for discussion and a decision on how to proceed. The decision could include revocation of the delegation credentialing agreement if the delegated entity does not fulfill its obligations.

Where a delegate is accredited or certified by NCQA for credentialing, the Plan still evaluates the delegate's performance by conducting annual reviews of their policies and procedures and letters of accreditation or certification they received from NCQA.

E. PHI

If the Plan contracts with a delegate and the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation agreement will include the following provisions to ensure that the information will remain protected:

- A list of the allowed uses of PHI;
- A description of delegate safeguards to protect the information from inappropriate use or further disclosure;
- A stipulation that the delegate will ensure that subdelegates have similar safeguards;
- A stipulation that the delegate will provide individuals with access to their PHI;
- A stipulation that the delegate will inform the organization if inappropriate uses of the information occur;
- A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends.

F. Pre-Delegation Audit

Prior to a delegated agreement being in effect, if the delegated entity does not have a current NCQA certification or accreditation for credentialing, the Plan will conduct a pre-delegation audit. The threshold for compliance is 100%. If deficiencies are identified, those areas of noncompliance shall be communicated to the Plan's Accreditation Department for a decision to approve the delegation with conditions or to deny the partnership for delegation until the entity can successfully meet the requirements. The Pre-Delegation evaluation/audit will include, at minimum:

- An on-site visit, telephone consult and/or virtual review;
- Policy and Procedure audit;
- Credentialing and Recredentialing file audit;
- Compliance with credentialing system controls and oversight.

G. Annual Audits

For delegated agreements in effect for 12-months or more, an annual audit or evaluation will be conducted by the Plan. The threshold for compliance is 95%. Deficiencies will be followed up on every 6-months until the deficiency is corrected. The delegated entity could be suspended, terminated or another appropriate action, as determined by the Chief Medical Officer and/or Credentialing Committee, if the deficiency is not corrected. The Annual evaluation/audit will include, at minimum:

- Policy and Procedure audit;
- Credentialing and Recredentialing file audit;
- Credentialing System Controls and Oversight compliance.

Sub-delegation: If a delegate redelegates credentialing to another entity, the Plan will either verify that the delegate performs oversight and annual audits, or the Plan must conduct the oversight.

Remainder of page intentionally left blank.