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COMMUNITY HEALTH OPTIONS POLICY AND PROCEDURE			
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Purpose

The purpose of these Credentialing and Re-Credentialing Policies and Procedures (the "Policy") is to promote quality of care through the establishment of Credentialing and Assessment procedures which Community Health Options ("Health Options") will follow to verify a Provider's Credentials and Assess an Organization's ability to deliver quality care to Health Options Members based on criteria that include licensure, relevant training, conduct, and experience. Health Options will Credential all Providers and Assess Organizations with whom it contracts for participation in its Network (as defined below) in accordance with this Policy

Definitions

As used in this Policy, the following terms have the following meanings unless the context otherwise clearly indicates:

Assess or Assessment: The administrative process that supports the collection, verification, review, and evaluation of an Organization's credentials.

Board Certification: The successful completion of a process by which Providers are initially certified in a given medical specialty or subspecialty. Organizations that may grant Board Certifications recognized by Health Options include, but are not limited to, the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialists, and the American Association of Physician Specialists.

CMO: Health Options Chief Medical Officer or assigned designee.

Council for Affordable Quality Healthcare (CAQH): CAQH is an organization that provides a centralized online database for healthcare professionals to store and share their credentialing information

Covered Services: The health care items and services covered under a policy issued or administered by Health Options.

Credentialed or Credentialing: The administrative process that supports the collection, verification, review, and evaluation of an individual's Credentials.

Credentialing Application: is an application used as a systematic review of a provider's qualifications to ensure they meet the standards for participation in the Network. For CHO it is the CAQH.

Credentialing File: The file that contains, as applicable, the Provider's or Organization's application, primary source verifications, education, training, professional qualifications, liability history, work history, notes, correspondence incoming and outgoing, and phone call documentation. Credentialing Files may contain PHI or other health care information subject to state or federal confidentiality laws.

Credentialing Verification Organization (CVO): An entity to which Health Options delegates certain Credentialing functions for Providers and Organizations to be conducted in accordance with standards established by the National Committee for Quality Assurance ("NCQA") and the Centers for Medicare and Medicaid Services.

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Credentials: Records of a Provider's or Organization's education, training certifications, licensures, experience, and other health care qualifications, as applicable.

Delegated Entity: A corporation, limited liability company, partnership, or other organization or entity to which Health Options delegates any Credentialing or Assessment function(s).

Hearing Procedure Rules: The written rules governing the conduct of hearings are attached as Appendix A to this Policy.

Maintenance of Certification Program: Participation in a program beyond the continuing medical education requirements established by, if applicable, the Maine Board of Licensure in Medicine or the Maine Board of Osteopathic Licensure, or initial board certification by a national or regional medical specialty board.

Member: An individual eligible to receive Covered Services or other benefits under the terms of the applicable Health Options policy as the subscriber or an eligible enrolled family dependent. A Member may also be referred to in this Policy as a Covered Person.

Network: The Providers and Organizations who have been Credentialed or Assessed by Health Options (or a Delegated Entity) and have entered into a Participation Agreement with Health Options to provide Covered Services to its Members.

Non-Routine File (or Category 2): A Credentialing File that does not meet the established threshold for participation in the Network.

Organization: An institution or organization that provides services or supplies to Members and includes, but is not limited to, hospitals, home health care agencies, skilled nursing facilities, and ambulatory clinics and surgical centers.

Participation Agreement: The written agreement between Health Options and a Provider or Organization whereby the Organization or Provider becomes a part of the Network.

Primary Source Verification (PSV): Is a credentialing industry standard that verifies a person's credentials and qualifications through the original source of information.

Protected Health Information (PHI): Individually identifiable health information subject to the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Provider: A licensed or certified professional who provides behavioral or medical health care services, who may be a physician or non-physician. Sometimes referred to in this Policy as a Practitioner.

Re-Assessment and Re-Credentialing: These terms refer to the periodic Re-Credentialing of Providers and Re-Assessment of Organizations, whose Credentials or Assessments have been initially approved by Health Options, for the purpose of maintaining the Providers' and Organizations' participation in the Network.

Routine File (or Category 1): A Credentialing File that meets the established threshold for participation in the Network as provided in this Policy.

Procedure Generally:

A. <u>Providers Subject to Credentialing and Organizations Subject to Assessment</u>

1. Credentialing requirements apply to:
   - Providers who are licensed, certified or registered by the state to practice.
   - Providers who have an independent relationship with Health Options.
     - An independent relationship exists when Health Options directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom Member can select as primary care practitioners.
   - Providers who provide care to Members under Health Options policies.

   The criteria listed above apply to Providers in the following settings:
   - Individual or group practices.
   - Facilities.
   - Rental networks:
     - That are part of Health Options' primary network and Health Options has Members who reside in the rental network area.
     - Specifically, for out-of-area care and Members may see only those Providers or are given an incentive to see rental network practitioners.
   - Telemedicine.

2. <u>Medical Providers</u>. The types of Health Options Credentialed Medical Providers may include, *but are not limited to*, the following:

   - Medical doctors
   - Oral Surgeons
   - Chiropractors
   - Osteopaths
   - Ophthalmologists
   - Optometrists
   - Podiatrists
   - Nurse Practitioners
   - Locum Tenens who serves 60 or more continuous days. (Provisional Credentialing is required for locum tenens serving less than 60 continuous days.)
   - Naturopathic doctors
   - Physician Assistants (who have met minimum clinical hours)

3. <u>Behavioral Healthcare Practitioners</u>. The types of Health Options Credentialed Behavioral Providers may include, *but are not limited to*, the following:

   - Psychiatrists and other physicians
   - Addiction medicine specialists
   - Psychologists
   - Master's-level clinical social workers
   - Masters-level clinical nurse specialists
   - Psychiatric Mental Health Nurse Practitioners
   - Other behavioral healthcare specialists as determined by Health Options

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4. Organizations. Health Options assesses Organizations that Members are directed to for services including *but not limited to* the following:

   - Hospitals
   - Home health agencies
   - Skilled nursing facilities
   - Ambulatory clinics and surgical centers
   - Behavioral health facilities: inpatient, residential and ambulatory.

   Health Options does not require facility-based pathologists, anesthesiologists, radiologists, emergency medicine specialists, neonatologists, behavioral health specialists, rehabilitation specialists, hospitalists, and other clinicians who practice exclusively in an inpatient hospital or another inpatient setting, or within a free-standing facility, and provide care for Members *only* as a result of Members being directed to the facility, to complete the Credentialing process.

5. Limiting Network Participation. Notwithstanding any other provision in this Policy, Health Options reserves the right to limit participation of Providers and Organizations in the Network, based on the business needs of the Network, without respect to the level of competence or skill, for the following reasons:

   a. Lack of need for additional Providers or Organizations within a specialty;
   b. Lack of need for Providers or Organizations based on geographic location and practice; or
   c. Any other reason permitted by law.

B. Delegation

When Health Options delegates any Credentialing or Assessment function to a Delegated Entity, the delegation will be consistent with NCQA Health Plan Standards and applicable federal and state laws and regulations, and Health Options will ensure that there will be a delegation agreement and sub-delegation agreement, as applicable. Each delegation/sub-delegation agreement will be specific to each Delegated Entity performing delegated or sub-delegated Credentialing or Assessment functions and will specify roles, responsibilities, the delegated or sub-delegated activities, reporting requirements (semi-annual reporting at a minimum), and the process by which Health Options evaluates and oversees the Delegated Entity's performance and accountability. Each agreement must provide Health Options with a right to suspend or terminate if the Delegated Entity fails to comply with the material terms of the agreement. The Credentialing Committee has the responsibility to ensure that Delegated Entities perform as stated in the respective delegation/sub-delegation agreement. The Quality and Accreditation Specialist will be responsible for completing delegation oversight annual audits and semi-annual reports. The Credentialing Committee shall oversee audits of Delegated Entities, including Credentialing Files when applicable. The Quality and Accreditation Specialist prepares documents for review and approval by the Credentialing Committee. Health Options will work directly with the Delegated Entity to resolve issues that arise to ensure compliance with NCQA Health Plan Standards as well as applicable

federal and state laws and regulations and Health Options policies. (If required, Health Options will perform a pre-delegation review to ensure that delegated functions can be performed as required.) Health Options has delegated the Credentialing of Providers to be included in our rental network. The delegation agreement clearly specifies the Credentialing requirements the rental network needs to meet.

C. Accountability

1. Chief Medical Officer (CMO). The CMO is responsible for providing oversight of the Credentialing program and reviewing and making decisions on Routine Files.
2. The CMO has the authority to approve or deny practitioner files when needed outside of a Credentialing Committee meeting in accordance with this Policy.
3. Credentialing Committee. The Credentialing Committee consists of the CMO and at least five (5) representative Members of the licensed healthcare provider community who may also provide services to Health Options Members (the "Community Providers"). Licensed physicians (one of which may be the CMO) shall be on the Credentialing Committee. This is a multidisciplinary committee representing a variety of specialties that are representative of types of practitioners participating in the Health Options Network. The Community Providers will be chosen by the CMO. The Community Providers will serve terms of three (3) years with a maximum of two (2) consecutive terms. Committee Members may serve additional terms at the discretion of the CMO. The committee staff members include the following: CMO (voting chair) and Provider Operations Lead (non-voting). The Credentialing Committee meets monthly or at a minimum six (6) times a year. A quorum will consist of at least 51% of the voting members. Meetings can be attended in person or via remote access. Committee members agree to full and active participation in meetings. If a committee member has a conflict of interest that might impair objectivity in any review or decision process, he/she will notify the CMO as soon as possible and will not participate in any deliberation involving such issues and shall not cast a vote on any related issue.

   The Credentialing Committee responsibilities include, but are not necessarily limited to:

   a. Reviews, provide feedback, and, if necessary, make recommendations for changes to this Policy on at least an annual basis.
   b. Reviews the credentials and gives thoughtful consideration of practitioners who did not meet criteria for participation in the network (non-routine files).
   c. Performs oversight of delegated Credentialing, Assessment, Re-Credentialing and Re-Assessment activities.
   d. Reviews results of Primary Source Verifications by the CVO.
   e. Reviews the contents of the Provider and Organization applications; and
   f. Reviews Provider and Organization licensure, insurances, sanctions, and certifications.

   The Credentialing Committee shall have other responsibilities as determined by Health Options.

D. Confidentiality and Credentialing File Contents

1. The Credentialing Committee members, the CVO, Health Options Credentialing staff, and Delegated Entities involved in the Credentialing/Re-Credentialing/Assessment/Re-Assessment process must treat all Credentialing/Re-Credentialing/Assessment/Re-Assessment information as confidential and may disclose such information only as allowed by law or by a written authorization signed by the applicable Provider or Organization. Members of the Credentialing Committee shall sign a confidentiality statement that includes a requirement not to make unlawful discriminatory decisions. Violations of the confidentiality policies relating to Credentialing are subject to disciplinary action for Health Options staff, or dismissal from the Credentialing Committee. All materials within Credentialing Files are considered confidential and will not be disclosed by any other department or person except as provided in this Policy. All requests for information should be directed to the Provider Operations Lead. If required to carry out a disclosure, the Provider Operations Lead will obtain any necessary written authorization to disclose information.

2. Provider- and Organization-specific data are kept in Credentialing Files and Health Options administrative files. All Provider and Organization files – paper and electronic – will be consistently handled and maintained in a confidential manner. Health Options will maintain Credentialing Files in locked file cabinets or in password-secured electronic files.

3. Credentialing Files contain data relating to the Credentialing and Re-Credentialing of Providers and Assessments and Re-Assessments of Organizations that result in decisions as to Providers' and Organizations' participation in the Network. Data collected for these purposes will include information on a Provider's education, training, professional qualifications, liability history, work history, licensure, and health status. Data collected for purposes of Assessing or Re-Assessing an Organization will include license verification, malpractice insurance, verification of accreditation, and occurrence of sanctions. The CVO documents verification of required items on the profile summary page of each credentialng file. Profile Summary will include date of the verification as well as the initials of the verifier.

   Credentialing Files will be made available only to those who have a right to access them within the scope of their authority or as permitted by law. The organization has a Credentialing Information Integrity Policy which outlines the protection of the credentialing information which is accessed by the Provider Network Team and Data Integrity Team. Health Options and any Delegated Entities will maintain the Credentialing Files in locked file cabinets or in password-secured electronic files. Additional data relating to Providers and Organizations is maintained and stored in a secure computerized Credentialing system. Access to such computerized data is limited through the use of passwords and individual levels of security and is restricted to Health Options CMO, Credentialing and PNO, Data Integrity, Quality Manager, CVO, Delegated Entity, or Health Options Credentialing Committee.

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Credentialing Files may include PHI or other health information protected by other laws. Delegated Entities will be contractually required to inform Health Options of inappropriate use or disclosure of PHI or other health information. Upon termination of a delegation/sub-delegation agreement, the Delegated Entity must ensure that all PHI and other health information is returned to Health Options, destroyed, or protected as required by law.

4. Health Options' Credentialing Files contain copies of correspondence (which may include notes, phone call documentation and records of outgoing correspondence), information related to practice patterns, results record reviews, patient complaints, and any other such evaluative information that may be collected in support of a Provider's or Organization's continuing participation in the Network.

5. Provider or Organization may, upon written request, obtain from Health Options copies of any information in the Credentialing File or administrative files that were originally provided by the Provider or Organization (e.g., application, CV, contracts, copies of license). Such requests should be directed to the Credentialing Staff. The Credentialing Staff will respond to such requests from Providers and Organizations within fifteen (15) business days after receipt of the request.

6. Each Delegated Entity must require any of its personnel or agents performing such delegated function(s) to sign a confidentiality form that is consistent with this Section D as applicable, maintain such signed forms on file, and make such signed forms available to Health Options or its designated agent upon request. Any improper disclosure of confidential information by a Delegated Entity or its personnel or agents is subject to corrective action up-to-and-including termination of the delegation agreement with Health Options.

7. Credentialing personnel will be trained on appropriate documentation and updating of Credentialing information. Training will include, but not be limited to, information on audits of Credentialing activities, the process for reporting inappropriate documentation, and the potential consequences of inappropriate documentation.

8. Documenting incorrect Credentialing dates, creating documents or information without performing the required activities to create such documents, fraudulently altering documents, falsely attributing verification or review, and performing unauthorized updates of information are prohibited and may result in disciplinary action up to and including termination of Health Options employees or termination of a delegation agreement with a Delegated Entity.

9. In accordance with NCQA requirements and applicable law, regular audits (at least annually) will be conducted to review Credentialing Files and delegated activities for inappropriate documentation and updates, and with respect to Delegated Entities, reviewing policies and procedures and compliance with NCQA standards. Inappropriate documentation and updates discovered during an audit will be reported to the Provider Network Lead and appropriate corrective action will be taken. Health Options will audit corrective actions within three (3) to six (6) months of the annual audit.

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E. <u>Provider and Organization Rights</u>

1. Credentialing Files are maintained as confidential medical review documents of the Credentialing Committee and are used solely for the purpose of conducting Credentialing and Assessment activities.

2. A Provider or Organization being Credentialed, Assessed, Re-Credentialed, or Re-Assessed has the right to review information obtained through the verification process, except as prohibited by law. Such right to review does not include the right to review National Provider Data Bank ("NPDB") queries or peer-review protected information except as expressly permitted by applicable law. A Provider or Organization may be granted access during regular business hours at an agreed appointment time in the presence of the Provider Operations Lead. A Provider or Organization is not allowed to copy or remove any documentation from the Credentialing File. Such access requests should be directed by the Provider Operations Lead.

3. A Provider or Organization has the right to clarify or correct information in the application that is inconsistent with information obtained via primary source verification during Credentialing, Re- Credentialing, Assessment, or Re-Assessment. If a Provider or Organization believes that such information is unclear or incorrect and wishes to submit a clarification or correction, such Provider or Organization may submit clarifications and corrections from another source in writing to Health Options' CMO and/or Provider Operations Lead within ten (10) business days from the date the Provider or Organization viewed the information. Health Options will respond to such submissions in writing within thirty (30) business days after receipt for initial Credentialing or Assessment and sixty (60) business days after receipt for Re-Credentialing or Re-Assessment; provided, however, Health Options shall make a decision on a completed application as described in Section N of this Policy.

4. Within thirty (30) days after initial receipt of the application, Health Options will review the entire application and, if the application is incomplete, return the application to the Provider or Organization with a comprehensive written list of all corrections needed at the time the application is first returned for corrections. Within fifteen (15) days after receipt of such request from Health Options, the Provider or Organization must submit to the CMO or Provider Network Lead a written explanation and/or must correct erroneous information. A Provider's or Organization's failure to comply within fifteen (15) days will result in the application process being terminated.

5. A Provider or Organization has the right, upon oral or written request, to be informed of the status of his/her/its Credentialing/Re-Credentialing/Assessment/Re-Assessment application. Such requests should be directed to the Provider Network Lead. Health Options will provide an oral or written response within fifteen (15) days after the Provider Network Lead's receipt of the request. If an oral response is provided, the Provider Network Lead shall contemporaneously document the response in the applicable Credentialing File.

6. A letter is sent to Providers and Organizations prior to Credentialing which notifies

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them of the delegation to the CVO, explains the Credentialing procedures, and describes their rights and responsibilities during the process including the right to correct erroneous information and to request the status of their Credentialing application.

F. Nondiscriminatory Credentialing and Re-Credentialing

Health Options is committed to monitoring and preventing unlawful discrimination in making Credentialing decisions. Accordingly, Health Options adopts the following to ensure that unlawful discrimination does not occur in the Credentialing process:

1. The Credentialing and Re-Credentialing of Providers and Assessment and Re-Assessment of Organizations will be conducted in a non-discriminatory manner. As applicable, decisions made by the Credentialing Committee and/or CMO will not discriminate against any person or entity based on race, color, sex, age, physical or mental disability, religion, ancestry or national origin, sexual orientation, or any other basis that is prohibited consideration or classification under Maine or Federal law, except where that disability renders the Provider incapable, with or without reasonable accommodation, of performing the essential functions of the specialty for which the Provider is being credentialed.

2. Health Options' Quality Manager, or designee, will conduct periodic audits (at least annually) of Health Options' Credentialing Files (applications in process, approved and denied files) to ensure that Providers/Organizations are not subject to improper discrimination. The auditor cannot be employed in either the Credentialing Department, Data Integrity or any department conducting routine Provider Relations or Contracting. The Provider Network Lead will be present during the audit of Credentialing Files.

3. Health Options will review Provider/Organization complaints to determine if any complaints allege unlawful discrimination.

4. Members of the Credentialing Committee will sign a statement, at appointment and again annually, that includes a requirement that Committee members will not unlawfully discriminate in making Credentialing/Assessment decisions. Violations of this requirement may result in dismissal by the Committee.

5. At the beginning of each Credentialing Committee meeting, a statement will be read re-affirming the Committee's commitment to Health Options' non-discrimination policy.

6. All agreements for delegation of Credentialing functions will state that the Delegated Entity will not unlawfully discriminate in performing the delegated Credentialing/Assessment functions.

   As used in this Section, "Credentialing" includes both Credentialing and Re-Credentialing, and "Assessment" includes both Assessment and Re-Assessment.

G. Initial Provider Credentialing

Initial Credentialing of Providers will include the following steps:

1. The CVO will obtain the application information via download from the CAQH secure website. The application will not be deemed complete until all items are fully and accurately completed and all required documents are submitted along with a signed attestation. Attestation which must be completed within 120 days of credentialing decision. (*CAQH requires practitioners to update the application every 120 calendar days)*

2. The CVO staff will conduct primary source verification. The methods of verification and sources used are detailed in Table 1 in Section L. The CVO will attempt source verification of all data elements three (3) times on a set schedule for batch processing of queries.

3. The CVO or Health Options (as appropriate) will contact the applicant to request missing information or if the information received during the Credentialing process varies substantially from the information submitted by the Provider with the application. If at any point in the process the applicant is requested to provide additional information or to submit to an interview, the applicant must be notified of the request in writing (email will be considered a written request). The request must include the specific data, explanation or examination required, and the time frame for submitting the response. The applicant's failure, without good cause, to respond in a satisfactory manner to the request by the specified date will be deemed a voluntary withdrawal of the application. At this point the credentialing process will not be processed further, and the CVO or Health Options Credentialing Staff will document Credentialing criteria in the applicant's Credentialing File, such as inactive CAQH account.

4. Once primary source verifications is completed, the CVO will forward the fully completed credentialing file to the Health Options Credentialing Department. The CVO process will be deemed complete when the primary source verification has been completed. CVO identifies who completed the PSV item and date of verification on the summary page, this cannot be altered by Health Options staff. CVO provides date and time application is complete on summary page; this also cannot be altered by Health Options staff.

5. An initial Credentialing File is determined to be Routine (Category 1) if it meets all the following criteria and time frames:

   a. A completed application and signed attestation within the last 120 days
   b. A valid and current state license for all states in which the practitioner provides care to Health Options Members. Licenses shall be verified no more than one hundred twenty (120) days prior to the Credentialing decision. The applicant must attest to any loss of license since their initial licensure.
   c. A valid and current Drug Enforcement Administration (DEA) or Controlled

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Dangerous Substances (CDS) Certificate, for all states the practitioner is providing care to Health Options Members, if applicable. This must be in effect at the time of the Credentialing decision. If a Provider eligible for a DEA or CDS certificate does not have a valid DEA or CDS certificate, Health Options requires written documentation from the Provider describing the arrangement set in place for another Provider to write prescriptions. This document will be kept in the Provider's Credentialing File.

d. Professional Liability/Malpractice insurance coverage to meet minimum contractual limits of $1million/$3million. Lower limits may be considered for non-physicians on a case-by-case basis with approval from CMO. If the Participation Agreement includes a different insurance coverage amount, the amount in the Participation Agreement will control.

e. Verification of Board Certification, if applicable. This must be verified no more than one hundred twenty (120) days prior to the Credentialing decision and the expiration date must be documented. Board Certification by an ABMS or other approved specialty society is considered one important means to assure that our participating physicians provide high quality service to our members. However, we do recognize that there are other factors that can be taken into consideration that may allow for an exemption to the Board Certification requirement. This Policy clarifies those circumstances that would inform the decision by the Credentialing Committee or CMO to make an exception to the requirement for Board Certification (please refer to Appendix B for the Exception Process). Notwithstanding the foregoing, a Provider shall not be required to participate in a Maintenance of Certification Program.

f. Education and training are verified as the highest of the following three levels of education and training, as applicable: Board Certification, residency, graduation from medical or professional school.

g. Work history for a minimum of five (5) years with no unexplained gaps of more than six (6) months. This must be verified no more than one hundred twenty (120) days prior to the Credentialing decision.

h. No federal or state sanctions & exclusions (Medicare & Medicaid). This must be verified no more than one hundred twenty dates (120) days prior to the Credentialing decision.

i. Licensing history for a minimum of ten (10) years with no licensure sanctions.

j. Malpractice history for a minimum of five (5) years from NPDB queries or the malpractice carrier. This must be verified no more than one hundred twenty (120) days prior to the Credentialing decision. See Section K (1) regarding thresholds for Routine files.

k. The applicant must attest to any felony convictions since their initial licensure.

l. The applicant must attest to any loss or limitation of privileges or disciplinary action since their initial licensure.

6. CVO prepares routine (Category 1) files in portal and sends it to Health Options via FTP to the CMO for review and decision. Routine files are considered Credentialed once approved by the CMO and the date the CMO approved will be the Provider's Credentialed effective date. An email from the CMO can designate such an example of an approval. The Credentialing Committee will receive a list of all Routine files at the next Credentialing

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Committee meeting. If the CMO determines the Credentialing File is Non-Routine, the file is re-classified as Non-Routine and sent to the Credentialing Committee for a review and decision at the next scheduled meeting.

7. If a Credentialing File is determined to be a Non-Routine File (Category 2), the CVO prepares the file in the Committee Portal for Committee Member review. Files are reviewed and discussed during the following Committee Meeting. Thoughtful consideration is made concerning acceptance into the network and final determination is made by the Credentialing Committee. The Credentialing Committee's considerations and final decision are recorded in the meeting minutes. If the file review raises concerns, the Credentialing Committee may, at its discretion, approve credentialing for a limited term of one year to allow for ongoing monitoring and reassessment.

8. The Credentialing Department will notify the Provider in writing of the final credentialing decision in accordance with Section N. The Provider must be Credentialed prior to treating Health Options Members except as otherwise required by law. As required by Maine law, Health Options will pay claims for services rendered to a Member under an insurance product prior to the granting of Credentials from the date a completed application is submitted; provided, however, (i) payment of such claims is required only if Health Options ultimately grants Credentials to the Provider or Organization, and (ii) the Provider or Organization may not submit claims for care rendered during this timeframe until Health Options has notified the Provider or Organization that Credentials have been granted and the effective date of such Credentials. If the Provider or Organization submits claims prior to receiving such notice, Health Options may process the claim as out-of-network.

9. Provisional Credentialing

   Provisional Credentialing can be used when it is in the **best interest of Members** to have the practitioner available before the initial credentialing process is complete. NCQA accepts provisional credentialing under the following conditions:

   a. There is primary source verification of a current, valid license to practice.
   b. There is a complete application and signed attestation, pulled and saved.
   c. The Credentialing Committee, CMO **or delegated staff** bases the decision to provisionally credential a Provider based on the above information.
   d. Provisional status cannot last for more than 60 calendar days, at which time the full credentialing process must be completed.
   e. A Provider can only be provisionally credentialed once.

H. Provider Re-Credentialing

Re-Credentialing of Providers will include the following steps:

1. Re-Credentialing will occur within thirty-six (**36**) months of the last Credentialing decision or sooner if Credentialing Committee had raised concerns at initial review. The Credentialing Verification Organization will obtain the Provider's CAQH application upon receipt of the start work file from Provider Operations Lead or delegated PNO staff.

Start work files are created at a minimum of 3 months prior to recredentialing due date. If there are any discrepancies on the application, the CVO or Health Options Credentialing Staff will notify the Provider to make corrections.

2. The Provider Operations Lead or delegated PNO Staff will be responsible for maintaining in the database used for managing Credentialing and Re-Credentialing, the correct status of Re- Credentialing of Providers.

3. CVO staff will access CAQH for Provider's Re-Credentialing application and executed Standard Authorization, Attestation, and Release.

4. CVO staff will verify licensure, current malpractice insurance, DEA/CDS certificates if applicable, Board Certification if applicable, State excluded organizations lists, current hospital affiliations, and sanctions for Providers. The Provider must attest to any loss of licensure since the last Credentialing cycle. The Provider must attest to any loss or limitation on privileges or disciplinary actions since the last Credentialing cycle.

5. CVO prepares routine (Category 1) files in the portal and sends to Health Options via FTP for CMO for review and decision. Routine files are considered Credentialed once approved by the CMO and the date the CMO approved will be the Provider's re-credentialed effective date. An email from the CMO can designate such an example of an approval. The Credentialing Committee will receive a list of all Routine files at the next Credentialing Committee meeting. If the CMO determines the Credentialing File is Non-Routine, the file is re-classified as Non-Routine and sent to the Credentialing Committee for a review and decision at the next scheduled meeting. If the file review raises concerns, the Credentialing Committee may, at its discretion, approve credentialing for a limited term of one year to allow for ongoing monitoring and reassessment.

6. The Provider must attest to any felony convictions since the last Credentialing cycle.

I. <u>Initial Organization Assessment and Re-Assessment</u>

Assessment and Re-Assessment consists of the following:

1. The Organization requests to participate in the Network.

2. Credentialing Staff will conduct an Assessment and Re-Assessment every three (3) years as applicable to the Organization. The assessment sources are detailed in Table 2 in Section L.

3. Within thirty (30) days after initial receipt of the application, Credentialing Staff will review the application and contact the applicant to request missing information or if the information obtained during the Assessment process varies substantially from the information submitted by the Organization. If at any point in the process, the applicant is requested to provide additional information, the applicant must be notified of the request

in writing. The request must include the specific data, explanation or examination required, and the time frame for submitting the response. The applicant's failure, without good cause, to respond in a satisfactory manner to the request by the specified date will be deemed a voluntary withdrawal of the application.

4. If the Organization is not accredited by an applicable accrediting body, a site visit may be scheduled and conducted by Network Organization staff. Health Options may substitute a CMS or state quality review in lieu of a site visit under the following circumstances:
    - The CMS or state review is no more than three (3) years old.
    - The Organization obtains a survey report or letter from CMS or the state, from either the provider or the agency, stating the facility was reviewed and passed inspection. The report will meet Health Options' quality assessment criteria or standards.

5. The Assessment process will be deemed complete when the verification of license, accreditation and malpractice insurance has been completed, any required site visit has been conducted in lieu of an accreditation, and review for sanctions has been completed.

6. An initial Organization Assessment file will be deemed Routine if it meets all the following:
    a. Organization application completed, signed and attested received with all requested documentation.
    b. Current unrestricted license
    c. Copy of current Certificate of Insurance (COI), if requested to meet minimum contractual limits of $1 million per occurrence and $3million aggregate or other limits required by the applicable Participation Agreement.
    d. Recognized Accrediting Organization Certification or acceptable site visit results
    e. No Federal and State Sanctions (Medicare & Medicaid)
    f. No Licensure Sanctions.
    g. Hospitals (50+ beds) Medicaid-only CMS Certification Number (CCN)

7. Health Options Credentialing Staff will send an application to the Organizations six (6) months prior to their Re-Assessment due date. The Application will request the items required by Health Options to complete the Re-Assessment.

8. The Credentialing Staff will track all assessed Organizations on the Organizational Assessment spreadsheet with the following information being maintained: 1) license status, 2) accreditation status, 3.) acceptable site visit results.

J. <u>Provider and Organization Information</u>

Once a Provider or Organization is credentialed, the Provider or Organization must provide Health Options with the following information (as applicable) if not already obtained through the Credentialing or Assessment process:

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- Provider or Organization name
- Provider gender
- Office name and location
- Office phone number
- Specialty/sub-specialty
- Hospital affiliations, if applicable
- Medical group affiliations when applicable
- Race, Ethnicity & Languages spoken by Provider; and
- Education/training and Board Certification.

Under federal law and regulations, Health Options must provide its Members with a provider directory that includes information as to whether or not a primary care provider is accepting new patients. Any changes to a Provider's or Organization's information, including whether or not the Provider or Organization is accepting new patients, must be reported to Health Options as soon as possible.

K. Additional Requirements

1. Providers. All Providers seeking participation in the Network must satisfy the following additional requirements:

   a. The Provider must have (i) current malpractice coverage, and (ii) a five (5) year history, immediately preceding the date of the application, with no record of cancellation or suspension of professional liability insurance or must provide evidence satisfactory to the Credentialing Committee that such a record is not indicative of substandard care. If malpractice case settlement is over ten (10) years old it is considered Routine, if under ten (10) years old it is considered non-routine.

   b. In the case of a Provider with a history of malpractice claims or Medicare/Medicaid sanction activity as reported by the NPDB, there must be evidence satisfactory to the Credentialing Committee that this activity does not suggest on-going substandard professional competence or conduct.

   c. The Provider must have a valid unrestricted license to practice in the State(s) where they are seeing Members with no history of sanctions or limitations on licensure in all states where the Provider has been licensed for the ten (10) years preceding the date of application. Secondary verification may be obtained from the NPDB. In the case of a Provider with such history, there must be evidence satisfactory to the Credentialing Committee that does not suggest on-going substandard professional competence.

2. Indian Tribal Providers. These Providers may not hold a valid medical license in the State they are providing services. Federally regulated Indian Health Service medical centers allow Providers to work in states other than their primary licensure state. In lieu

of malpractice insurance coverage, these Providers are covered under the Federal Tort Claims Act for malpractice claims. Indian Health Service Providers will be Credentialed by the Credentialing Committee.

3. Federally Qualified Health Centers (FQHCs): In lieu of malpractice insurance coverage, Providers rendering services through an FQHC are covered by the Federal Tort Claims Act for malpractice claims.

4. Providers and Organizations. All Providers and Organizations seeking participation in the Network must agree to:

   a. Adhere to fundamental standards of ethical behavior as established by the applicable licensing agency or accreditation organization.

   b. Cooperate and collaborate, as requested by Health Options, in all quality improvement and utilization management activities of Health Options, including adherence to referral protocols and timely filing of treatment plans.

   c. Permit Provider and Organization site visits to be conducted periodically by Health Options Organization Services; and

   d. Permit an office site review by Health Options staff of the Provider's or the Organization's (i) record keeping practices, and (ii) office space as to physical accessibility, physical appearance, and adequacy of waiting and examination room space (See Office Site Quality Policy).

L. Primary Source Verifications

Following are summaries of the primary source verifications that the CVO will conduct for Providers:

PRIMARY SOURCE VERIFICATIONS CONDUCTED BY CVO FOR PROVIDERS:

VERIFICATION ITEM	ACCEPTABLE SOURCE(S)
License- current, valid, unencumbered, and unrestricted in all states where providers see members	State Licensing Boards

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Education/Training (initial Credentialing only) highest level of credentials is verified. Includes training programs accredited by the Accreditation Council for Graduate Medical Education.	*MD, DO: Verification of Board Certification (if applicable) fully meets requirement. American Medical Association (AMA) American Osteopathic Association (AOA) American Academy of Nurse Practitioners Federation of Chiropractic Licensing Boards Chiropractic Information Network and Board Action Databank. (CIN-BAD) Physician Profile Report of AOA Physician Master File Educational Commission for Foreign Medical Graduates (ECFMG) for international Medical graduates licensed after 1986. American Academy of Nurse Practitioners Federation of Chiropractic Licensing Boards Chiropractic Information Network and Board Action Databank. (CIN-BAD) *Contact school/college via letter, fax or phone call.
Board Certification Status	Primary Source (appropriate specialty board) State licensing agency if its primary source verifies board certification
Work History- Minimum of five (5) years required (initial Credentialing only).	Application or Curriculum Vitae- Provider will need to explain in writing gaps in most recent 5-year work history. Gaps greater than six (6) months will require written explanation upon verification or within the credentialing application. Residency and Fellowship can be counted in work history timeframe.
Hospital Privileges	Status of hospital privileges, if applicable.
Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) certificate if applicable. In all states where providers see members.	Copy of DEA or CDS certificate(s) Confirmation by National Technical Information Service (NTIS)
Malpractice History	NPDB. Five (5) years of malpractice history required for initial, three (3) years for re-credentialing.

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Federal and State Sanctions (Medicare & Medicaid) Licensure sanctions all states where Provider was licensed last five (5) years.	Office of Inspector General (OIG) State Excluded Providers List Federation of State Medical Boards (FSMB) National Provider Data Bank Continuous Query (NPDB) Federation of Chiropractic licensing boards chiropractic information network and board action databank (CIN-BAD) State Board of Chiropractic Examiners State Board of Dental Examiners or State Medical Board (Oral Surgeons) State Board of Podiatric Examiners Federation of Podiatric Medical Boards Other appropriate state licensing boards and state agencies

ASSESSMENTS CONDUCTED BY HEATH OPTIONS FOR ORGANIZATIONS:

ASSESSMENT ITEM	ACCEPTABLE SOURCE(S)
License- Current unrestricted license	Division of Licensing and Regulatory Services Other applicable state licensing agencies
Recognized Accrediting Organization Certification	Centers for Medicare & Medicaid Services (CMS) Survey The Joint Commission (TJC) Intersocietal Accreditation Commission (IAC) – Home Health & Hospice. Accreditation Commission for Health Care (ACHC) Accreditation Association for Ambulatory Health Care Inc. (AAAHC) Healthcare Facilities Accreditation Program (HFAP) Other recognized accreditation organizations
Federal and State Sanctions (Medicare & Medicaid) Licensure sanctions	Office of Inspector General (OIG) State Excluded Providers List
Onsite Quality Assessment if not accredited	In lieu of a site visit: CMS or State quality review which is no more than three years old.
Hospitals with greater than 50 beds	Medicare-certified or has been issued a Medicaid-only CMS certification Number (CCN)

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M. Ongoing Monitoring

Health Options has established an ongoing monitoring program to support Credentialing standards between Re-Credentialing cycles to ensure Provider compliance with Credentialing standards and to monitor instances of possible substandard professional conduct and competence. The Provider Operations Lead will review periodic listings/reports as soon as possible but no more than thirty (30) calendar days after the date they are made available from the following and other sources:

1. There will be continuous query of the National Practitioner Databank (NPDB) and other sources as provided herein. Provider Operations Lead will receive notification of any malpractice updates, limitations on licensure, and Medicare, Medicaid and/or other sanction and exclusion information within twenty-four (24) hours after posting and will forward the notification to Health Options' CMO or designee no more than thirty (30) calendar days after receipt of the notification. CMO or designee reviews to determine if Committee Review is warranted. The minimum threshold criteria to send a NPDB report to Committee for full review will be for cases involving a settlement of more than $250,000, a practitioner who has had 3 or more NPDB reports within the past 5 years and any cases deemed clinically appropriate as reviewed by the CMO or designee.
2. Health Options' Provider Network Lead will receive and tracks complaints and adverse events relating to Providers and Organizations. The Provider Network Lead will submit this information to the Credentialing Committee for review at the next Credentialing Committee meeting. The Credentialing Committee will consider data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available. The Credentialing Committee will evaluate the history of all complaints for all providers at least every six (6) months.
3. Any Health Options Department, claim processing, Members, Organizations, or facilities.

Complaints, adverse events and NPBD alerts will be reviewed by the Credentialing Committee at the next scheduled meeting. Opportunities for improvement identified during ongoing monitoring will be addressed with the Provider or Organization as appropriate and as soon as possible based on the particular issue. Appropriate interventions include, but are not limited to, required participation in continuing education, required supervision, a written plan for improvement, or termination of participation in the Network.

When a participating Provider or Organization has been identified by any of the sources listed in Subsections M (1)-(3), Health Options' response may include review by the Credentialing Staff, review by the CMO, referral to the Credentialing Committee, termination of participation in the Network, or other response. If required by law, the Health Options' Credentialing program will report Providers or Organizations to the appropriate authorities.

N. Credentialing Decisions

1. Credentialing, Re-Credentialing, Assessment, and Re-Assessment decisions will be documented in the Committee Meeting minutes. All Credentialing decisions will be issued in writing to the Provider.

2. Health Options will make all Credentialing, Re-Credentialing, Assessment, and Re-Assessment decisions, including those granting or denying Credentialing, Re-Credentialing, Assessment, or Re-Assessment, within sixty (60) days after receipt of a completed application. If Health Options is unable to make a decision within this sixty (60)-day period, Health Options shall before the expiration of this period notify the Maine Bureau of Insurance (BOI) in writing to request authorization for an extension of time to make the decision. Health Options will notify the BOI as instructed on the BOI's website. Credentialing/Assessment decision letters will be issued as soon as possible after the Credentialing/Assessment decision but no later than 30 days after the decision.

   For purposes of this Policy, a Credentialing, Re-Credentialing, Assessment, or Re-Assessment CAQH application is deemed complete if the application includes (i) all of the information required by the uniform Credentialing/Assessment application used by insurance carriers, (ii) all attachments to the uniform Credentialing/Assessment application required by Health Options at the time of the application, and (iii) all corrections to the application required by Health Options.

3. A decision denying an application for Credentialing, Re-Credentialing, Assessment, or Re-Assessment must include:

   a. A statement of all the reasons for denying the application; and
   b. An explanation of the right to request an appeal under Section O of this Policy.

O. Hearing Procedures and Timelines

a. Notice. Whenever the Credentialing Committee takes any action adverse to a Provider or Organization regarding their participation in the Network for any reason, including, but not limited to clinical quality, service, or competence, or professional conduct (an "Adverse Decision"), or terminating a Participation Agreement without cause, Health Options will notify the Provider or Organization in writing of the Adverse Decision. The notice will include the reason(s) for the action, the Provider's or Organization's right to appeal (if applicable), a summary of the appeal process, and a copy of any documents relied upon in making the Adverse Decision.

2. Request for Hearing. The Provider or Organization shall have thirty (30) days after Provider's receipt of a notice of Adverse Decision to file a written request for a hearing with Health Options. Failure to file such a request within the thirty (30)-day period will constitute a waiver of hearing and acceptance of the Adverse Decision. Any action of the Credentialing Committee voluntarily accepted by the Provider or Organization is not subject to appeal.

   a. Non-Appealable Adverse Decisions. Any termination or nonrenewal of a Provider's or Organization's participation in the Network based on any of the following grounds is not subject to a hearing: (i) a final disciplinary action by a state licensing board or governmental agency that impairs the Provider's or Organization's ability to render health

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services; (ii) a final determination of fraud by a governmental agency; (iii) imminent harm to patient care; or (iv) a determination by a governmental agency that Provider or Organization is debarred, excluded, or otherwise ineligible for participation in any federal or state health care program, including Medicare or Medicaid. A termination or nonrenewal based on any of the grounds in this Subsection O(2)(a) is effective on the date Provider receives the notice described in Subsection O.

3. Hearings. The hearing process shall consist of the appointment of a hearing panel, a hearing, and a report and decision as described in the Hearing Procedure Rules attached as Appendix A. In accordance with the Hearing Procedure Rules, each party at the hearing has the right to call and examine witnesses, introduce evidence, and submit a written statement at the conclusion of the hearing.

P. Reporting Adverse Decisions

If Health Options makes an Adverse Decision against a Provider, Health Options may have an obligation to report the Adverse Decision to the applicable state licensing board and/or the NPDB.

If the Adverse Decision is made as the result of the Health Options' independent review of a Provider's professional conduct, professional competence, or quality of clinical services rendered, the decision shall be reported in writing by the CMO to the applicable state licensing board, in accordance with the state's requirements for filing a written report. Health Options will also report Adverse Decisions electronically to the NPDB as required by federal law.

The report of the Adverse Decision shall be filed with the state licensing board and NPDB no later than twenty (20) days after the actual effective date of the Adverse Decision (i.e., after all hearings or time frames for hearings have been exhausted).

Q. Miscellaneous

1. Health Options shall make available to a Provider or Organization upon written request Health Options' form of application for Credentialing, Assessment, this Policy, and the Hearing Procedure Rules.

2. Health Options will retain all records and documents relating to a Provider's Credentialing and Re-Credentialing or Organization's Assessment or Re-Assessment for at least three (3) years from the date of the decision or, in the event of a hearing of an Adverse Decision, from the date of the Board's decision, whichever is the later date.

3, Unless otherwise expressly provided, lengths of time expressed in terms of days in this Policy shall mean calendar days.

4. Community Health Options may, at their discretion, credential facilities and practitioners from states other than Maine, but within the continental United States. Applicable credentialing laws of each state are adhered to in the credentialing process.

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R. Review of Policy

The Credentialing Committee will review and recommend revisions and approval of the Policy on at least an annual basis, and from time to time as necessary and appropriate.

REFERENCES

Quality of Care Policy: 1.6.1.7 Quality of Care

Credentialing Information Integrity Policy: 1.9.1.2 Credentialing Information Integrity

Health Care Quality Improvement Act, 42 U.S.C. §§ 11101 et
seq. Maine Health Security Act, 24 M.R.S.A. §§ 2501 et seq.
Maine Health Plan Improvement Act, 24-A M.R.S.A. §§ 4301 et seq

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (the Affordable Care Act)
45 CFR §156.230

Maine Bureau of Insurance, 02 031, Ch. 850

NCQA Standards CR1-9

Footnote: Hospital Privileges not an NCQA requirement; but required by State regulation.

Revision History:

Revision Date: 12/13/2013, 6/1/16, 9/12/2016, 11/6/2018, 1/17/2019, 12/4/2024
Approval Date: 12/17/2013, 6/7/2016, 9/12/2016, 12/18/2018, 1/30/2019, 2/7/2025

Signature

Lori Wiviott Tishler, MD MPH CMO

Date: 2/7/2025

APPENDIX A

Hearing Procedure Rules

1. Purpose. These Hearing Procedure Rules ("Rules") shall govern the conduct of hearings described in Section O of the Credentialing Policies and Procedures ("Policy") of Community Health Options ("Health Options"). The Rules supplement the Policy.

2. Definitions. Unless otherwise provided in these Rules, capitalized terms shall have the meanings given to them in the Policy and in these Rules.

3. Hearing Panel. Upon receipt of a timely written request for a hearing of an appealable Adverse Decision, the CMO will appoint a hearing panel to conduct the hearing. The hearing panel will be composed of at least three (3) individuals, at least one-third of whom shall be a clinical peer in the same discipline and the same or similar specialty, not involved in the original Adverse Decision. As provided in these Rules, after the hearing, the hearing panel will make a recommendation to the Board. The Board shall have the final decision with respect to the appeal.

    a. Presiding Officer. The CMO shall appoint a hearing panel member to preside over the hearing (the "Presiding Officer").

        i. Responsibilities. The Presiding Officer shall have the following responsibilities:

            (1) Rule on the admissibility of evidence;

            (2) Regulate the course of the hearing, set the time and place for continued hearings, and fix the time for filing evidence or other submissions;

            (3) Assist all those present in making a full and free statement of the facts to address all issues which may govern the outcome of the hearing, and to ascertain the rights of the parties;

            (4) Ensure an orderly and efficient presentation of the evidence;

            (5) Ensure that the parties have a reasonable opportunity to present their claims orally or in writing; and

            (6) Ensure that a record is made of the hearing.

    b. *Ex Parte* Communications

        i. General Rule. In any hearing, the hearing panel members may not communicate directly or indirectly in connection with any issue with any party or other persons interested in the outcome of the hearing, except upon

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notice and opportunity for all parties to participate. When sending documents to the Presiding Officer, a party to a hearing must also send copies of the documents to all other parties.

ii. Exceptions. This section shall not prohibit the hearing panel members from:

(1) Communicating in any respect with other hearing panel members;

(2) Having the aid or advice of those members of Health Options staff, counsel, or consultants retained by Health Options who have not participated and will not participate in the hearing in an advocate capacity;

(3) Requesting from Health Options any relevant rules, regulations, policy, or procedure;

(4) Ascertaining their position regarding an issue raised by the other party, if the party who raised the issue has been unable or has failed to do so; and

(5) Scheduling or rescheduling hearings or conferences.

4. Representation. The Credentialing Committee and the Provider or Organization have the right to be represented by an attorney or other representative at the hearing.

5. Scheduling the Hearing and Attendance. The hearing shall be scheduled for no earlier than thirty (30) and no later than sixty (60) days after Health Options' receipt of a timely written request for a hearing. The Provider or Organization requesting the hearing is required to attend the hearing; failure to attend will constitute a waiver of the hearing and acceptance of the Adverse Decision. Health Options may postpone the hearing at the request of the Provider or Organization for no more than sixty (60) days. Except for cases where there are extenuating circumstances, the Provider or Organization must make such a request at least fifteen (15) days before the hearing. The Provider or Organization may only make one such request for postponement.

6. Notice of Hearing. The hearing panel shall send written notice of the hearing to the Credentialing Committee and the Organization or Provider at least fifteen (15) days prior to the hearing. Notice shall be deemed given to the Provider or Organization on the date that the hearing panel sends the notice to at least one current method of contact listed for the Provider or Organization in Health Options' records. The notice shall contain the following information:

a. Date, time, and location of the hearing;
b. The issues to be considered at the hearing;
c. Names of members of the hearing panel;
d. Identity of the Presiding Officer;
e. Deadline for the parties to identify witnesses to the hearing panel and each other;

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f. Rights of the parties to present evidence and arguments, cross-examine witnesses, be represented by an attorney or other representative, and to have the hearing postponed; and
g. Other matters as determined by the Presiding Officer.

7. Hearing Process

a. Burden of Proof. The Provider or Organization who requested the hearing shall have the burden of proving by a preponderance of the evidence that the Adverse Decision lacks any factual basis or that the Adverse Decision is arbitrary, unreasonable, or capricious.

b. Order of Presentations. The Provider or Organization shall present testimony and evidence first. The Credentialing Committee may then present its own testimony and evidence. Then the Provider or Organization may present rebuttal testimony and evidence limited to matters brought out by the Credentialing Committee.

c. Evidence

i. Generally. Evidence shall be admitted if it is the kind of evidence upon which reasonable persons are accustomed to rely in the conduct of serious affairs. Formal rules of evidence shall not be observed. The fact that evidence is admitted, however, shall not limit the authority of the hearing panel in determining the appropriate weight to be given such evidence.

ii. Irrelevant or Repetitious Evidence. Evidence which is irrelevant or unduly repetitious may be excluded.

iii. Examination of Witnesses. Each party may cross-examine the witnesses of the other party. Any re-examination of witnesses shall be limited to matters brought out in the last examination by the adverse party unless permitted by the Presiding Officer.

d. Written Closing Arguments. Within ten (10) days after the conclusion of the hearing, the Provider or Organization and the Credentialing Committee may submit written closing arguments to the hearing panel, which shall not exceed twenty (20) pages in length. Such written closing arguments shall be typed in at least 12-point font on one side of 8 ½ x 11 inch paper and double spaced, except that footnotes and quotations may appear in 11-point font and single spaced. All pages must be numbered.

8. Written Report. Within twenty (20) days after the conclusion of the hearing, the hearing panel will submit a written report to the Board. The report will include a recommendation for reinstatement, provisional reinstatement subject to conditions determined by Health Options, or affirmation of the Adverse Decision. In its written report, the hearing panel shall include:

a. A listing of all the material, including records, reports, and other documents placed into evidence at the hearing, upon which the written report is based;

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b. The findings of fact, based upon the entire hearing record, including testimony and exhibits. The findings must be sufficient to apprise the parties of the basis for the recommended decision; and

c. A clear and precise statement of the recommended decision resolving the matter under consideration, and a clear explanation of the reasoning underlying the decision.

In the event that the recommended decision is not unanimous, the dissenting hearing panel member(s) shall submit a written report(s) to the Board containing the items provided in Rule 8(a)-(c).

9. Decision of the Board. The Board will issue a final decision of reinstatement, provisional reinstatement subject to conditions determined by Health Options, or affirmation of the Adverse Decision within thirty (30) days after receipt of the hearing panel's report.

10. Notice of Decision. Health Options will send written notification of the Board's decision to the Provider or Organization within thirty (30) days after the date of the Board's decision. If the Board decides to terminate or non-renew Provider's/Organization's participation in the Network, such termination will be effective the earlier of (i) sixty (60) days after Provider's/Organization's receipt of the Board's decision, or (ii) the termination date in Provider's/Organization's Participation Agreement with Health Options. The notification shall include the following:

a. The action being taken against the Provider/Organization, if any; and
b. Reason(s) for the decision (includes standards used to evaluate the Provider/Organization, if applicable).

11. Hearing Records. The hearing panel shall maintain a hearing record, which shall consist of:

a. The hearing notice and any other hearing related correspondence or papers;
b. Documents admitted by the hearing panel into evidence;
c. An audio recording of the hearing. The Organization or Provider may request that a transcription be made of the hearing at Organization's or Provider's own expense;
d. The written closing arguments of the parties; and
e. The hearing panel's written report(s) to the Board.

12. Miscellaneous

a. Amendment. These Rules may be amended at any time by the Board.
b. Computation of Time. In computing any period provided for by these Rules, the following shall apply:
   i. The date of the act or non-act which begins the period of time shall not be counted.
   ii. The last day of the period shall be counted unless it is a Saturday, Sunday, or holiday recognized by the State of Maine, in which case the period of time shall run until the next day which is not a Saturday, Sunday, or such holiday.

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iii. If the period of time provided for is less than seven days, Saturdays, Sundays, or holidays recognized by the State of Maine, shall not be counted.

c. Other Procedures. When no procedure is specifically prescribed, the Presiding Officer shall proceed in any manner not inconsistent with these Rules, the Policy, or applicable law.

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Appendix B

Board Certification Exception Procedure:

The Provider must either have initial Board Certification for Provider's Specialty or be an active candidate for such Board Certification at the time of application. Board Certification in Provider's specialty must be obtained no later than five (5) years from the initial Credentialing. Providers shall not be required to comply with a Maintenance of Certification Program. The Credentialing Committee, upon recommendation by the CMO, may waive the requirement for specialty Board Certification if the specialty is underserved and/or the Provider's training and experience meet the qualifications of certification and current practice is of high quality as attested by peer references. This paragraph applies only to Providers who can obtain Board Certification.

Board certification by an ABMS approved specialty society is considered one important means to assure participating physicians can provide high quality service to our Members. However, Health Options recognizes there are other factors that can be taken into consideration that may allow for an exemption to the Board Certification requirement. This policy clarifies those circumstances that would inform the decision by the Credentialing committee to make an exception to the requirement for Board Certification.

Definitions:

Board Certification: Successful completion of all requirements of the relevant specialty board, with the exception of a Maintenance of Certification Program.

Board eligibility: Having completed all preliminary requirements, the physician is able to sit for the final certification exam.

ABMS: American Board of Medical Specialties.

NCQA: National Committee on Quality Assurance.

Procedure Generally:

As part of the Credentialing process the applicant states on the submitted application, Board Certification status including the board identifier, the date of certification, and the date of recertification. Health Options' Credentialing process verifies this information during the Credentialing process. If the applicant states on the application s/he is board eligible and there is noted intent to sit for the board certification examination with the proposed date and board identifier, the applicant may be approved provided all other applicable criteria are met and Board Certification will be evaluated again at the time of Re-Credentialing. If the applicant is neither Board Certified nor board eligible or declares no intent to take a certifying exam, the following will be considered as possible exceptions to the requirement for Board Certification. The Credentialing Committee may inquire further with the applicant if an eligible applicant declares they have no intention of taking a certifying exam.

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1. Alternative Board Certification: Board Certification from a non-ABMS approved specialty society may be considered equivalent. An example would be certification by the Royal College of Surgeons.
2. Practice Experience: Physicians who have practiced successfully in a community for more than 10 years should have that service taken into consideration.
3. Malpractice history: Physicians with a malpractice history that is not unusual in judgment amounts or frequency.
4. Community need: Physicians that practice in shortage areas as defined by the Public Health Service.
5. Any other information that is provided by the applicant that the Committee deems relevant to the process of making an exception. This may include but is not limited to Quality Data for the provider's practice, Meaningful Use recognition and, NCQA, Patient Centered Medical Home (PCMH) or Specialty Practice recognition.

   a. The Provider should not have a history of disciplinary action, based on professional competence or conduct, imposed by a hospital, health care institution, managed care plan, professional society, state professional licensure board, or a governmental health care program (e.g., Medicare, Medicaid, CHAMPUS). In the case of a Provider with such a history, there must be evidence satisfactory to the Credentialing Committee that it does not suggest on-going substandard professional competence or conduct. For purposes of this Section, the surrender of a license or privileges while a formal disciplinary proceeding is pending shall be treated as a disciplinary action.

      The Provider should not have a history of criminal conviction or indictment. In the case of a Provider with such a history, there must be evidence satisfactory to the Credentialing Committee that such history does not suggest an effect on current professional competence of conduct. A conviction within the meaning of this Section includes a plea or verdict of guilty or a conviction following a plea of nolo contendere. This criterion may be waived if Health Options concludes, based on the Provider's submission of information, that such conviction or conduct does not demonstrate, and has not been followed by, an ongoing lack of integrity and failure to perform as a responsible and professional competent health care provider.

   b. The Provider should not have a record of improper acts substantially related to the qualifications, functions, or duties of a health care provider. If such a record does exist, there must be evidence that it does not, in the opinion of the Credentialing Committee, suggest on-going clinical or professional difficulties.

   c. The Provider must sign an attestation affirming the correctness and completeness of the application.

   d. The Provider must not have misrepresented, misstated, or omitted a relevant or material fact in the Credentialing documents.

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e. The Provider must attest to lack of present illegal drug use.

f. The Provider must attest that s/he is able to perform the essential functions of Provider's proposed services to Members, with or without reasonable accommodation.

g. Providers who prescribe controlled substances to Members must have a valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate valid in the state(s) where they provide services to Members

h. Providers must explain in writing gaps in their most recent five (5) year work history (upon completion of professional training) that are greater than six (6) months. Credentialing Committee considers the following gaps as routine Category 1 files: Maternity leave, family leave, additional training, immigration, and sabbatical. All other gaps are considered Non-Routine Category 2 files and will require Credentialing Committee review.

i. Education/Training of a Provider will be verified for initial Credentialing only, and only the highest level of education/training stated on the application will be verified.

j. Health Options will determine whether any federal sanctions have been imposed against the Provider, and whether any state sanctions were imposed in all states where the Provider was licensed, for the last five (5) years.

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Appendix C

New Hampshire Midwifery and Birthing Center Requirements

New Hampshire Certified Midwife Credentialing Criteria:

- Certified by New Hampshire Midwifery Council
- Malpractice Insurance to meet contractual limits
- Current Complete signed attested CAQH Application
- Written Plan of Action in Case of Emergency

New Hampshire Birthing Centers Requirements:

- Current New Hampshire License
- Malpractice Insurance to meet contractual limits
- Accreditation by the American Association of Birth Centers
- Copy of the Birthing Centers plan for: Provision of emergency and non-emergency care in the event of complications in mother and newborn.