Health, Housing & Human Services
CLACKAMAS COUNTY

Rodney A. Cook
Director

February 17, 2022

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of a revenue Professional Services Agreement with
Trillium Community Health Plan, Inc., for point of care provider services.
There is no maximum value. This is a fee for service Agreement.
No County General Funds are involved.

Purpose/Outcomes	This Agreement will allow Clackamas County Public Health Division (CCPHD) to get reimbursed for medical services provided to Trillium Community Health Plan, Inc. members.
Dollar Amount and Fiscal Impact	No Maximum Value.
Funding Source	Fee for Service - No County General Funds are involved..
Duration	Effective February 01, 2022 and terminates on December 31, 2026
Previous Board Action	This item was presented at issues on 2/15/22
Strategic Plan Alignment	1. Improved Community Safety and Health 2. Ensure safe, healthy and secure communities
Counsel Review	*County Counsel has reviewed and approved this document on: December 13, 2021 - KR:*
Procurement Review	1. Was the item processed through Procurement? yes ☐ no ☑ This is a revenue Agreement
Contact Person	Philip Mason-Joyner, Public Health Director – (503)742-5956
Contract No.	9841

BACKGROUND:
The Clackamas County Public Health Division (CCPHD) of the Health, Housing & Human Services Department requests the approval of a revenue Professional Services Agreement with Trillium Community Health Plan, Inc., for point of care provider services.

CCPHD provides screening and treatment for tuberculosis control, sexually transmitted infections, and immunization administration and tracking, and COVID Screening. The County has worked with Trillium Community Health Plan, Inc. to receive reimbursement for services provided to their members. Trillium Community Health Plan, Inc. has agreed to pay retroactively to February 1, 2022.

This Agreement has no maximum value, is effective January 1, 2022 and continues through December 31, 2026. This Amendment has been reviewed by County Counsel on December 13, 2021.

RECOMMENDATION:
Staff recommends the Board of County Commissioners approve this Agreement.

Respectfully submitted,

Rodney Cook

Rodney A. Cook, Director
Health, Housing, and Human Services

SERVICES AGREEMENT

between

TRILLIUM COMMUNITY HEALTH PLAN, INC.,
an Oregon corporation

and

CLACKAMAS COUNTY
(Public Health)

Agreement #9841

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PUBLIC HEALTH PROVIDER AGREEMENT

BETWEEN: Trillium Community Health Plan, Inc., an Oregon corporation **("Trillium")**

AND: Clackamas County, by and through it Health, Housing and Human Services Department Public Health Division **("Public Health")**

EFFECTIVE DATE: February 1, 2022

RECITALS

A. Trillium is an Oregon corporation which intends to enter into agreements with Plans to arrange for the provision of medical services to Members.

B. Clackamas County is a political subdivision of the State of Oregon, which through its Health, Housing and Human Services Department Public Health Division, provides community health functions for Clackamas County.

C. Trillium and Public Health desire to enter into an agreement whereby Public Health agrees to provide Covered Services to Members pursuant to the terms and conditions set forth in this Agreement.

AGREEMENT

1. **Definitions**. The following capitalized terms (and the plural thereof, when appropriate) shall have the meanings given below:

1.1 **Agreement.** This Public Health Provider Agreement by and between Trillium and Public Health.

1.2 **Capitation Fee.** The predetermined monthly payment to be made to Public Health or Public Health Provider, if applicable, for Covered Services to be provided to each Member assigned to Public Health or Public Health Providers.

1.3 **Clean Claim.** A bill for services, line item of service or all services for one Member on a bill, on a claim form that meets current industry standards and is approved by Trillium that can be processed without obtaining additional information from the provider of the services or from a third party. A Clean Claim does not include a claim from a provider under investigation for fraud or abuse, or a claim under review for whether a service or services were Medically Appropriate.

1.4 **Public Health Provider.** The following individuals who are employed by, or contracted with, Public Health, through whom Public Health will arrange for the provision of Covered Services under this Agreement:

1.4.1 Any physician who meets the qualifications required of a Participating Provider under this Agreement; and

1.4.2 Any other health care provider licensed to practice in Oregon who has been credentialed in accordance with Trillium's Policies and Procedures**.**

1.5 **Coinsurance.** The percentage or portion of the cost of care that Members may be obligated to pay for a Covered Service.

1.6 **Copayment.** The portion of a claim of medical, dental or pharmaceutical expense that a Member must pay out of their own pocket to Public Health for each service in accordance with the Member Contract.

1.7 **Covered Services.** Medically Appropriate health care services and supplies to which an Member is entitled under a Plan's benefit program and which are described and defined in an Member Contract.

1.8 **Deductible.** The amount of out-of-pocket expense that a Member is responsible to pay for Covered Services prior to being eligible to receive Plan benefits.

1.9 **Emergency or Emergency Medical Condition.** Except as otherwise defined in the Member Contract, a medical condition (a) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in (i) serious jeopardy (ii) serious impairment to bodily functions or (iii) serious dysfunction of any bodily organ or part, or (b) with respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer poses a threat to the health or safety of the pregnant woman or unborn child. An "Emergency" or "Emergency Medical Condition" is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a health care professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence. The final determination of whether a condition is an Emergency or Emergency Medical Condition rests with Trillium CCO except as otherwise provided by the applicable Plan.

1.10 **Medical Director.** A Physician licensed to practice medicine in the state of Oregon who is authorized by Trillium to be responsible for administering Trillium's medical affairs, quality management and utilization management review, and for serving as Trillium's medical liaison to Plans, including, if appropriate under the Plan(s), making all final medical and behavioral health decisions relating to coverage or payment.

1.11 **Medically Appropriate.** Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are: (a) consistent with the symptoms of a health condition or treatment of a health condition; (b) appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, evidence-based medicine and professional standards of care as effective; (c) not solely for the convenience of an Member or a provider of the service or medical supplies; and (d) the most cost effective of the alternative levels of medical services or medical supplies which can be safely provided to a Member in Trillium's judgment. The final determination of whether a service item is Medically Appropriate for purposes of qualifying for payment rests with Trillium, subject to the Plan procedures for reconsideration.

1.12 **Member.** A person who is enrolled in a Trillium Plan, including enrolled dependents, and is entitled to receive Covered Services.

1.13 **Member Contract.** The contract or agreement between Trillium and a payor of the health care benefits under a Plan setting forth the Covered Services to which a Member is entitled, such as Member handbooks, disclosure forms, and subscriber and group contracts. In the case of a government health benefits program, the Member Contract includes statutes and regulations governing the program.

1.14 **Non-Covered Services.** Those health care services which are not covered benefits under the Member Contract.

1.15 **Participating Hospital.** A hospital that contracts with Trillium to provide Covered Services to Members. Participating status shall be contingent upon Trillium's designation as such.

1.16 **Participating Practitioner.** A licensed physician or other health care professional, credentialed in accordance with Trillium's Policies and Procedures, who is a provider in an organization (Public Health) contracted with Trillium directly to provide Covered Services to Members. Participating status shall be contingent upon Trillium's designation as such.

1.17 **Participating Practitioner Group.** Intentionally left blank.

1.18 **Participating Provider.** A Participating Practitioner, Participating Practitioner Group, Participating Hospital, or other licensed health facility, Public Health Agency or licensed health professional which has entered into an agreement with Trillium to provide Covered Services to Members.

1.19 **Plan.** Government health benefits programs (Medicare, Oregon Health Plan), employer group health benefits programs and health benefits programs of other purchasers of Covered Services that contract with Trillium or an affiliated organization on a capitated, risk, or other basis. Plan includes those policies and procedures with which Trillium or Public Health must comply as required under the agreement between Trillium and the payor.

1.20 **Plan Addendum.** An Addendum to this Agreement setting forth payment and other terms applicable to a particular Plan prepared by Trillium and made part of this Agreement pursuant to paragraph 7.1.

1.21 **Policies and Procedures.** The criteria and procedures pertaining to credentialing and re-credentialing, participation, compensation, payment rules, processing guidelines, medical policy, utilization management, quality improvement, fraud and abuse, health benefit plan standards, and such other matters determined from time to time by Trillium.

1.22 **Primary Care Provider.** A Participating Practitioner who is deemed a Primary Care Provider by Trillium, which determination shall not be inconsistent with Trillium's credentialing process.

1.23 **Primary Care Services.** Those Covered Services routinely provided by Primary Care Providers in their practice of medicine or as may be further defined in Member Contracts.

1.24 **Prior Authorization or Preauthorization.** Prior authorization or Preauthorization is approval given by Trillium in advance of a proposed hospitalization, treatment, supply purchase or other Covered Service, in accordance with Trillium's Policies and Procedures.

1.25 **Referral.** The process required by this Agreement by which the Primary Care Provider directs a Member to seek and obtain Covered Services from a Participating Practitioner or any other provider of Covered Services..

1.26 **Regulatory Requirements**. All applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of governmental contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Plan or Plan Addendum.

1.27 **Specialty Services.** Those Covered Services provided by physicians professionally qualified to practice a designated specialty as determined by Trillium, which determination shall not be inconsistent with Trillium's credentialing process.

2. **Public Health Services**.

2.1 **Services.** Public Health shall, and shall cause Public Health Providers to, provide Covered Services (as appropriate to their professional qualifications and the scope of Public Health) to Members being screened or who have been determined to have an infectious disease reportable to Public Health. Public Health does not provide full primary care services but a limited scope of services specific to control of infectious disease. . Covered Services shall be rendered in accordance with this Agreement, Referral and Preauthorization Policies and Procedures of Trillium and provisions of the applicable Plan(s).

2.2 **Public Health Providers.** Public Health will require all Public Health Providers to comply with all of the provisions of this Agreement. Public Health represents and warrants that it has and will maintain current and valid contracts, employment agreements or other employer/employee relationships with all Public Health Providers pursuant to which Public Health can and will require Public Health Providers to comply with the terms and conditions of this Agreement. Contracts with Public Health Providers who are not employees of Public Health shall be in form acceptable to Trillium and available for inspection on request by Trillium or the Oregon Health Authority. In the event that Public Health Providers have individual contracts with Trillium, any ambiguities shall be resolved and controlled by the terms of this Agreement unless inconsistent with applicable law. The parties acknowledge that the providers listed in Exhibit 2.2 have been credentialed in accordance with Trillium Policies and Procedures and Public Health represents and warrants that Public Health Providers will continue to comply with Trillium's credentialing and re-credentialing Policies and Procedures. Public Health will not permit any other provider to provide services to Members on Public Health's behalf until such provider has been credentialed as a Participating Provider by Trillium. Public Health shall give Trillium at least 45 days notice, or as much notice as possible under the circumstances if less than 45 days, before the date on which any Public Health Provider will cease to provide services to Members.

2.3 **Performance.** Public Health and Public Health Providers are not employees of Trillium. Subject to practice protocols and utilization standards adopted by Trillium or the Plan, Public Health and Public Health Providers will determine the method, details, and means of performing Covered Services pursuant to this Agreement. Trillium shall provide Public Health with copies of protocols and standards, and amendments thereto, promptly upon adoption or receipt by Trillium unless the Plan has provided copies directly to Public Health. Covered Services will be provided as promptly as practicable consistent with sound medical practice and in accordance with accepted community professional standards and Public Health shall ensure Public Health Providers devote the time, attention, and energy necessary for the competent and effective performance of their duties hereunder to Members. Public Health shall ensure that Public Health Providers communicate to Members in a linguistically and culturally appropriate fashion in accordance with Trillium's Policies and Procedures. Notwithstanding anything to the contrary in this Agreement, Public Health may request Trillium and Trillium shall assist Public Health to transfer Members to another Participating Provider in accordance with the policies and procedures of the respective Plan in the event Public Health is unable to provide effective medical care to the Members, or when, in the professional judgment of a Public Health Provider, it is in the best interest of the Member to do so. Public Health agrees at all times to maintain a sufficient number of Public Health Providers to guarantee prompt and adequate access to Members.

2.4 **Personnel.** Public Health shall, at Public Health's sole cost and expense, arrange for the provision of Covered Services. Subject to practice protocols and utilization standards adopted by Trillium, Trillium may not control, direct, or supervise Public Health Providers or Public Health employees in the performance of Covered Services. Public Health shall be solely responsible for payment of all wages, salary, compensation, payroll and withholding taxes, unemployment insurance, workers' compensation coverage and all other compensation, insurance and benefits with respect to personnel employed or contracted by Public Health.

2.5 **Hours.** Public Health agrees to arrange for the provision of Covered Services as required by this Agreement 24 hours per day, seven days per week, 365 days per year.

2.6 **Coverage.** If Public Health is, for any reason, from time to time unable to provide those Covered Services Public Health has agreed to render under this Agreement when and as needed, Public Health may secure the services of a qualified covering provider who shall render such Covered Services. The covering provider must be a provider approved by Trillium to provide the Covered Services to Members otherwise required of Public Health. Public Health shall be solely responsible for securing the services of such covering provider. Public Health shall ensure that the covering provider: (a) looks solely to Public Health, Trillium, or the Plan(s), as the case may be, for compensation; (b) accepts Trillium's peer review procedures; (c) does not directly bill Members for Covered Services under any

circumstances, unless expressly required by the Plan(s); (d) obtains authorization in accordance with Trillium's utilization management program prior to all elective hospitalizations; and (e) complies with the terms of this Agreement and policies, procedures, and rules adopted by Trillium and the Plan related to performance of medical services under this Agreement.

2.7 **Patient Centered Primary Care Homes ("PCPCH"). If permitted by law and the patient,** Public Health and Public Health Providers shall communicate and coordinate care with the patient centered primary care home, if applicable, in a timely manner using electronic health information technology in accordance with Trillium's Policies and Procedures.

2.8 **Individualized Care Plans.** Public Health and Public Health Providers shall maintain individualized care plans to the extent feasible for each Member to address the supportive and therapeutic needs of each Member, particularly those with intensive care coordination needs, in accordance with Trillium's Policies and Procedures.

2.9 **Referral and Preauthorization Procedure**. Intentionally left blank.

2.10 **Hospital Admission Authorization.** Intentionally left blank.

2.11 **Compliance with Trillium Pharmaceutical Formularies.** If applicable, Public Health and Public Health Providers shall comply with pharmaceutical formularies and prior pharmaceutical authorization requirements developed or adopted by Trillium or contracting Plans, unless otherwise Medically Appropriate.

2.12 **Provision of Non-Covered or Unauthorized Services or Referral Care.** Intentionally left blank**.**

3. **Public Health Obligations**.

3.1 **Public Health Representations.** Public Health warrants and represents that it is part of the county which is a political subdivision of the State of Oregon; that each Public Health Provider is, and for the duration of this Agreement shall remain, duly licensed, certified, or accredited to practice the Public Health Provider's health care profession in the state of Oregon and is and for the duration of this Agreement shall remain, in good standing with the appropriate licensing, certification, or accreditation board(s); and that each Public Health Provider is a participating provider in Medicare and Oregon Health Plan and the holder of a valid DEA Certificate (if applicable). Public Health warrants and represents that Public Health Providers are currently, and for the duration of this Agreement shall remain, in compliance with Trillium's credentialing and re-credentialing criteria. Public Health warrants and represents that it does not and will not during the term of this Agreement employ or contract with any person who is excluded from participation in Medicare or Oregon Health Plan in connection with services provided under this Agreement.

3.2 **Nonexclusivity.** This Agreement is nonexclusive. Public Health may enter into agreements with other payers for the provision of health care services, both within and outside of Trillium's service area. Likewise, Trillium may enter into agreements for the provision of health care services with other health care providers. In addition, Trillium and Public Health agree that:

3.2.1 Public Health may continue to provide professional medical services to Public Health's own patients, to patients of other physicians or medical groups, and to patients under other medical plans not under contract with Trillium.

3.2.2 In rendering medical services to patients other than Members, Public Health shall ensure Public Health Providers neither represent nor imply in any way that such medical services are being rendered by or on behalf of Trillium.

3.2.3 Any professional medical services rendered by Public Health outside the scope of this Agreement shall not be billed by or through Trillium, and Trillium shall not be entitled to any administrative fees with respect to provision of such services.

3.2.4 Public Health may independently determine that Public Health will not participate in a particular Plan offered by Trillium as described in the Plan Summary Exhibit. Public Health will decide independently of any other health care professional or group whether to accept or reject participation in any Plan, or any price or other terms thereof.

3.3 **Accepting Members.** Public Health agrees to accept all Members being screened or who have been determined to have an infectious disease reportable to Public Health.

3.4 **Personnel, Equipment, and Supplies.** Public Health will supply all necessary office personnel, equipment, instruments and supplies required to perform Covered Services and which are usual and customary for a medical practice in the community.

3.5 **Compliance with Law and Ethical Standards.**

3.5.1 Public Health and Public Health Providers shall at all times during the term of this Agreement, comply with all applicable federal, state, and municipal laws, statutes, and ordinances, and any regulations promulgated thereunder; all applicable rules and regulations of each Public Health Provider's licensing board; and the ethical standards of the applicable professional associations.

3.5.2 In particular, and not to the exclusion of any other applicable law or regulation, Public Health and Trillium acknowledge that in the course of performing under this Agreement, they may use or disclose to each other or to outside parties certain confidential health information that may be subject to protection under state and/or federal law, including the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder with respect to privacy and security of health information, as well as standards for health information coding and transmission (collectively, "HIPAA"). Nothing in this Agreement is intended or shall be construed to permit or require Public Health or Trillium to undertake or fail to undertake any action in contravention of HIPAA, either as they exist at the date of this Agreement or as subsequently amended or modified. Trillium and Public Health specifically agree to take such action as may be necessary to comply with the requirements of HIPAA and any additional requirements prescribed under the Health Information Technology for Economic and Clinical Health Act ("HITECH") and other laws relating to the security and privacy of health information, including, without limitation, amendment of this Agreement to ensure compliance.

3.5.3 Public Health, following the discovery of a "Breach" of "Unsecured Protected Health Information" of a Trillium Member (as those terms are defined under HITECH), shall notify Trillium of such Breach. Except as otherwise required by law, Public Health shall provide such notice without unreasonable delay, and in no case later than thirty (30) calendar days after discovery of the Breach. Notice to Trillium required by this paragraph 3.5.3 shall include the information required under 45 CFR 164.404(c). After receipt of notice, from any source, of a Breach involving Unsecured Protected Health Information used, disclosed, maintained, or otherwise possessed by Public Health or Public Health Providers or of a Breach, involving Unsecured Protected Health Information, for which the Public Health or Public Health Provider is otherwise responsible, Public Health, at Public Health's sole expense agrees to notify the individual(s) affected by the Breach, in accordance with the notification requirements set forth in 45 CFR 164.404, without unreasonable delay, but in no case later than sixty (60) days after discovery of the Breach.

3.5.4 Public Health will cooperate with and participate in Trillium's compliance plan, including provision of information, cooperation with auditing and monitoring activities, participation in training and education, and implementation of compliance initiatives and programs as reasonably requested by Trillium from time to time.

3.6 **Continuing Education.** Public Health shall require Public Health Providers to maintain professional competence and skills commensurate with the medical standards of the community, and as required by law, by attending or participating in approved continuing education courses during the term of this Agreement.

3.7 **Compliance With Trillium Policies and Procedures.** Trillium will make available to Public Health any applicable policies and procedures electronically, or by request on paper, that apply to the services offered by Public Health. Public Health shall, and shall cause Public Health Providers to, agree to be bound by Trillium's Policies and Procedures necessary to meet their obligations under this Agreement. Trillium shall promptly provide Public Health with thirty (30) days' written notice of newly adopted or amended Policies and Procedures, which shall become binding on Public Health at the end of the thirty days' notice period. Public Health shall, and shall cause Public Health Providers to, cooperate with any administrative procedures which may be adopted by Trillium regarding the performance of Covered Services pursuant to this Agreement. Trillium may copy certain documents for Public Health at Trillium's own expense. Trillium shall monitor Public Health's and Public Health Provider's compliance with Trillium's Policies and Procedures and Public Health agrees to cooperate with Trillium with respect to any review of its performance, and the Parties agree to confer to address any compliance issues.

3.8 **Provider Directory.** Public Health agrees that Trillium and each Plan in which Public Health and Public Health Providers agree to participate may use the name, specialty, board certification, medical school(s), addresses, phone numbers, languages spoken other than English, prescription drug formularies used and type of practice of Public Health and Public Health Providers with regard to access and acceptance of new patients, in the Trillium or Plan directory of Participating Providers. The directory may be inspected by and is intended to be used by prospective parties such as patients, Trillium providers, employers, and insurers.

3.9 **Medical Records (Maintenance and Access).** Public Health shall maintain with respect to each Member receiving Covered Services hereunder a single standard medical record in such form, containing such information, and preserved for such time period(s), as are required by state and federal law, accepted standards of practice, and Trillium's Policies and Procedures. Subject to confidentiality laws, and upon receipt of three business days' reasonable prior written notice from Trillium, Public Health shall (a) share such records with Participating Providers in accordance with Trillium's Policies and Procedures; (b) permit Trillium, Trillium's designated representative, contracting Plans, or applicable state and federal regulatory agencies to inspect such records; and (c) provide copies of such records to Trillium upon request. Public Health shall also cooperate with Trillium, the Oregon Health Authority, Oregon Division of Medical Assistance Programs, Oregon Addictions and Mental Health Division, the Oregon Department of Justice Oregon Health Plan Fraud Unit, and the Centers for Medicare and Oregon Health Plan Services, or other authorized state or federal reviewers, for purposes of audits, inspection and examination of Member medical records. Medical records documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services were authorized and provided, Referrals were made, and outcomes of coordinated care and Referrals were sufficient to meet professional standards applicable to the health care professional and must meet the requirements under Trillium's Policies and Procedures. Medical records of Members shall be preserved by Public Health for a time period of no less than ten (10) years, or longer as required by law, e.g. tuberculosis records. If an audit, litigation, or other action involving the records is started before the end of the ten (10)-year period, the records must be retained until all issues arising out of the action are resolved or until the end of the ten (10)-year period, whichever is later. The obligations set forth in this paragraph shall survive termination of this Agreement.

3.10 **Financial Records (Maintenance and Access).** Public Health and Public Health Providers agree to cooperate with Trillium so that Trillium may meet any state or federal access requirements imposed on Trillium and arising out of this Agreement. Public Health shall maintain financial records, including the amounts of any payments received from Members or from others on behalf of such Members for a term of at least ten years from the date the record is created. All such records shall be maintained pursuant to generally accepted accounting standards and in accordance with applicable state and federal law and all regulations issued pursuant thereto. Public Health shall provide access to such records to Trillium, Trillium's designated representative, contracting Plans, and to applicable state and federal regulatory agencies for review, as may be required. The obligations set forth in this paragraph shall survive termination of this Agreement.

3.11 **Access.** This Agreement and all records which are directly pertinent to this Agreement necessary to verify the nature and extent of costs of services provided by Public Health or Public Health Providers, or relating to medical services, price, performance, compliance, quality of services and timeliness of services, will be made available to Trillium, the State of Oregon, the U.S. Department of Health and Human Services, the Centers for Medicare and Oregon Health Plan Services, the Comptroller General of the United States, and all of their duly authorized representatives as may be necessary for compliance by Trillium with all applicable federal and state laws and regulations. Such representatives shall have access to documents, papers, and records of Public Health and Public Health Providers, which are pertinent to the Plan for the purpose of making examination, excerpts and transcripts. Public Health and Public Health Providers shall, upon thirty (30) days' notice, provide a suitable work area and copying capabilities or make such copies as requested to facilitate such a review upon reasonable written notice to Public Health or Public Health Providers. Such rights to inspect and copy records and information shall continue for ten (10) years following the date of termination of this Agreement or completion of any audit commenced prior to termination, whichever is later. Public Health and Public Health Providers shall include a provision requiring any contractor of Public Health or Public Health Providers providing services under this Agreement to comply with this paragraph, and shall require all organizations related to Public Health and Public Health Providers to comply with this paragraph.

3.12 **Required Information.** Public Health shall provide Trillium with information necessary for Trillium to fulfill its obligations with Plans and to comply with state and federal law. Public Health authorizes Trillium to release such information as required by Plans or state and federal law and shall promptly procure such additional consents as may be necessary from time to time, if any, for purposes of this paragraph.

3.13 **Nondiscrimination.** Public Health and Public Health Provider agree, within the limits of Public Health Provider's specialty, to:

3.13.1 Not discriminate in his, her or its provision of Covered Services to Members on the basis of: race, color, national origin, ethnicity, ancestry, religion, sex, marital status, sexual orientation, mental or physical disability, medical condition or history, age, genetic information, source of payment, claims experience, receipt of health care, mental or physical condition, disability or illness, evidence of insurability, including conditions arising out of acts of domestic violence (42 CFR 422.110) or any other characteristic or classification deemed protected under state or federal law; and

3.13.2 Subject to this Agreement, provide Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-Plan patients of Public Health consistent with existing medical ethical/legal requirements for providing continuity of care to any patient.

3.14 **Cooperation with Plan and Trillium Medical Directors.** Public Health understands that contracting Plans will place certain obligations upon Trillium regarding the quality of care received by Members and that contracting Plans in certain instances will have the right to oversee and review the quality of care administered to Members. Public Health agrees to cooperate with Trillium's Medical Director and the medical directors of contracting Plans in their review of the quality of care administered to Members and to submit information as requested.

3.15 **Fraud and Abuse Programs.** Public Health and Public Health Providers agree to comply with Trillium's fraud and abuse program and questionable or inappropriate billing practices Policies and Procedures. The parties agree that Public Health shall have a reasonable opportunity to challenge any findings of fraud or abuse by Trillium.

4. **Trillium Obligations.**

4.1 **Eligibility Determinations and Reports.** Trillium will make eligibility information available to Public Health and Public Health Providers by telephone or by electronic means.

4.2 **Authorizations.** Trillium will provide authorization for non-Emergency Covered Services in the form of a Preauthorization and shall certify or recertify lengths of stay if required by telephone contact or other mutually agreeable form of communication between Public Health or Public Health Providers, the Member's Primary Care Provider or referral provider and/or Trillium personnel, according to Trillium's Quality Improvement and Utilization Management Policies and Procedures.

4.3 **Claims Processing.** Trillium shall be responsible for adjudicating and paying claims for Covered Services consistent with the terms of this Agreement and Trillium's Policies and Procedures.

4.4 **Policies and Procedures.** Attached as Exhibits B1-B8 are the Trillium Policies and Procedures applicable to Public Health and Public Health Providers under this Agreement.

4.5 **Compliance with Law.** Trillium shall at all times during the term of this Agreement comply with all applicable federal, state, and local laws, statutes and ordinances, and any regulations promulgated thereunder.

4.6 **Advocacy.** Public Health and Public Health Providers shall not be subject to termination or penalty for the sole reason of advocating or advising Members concerning (a) a decision, policy, or practice in conformity with ORS 677.095 (statutory duty of care) or (b) the Member's health status, medical care, treatment options, including alternative treatments, that may be self-administered; any information the Member needs in order to decide among relevant treatment options; risks, benefits and consequences of treatment or non-treatment; or the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. When communicating about Non- Covered Services, Public Health and Public Health Providers shall comply with paragraphs 2.9 and 5.3 of this Agreement.

4.7 **Patient Communications.** Unless otherwise provided by law or this Agreement, Public Health or Public Health Providers shall not be subject to termination or penalty for the sole reason of (a) communicating with a Member concerning any aspect of the Member's condition; any proposed treatment or treatment alternatives, whether or not covered by a third party payor; or Public Health or Public Health Provider's financial arrangement with a Plan, or (b) Public Health decisions regarding length of state in a health care facility, transfer between levels of care, and follow-up care.

4.8 **Member Referrals.** Notwithstanding any other provision of this Agreement, Public Health or Public Health Provider shall not be subject to termination or penalty for the sole reason of referring a Member to another provider, whether or not that provider is under contract with Trillium. However, Public Health and Public Health Providers must comply with Trillium's written Policies and Procedures with respect to any such Referrals in accordance with paragraphs 2.9 and 5.3 of this Agreement. Allocation of costs to Public Health for Referrals made to non-Participating Providers shall not be deemed a penalty.

5. **Compensation**.

5.1 **Compensation Formula.** Public Health shall be entitled to compensation by Trillium or the Plan for the provision of Covered Services rendered by Public Health or Public Health Providers to Members at the lesser of Public Health's billed charges or the rate determined in accordance with terms of the applicable Plan Addendum attached to this Agreement. Trillium and Public Health acknowledge that different methodologies or formulas for compensation may be established under different Plans or may vary for other providers.

5.2 **Payment of Compensation by Trillium or Plan.**

5.2.1 Subject to additional time as necessary for Coordination of Benefits pursuant to this Agreement, Public Health shall, within one hundred eighty (180) days following the provision of Covered Services, submit to Trillium a Clean Claim on a completed CMS 1500 statement or other claim form approved by Trillium. Failure of Public Health to submit a Clean Claim within one hundred eighty (180) days of service delivery may result in nonpayment to Public Health. Public Health shall be solely responsible for timely and proper billing to Plan(s) where such direct billing is required in accordance with the applicable Plan as summarized in the Plan Addendum. Public Health will also submit such additional encounter data as Trillium may request, including accurate and specific data describing the services rendered. Public Health and Public Health Providers will follow Medicare Correct Coding guidelines, or other industry standard guidelines approved by Trillium in coding services in all claims and data submitted to Trillium. Except for inadvertent error, claims statements must reflect Co-payments, Coinsurance and Deductibles collected or to be collected, and must be true, correct and complete. Trillium agrees to pay a Clean Claim within the time required by applicable state and federal law.

5.2.2 Coordination of Benefits ("COB"). Public Health agrees to comply with COB procedures adopted by Plan(s) and COB Policies and Procedures adopted by Trillium, and Trillium agrees to assist Public Health in obtaining such procedures from Plan(s), if necessary.

5.2.3 Trillium will adjudicate and pay claims for non-capitated Covered Services in compliance with applicable law, including time requirements under applicable law, and this Agreement.

5.2.4 Public Health shall maintain records to identify any third party or payor responsible for payment for services provided to Members. Public Health shall notify Trillium within thirty (30) days of any potential responsible third party and shall provide Trillium with all relevant identifying information concerning the Member, the claim and the third party resource available to Public Health.

5.2.5 Nothing herein is intended to require Trillium to adopt, or prevent Trillium from adopting, different billing and payment policies with respect to workers' compensation cases or other unique situations in which Trillium is or could be a secondary or conditional source of reimbursement for Covered Services.

5.3 **Patient Billing. If applicable,** except as may be expressly required by the Plan(s), Public Health and Public Health Providers shall look only to Trillium or the Plan(s) for compensation for Covered Services and shall at no time seek compensation from Members for Covered Services. In the event of non-payment by Plan or Trillium, Public Health and Public Health Providers shall not bill or otherwise attempt to collect from Members any amounts owed by Plan or Trillium and shall continue providing services to Members for the duration of the period for which premium payments have been made by or on behalf of the Member and until Member is discharged from the hospital (if applicable) or until the Member's Primary Care Provider determines that care in the hospital is no longer Medically Appropriate (if applicable). No surcharge to a Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to be any additional fee not provided for in the Plan and Member Contract; provided however that a charge for Non-Covered Services shall not be prohibited if Public Health has informed the Member in advance that the services are not Covered Services and the Member has agreed in advance, in writing, to pay for the services and such billing is permitted under the Plan(s) or otherwise by CMS. This paragraph shall survive termination of this Agreement and shall be interpreted for the benefit of Members.

5.4 **Patient Responsibility.** If applicable, Public Health and Clinic Public Health Providers shall bill and make reasonable efforts to collect all Copayments, Coinsurance and Deductibles from Member as specifically permitted in the Plan and Member Contract.

5.5 **Offsets, Adjustments and Recoupments.** Public Health authorizes Trillium to audit Public Health and offset any amounts owed by Public Health to Trillium, including all overpayment amounts paid by Trillium to Public Health or Public Health Providers, against amounts owed by Trillium to Public Health in accordance with applicable OAR, 410-120-1397, Recovery of Overpayments to Providers – Recoupments and Refunds. Public Health and Trillium shall mutually agree upon the amount to be recouped or offset.

5.6 **Accounting and Reports.**

5.6.1 To the extent that payments to Public Health or Public Health Providers for Covered Services include financial risk withholds, Trillium shall provide an accounting of risk withhold funds on an annual basis. Requests for information under this paragraph concerning such accounting must be made within two years after the end of the Agreement term pertaining to the requested information. Reconciliation and settlement shall be in accordance with the agreement between Trillium and each applicable Plan.

5.6.2 Upon request by Public Health, Trillium shall provide an annual accounting accurately summarizing the financial transactions between Trillium and Public Health and Public Health Providers for the preceding calendar year.

6. **Term and Termination**.

6.1 **Term of Agreement.** This Agreement will become effective on the Effective Date specified on the first page of this Agreement and will continue in effect through January 31st of the fourth year in which the Effective Date falls, unless sooner terminated pursuant to the terms of this Agreement.

6.2 **Without Cause Termination.** This Agreement may be terminated by either party, by giving the other party no less than ninety (90) days' advance written notice. Reasons for without cause termination may include, but are not limited to, Public Health moving to a new location, Public Health closes or ceases providing medical services or revises the provision of its services under this Agreement due to funding or staff changes.

6.3 **Immediate Termination.** Either party may immediately terminate this Agreement upon delivery of written notice to the other party or at such later date as may be set forth in the written notice if:

6.3.1 Federal or state regulations or guidelines are modified or changed in such a way that Covered Services are no longer allowable or appropriate for purchase under this Agreement;

6.3.2 Any license, certification, or privilege required by law or regulation to be held by the other party to fulfill obligations under this Agreement is for any reason denied, revoked, restricted, limited, suspended or not renewed;

6.3.3 The other party is suspended or excluded from participating in the Medicare or Oregon Health Plan programs;

6.3.4 The other party fails to maintain insurance required by this Agreement;

6.3.5 Conviction of the other party of a felony in any court of the United States, state or federal;

6.3.6 A petition in bankruptcy is filed by or against the other party (and, if an involuntary petition, the same is not dismissed within sixty (60) days after the filing thereof), the other party is adjudicated bankrupt, execution by the other party of any assignment for the benefit of creditors, the appointment of a receiver for the other party, or the cessation of business of the other party for any reason which renders the other party unable to perform its obligations under this Agreement; or

6.3.7 If Trillium or Plan fails to receive funding, appropriations, limitations, allotments or other expenditure authority sufficient to allow Trillium or Plan in the exercise of its reasonable discretion, to continue to make payment under this Agreement.

6.4 **For Cause Termination.** If either party commits a material breach of this Agreement, the other party may commence to terminate the Agreement by giving written notice to the party committing the breach stating its intention to terminate and stating with particularity the alleged breach. If the breach is not cured within thirty (30) days after the notice is given, the other party may terminate this Agreement immediately upon written notice. This right of termination shall be in addition to all other rights and remedies.

6.5 **Termination of Provider Upon Request of Plan.** Notwithstanding any other provision of this Agreement, Trillium shall have the right to terminate participation in a Plan by Public Health or a Public Health Provider, if the Plan notifies Trillium to remove Public Health or a Public Health Provider from its directory of Participating Providers.

6.6 **Fair Hearing Plan.** Public Health and Public Health Providers will comply with Trillium's fair hearing plan, credentialing policy and related Policies and Procedures. Trillium may suspend, restrict or terminate a Public Health Provider's privileges to see Members in accordance with such plans, policies and procedures, as applicable. In the event that a Public Health Provider's privileges are terminated in accordance with such Policies and Procedures, Public Health shall not permit such Public Health Provider to provide services to Members after the termination date. If Trillium proposes to terminate the participation of a Public Health Provider, Public Health Provider may be entitled to a review or hearing if and as provided by Trillium's fair hearing plan, credentialing policy or related Policies and Procedures.

6.7 **Responsibility for Members at Termination.** Public Health shall continue to provide Covered Services to a Member who is receiving Covered Services from Public Health on the effective termination date of this Agreement, an agreement between Trillium and a Plan, or Public Health's participation in a specific Plan, until the Covered Services being rendered to the Member by Public Health are completed (consistent with existing medical ethical and legal requirements for providing continuity of care to

a patient) or as mandated by law, unless Trillium or the Plan(s) make reasonable and medically appropriate provision for the assumption of such Covered Services by another Participating Provider. Public Health shall be compensated for those Covered Services provided to a Member pursuant to this paragraph (prior to and following the effective termination date) in accordance with compensation provisions stated in the applicable Plan Addendum or by mutual agreement.

6.8 **Effect of Termination.** Termination of this Agreement shall have no effect upon the rights and obligations of the parties arising under this Agreement prior to the effective date of termination or upon those provisions which are specifically identified as surviving termination.

6.9 **Survival.** The following provisions shall survive termination of this Agreement for any reason: paragraphs 3.9, 3.10, 3.11, 3.12, 3.15, 5.3, 5.5, 5.6, 6.7, 6.8, and 6.9; and sections 10, 11, 12, and 13, including all paragraphs in each of those sections.

7. **Addition, Amendment, or Termination as to a Plan**.

7.1 **New Plan.** Trillium may, in its sole discretion, notify Public Health from time to time of new Plans by sending Public Health a Plan Addendum for each new Plan in which Trillium wishes Public Health to participate. Public Health shall be deemed to have accepted the terms and conditions of a new Plan if Public Health does not reject the Plan in writing within thirty (30) days of being notified by Trillium. If the Plan Addendum becomes effective as provided in this Agreement, Public Health shall notify Public Health Providers about the new Plan and shall make any contract amendments required to make the terms and conditions of the Plan Addendum binding on Public Health Providers.

7.2 **Termination of Agreement with Plan.** Trillium will give advance written notice of the termination of Trillium's agreement with a Plan at least thirty (30) days before the effective date of termination or within three business days after Trillium receives written notice as to termination of any Plan, whichever is later. If the Plan directly notifies Public Health of termination, notice by the Plan shall constitute notice by Trillium. Upon termination of Trillium's agreement with a Plan, this Agreement shall terminate with respect to that Plan, but shall otherwise continue in full force and effect. Such termination with respect to a Plan shall have no effect on rights and obligations arising prior to the effective date of termination or upon those provisions which are specifically identified as surviving termination of this Agreement or the Plan Addendum.

7.3 **Termination Prior to Renewal. Intentionally left blank.**

7.4 **Amendment of a Plan.** Trillium shall notify Public Health of any amendment to a Plan Addendum. The amendment[s] to the Plan shall be effective when agreed upon in a writing signed by Public Health and Trillium.

8. **Suspension and Removal of Public Health Provider**.

8.1 **Notice to Trillium.** Public Health and Public Health Providers will promptly notify Trillium at any time any of the following occurs:

8.1.1 Any Public Health Provider ceases to meet any of Trillium's credentialing criteria.

8.1.2 Any Public Health Provider's license to practice in any state is suspended, restricted, revoked, not renewed, conditioned or made subject to any probation, limitation or qualification of any kind.

8.1.3 Any Public Health Provider has his or her participation or membership in any government or private health care benefits program or provider organization terminated, suspended, limited, restricted or conditioned in any way.

8.1.4 Any Public Health Provider's medical staff membership or Public Health privileges at any hospital are terminated, suspended, restricted, limited, reduced or conditioned in any way.

8.1.5 A Public Health Provider's authority to prescribe medications or DEA certificate is terminated, suspended, restricted, limited, reduced or conditioned in any way.

8.1.6 A Public Health Provider is convicted of any crime (other than a non-felony motor vehicle offense).

8.1.7 Insurance coverage of a Public Health Provider is terminated or reduced.

8.1.8 A Public Health Provider dies, becomes incapacitated, or fully or partially retires.

8.2 **Suspension of Service to Members**. Trillium may request that Public Health require a Public Health Provider to cease providing services to Members immediately on request for any of the following reasons:

8.2.1 Trillium has reasonable grounds to believe that the health, safety or welfare of any Member is in jeopardy because of such Public Health Provider;

8.2.2 A Plan has requested Trillium to remove the Public Health Provider from provision of services to Plan's Members;

8.2.3 Any of the events listed in paragraph 8.1 occurs; or

8.2.4 Public Health Provider fails to meet objective patient care quality standards. In the event a Public Health Provider is required to cease providing services under this paragraph, Public Health shall arrange for services to Members to be provided by other Public Health Providers.

8.3 **Hearing Procedures.** A Public Health Provider who is suspended under paragraph 8.2 may have Participating Provider status terminated in accordance with Trillium Policies and Procedures, and shall be entitled to such rights as are provided by Trillium's Policies and Procedures.

8.4 **Notice of Termination of Public Health Provider.** Public Health agrees to cooperate with Trillium as requested by Trillium in notifying Members of termination of a Public Health Provider.

9. **Utilization Management and Quality Improvement Programs**. Trillium shall establish and maintain utilization management ("UM") and quality improvement ("QI") programs to guide and review individual and aggregate performance of Public Health and other Participating Providers in the delivery of Covered Services. Review may include but not be limited to whether services are or were Medically Appropriate and compliance with protocols, Referrals, Preauthorization standards, and the evaluation of the results of care. The UM/QI programs, whether separate or combined, will be managed by Trillium or an affiliate of Trillium. Public Health shall comply with and, subject to Public Health's and Public Health Provider's rights of appeal or reconsideration, shall be bound by the UM/QI programs, and if requested shall serve on the UM and/or QI committee(s) in accordance with the procedures established by Trillium and contracting Plans. Public Health shall allow Trillium to use practitioner and provider performance data in quality improvement and utilization management programs. Failure to comply with the requirements of this paragraph may be deemed a material breach of this Agreement and may, at Trillium's option, be grounds for immediate termination of this Agreement. Public Health agrees that decisions of Trillium's UM or QI committees may be used to deny Public Health payment hereunder for Covered Services provided to a Member in a manner inconsistent with Trillium's UM or QI Policies and Procedures.

10. **Grievance Procedures**. Trillium or Plan will have appeal Policies and Procedures for disputes related to Prior Authorization and Referral procedures and final determinations by Trillium's Medical Director or a Plan medical director. Public Health shall comply with grievance and appeal procedures of Trillium or the Plan and shall be bound by such procedures. Nothing in this Agreement shall restrict or prevent Public Health's or Public Health Provider's right to file grievances or appeals directly with Plans. If a Plan fails to comply with its own grievance or appeals procedures to the detriment of Public Health, Trillium shall make reasonable efforts to enforce such compliance.

11. **Relationship of the Parties**. Nothing in this Agreement is intended to create any relationship between Trillium and Public Health or Public Health Provider other than that of independent entities contracting with each other solely for purposes of effectuating the provisions of this Agreement. Neither of the parties nor any of their respective employees or agents shall be deemed to be the employee or agent of the other. Except as specifically provided otherwise in this Agreement, Trillium shall have no authority to control or direct the time, place or manner in which Covered Services are provided by Public Health or Public Health Provider to Members.

12. **Insurance and Indemnity**.

12.1 **Indemnification.**

12.1.1 Subject to the limits of the Oregon Constitution and the Oregon Tort Claims Act, The parties mutually agree to indemnify and to hold each other (including their officers, agents and employees) harmless against any and all claims, demands, damages, liabilities and costs incurred by the other party arising out of or in connection with, either directly or indirectly, the breach of this Agreement or willful misconduct of the indemnifying party or its employees or agents. The fact that a person or entity is a Participating Provider does not make such person an agent of Trillium. The principles of comparative fault shall govern the interpretation and enforcement of this indemnity provision.

12.1.2 Trillium shall not be liable to Members for any act of malpractice on the part of Public Health or Public Health Providers and Public Health and Public Health Providers shall indemnify, defend, and hold harmless Trillium from any such liability. The indemnity in the immediately preceding sentence shall not apply to any alleged act of independent liability on the part of Trillium, or any of its respective employees or agents.

12.2 **Professional Liability Insurance.** Trillium shall provide, at Trillium's sole cost and expense, throughout the entire term of this Agreement, a policy of errors and omissions liability insurance with a licensed insurance company in a minimum amount of one million eight hundred thousand dollars per claim and three million six hundred thousand dollars in the annual aggregate to cover Trillium and Public Health Providers who are authorized or requested by Trillium to participate in Trillium's utilization management and quality improvement programs. In the event the policy is a "claims made" policy, Trillium shall purchase or otherwise be covered by a "tail" policy for a period of not less than three years following the effective termination date of the policy required by this paragraph. The "tail" policy shall have the same policy limits as the errors and omissions policy.

12.3 **Malpractice Insurance.** Intentionally left blank.

12.4 **Comprehensive Insurance.** Each party shall provide, at its sole cost and expense, throughout the entire term of this Agreement, a policy or policies of general commercial liability insurance insuring it against risks customarily covered by such insurance including any claim of loss, liability or damage committed or arising out of the alleged condition of the premises, or the furniture, fixtures, appliances or equipment located therein, together with standard liability protection against any loss, liability or damage as a result of the party's operation of a motor vehicle for business purposes, in a minimum amount of one million dollars per claim and two million dollars in the annual aggregate. Public Health will provide proof of self-insurance in the required amounts to satisfy this section.

12.5 **Workers' Compensation Insurance.** Each party agrees to provide, at its sole cost and expense, workers' compensation coverage for its employees throughout the entire term of this Agreement to the extent required by Oregon law, as the same may from time to time be amended.

12.6 **Evidence of Insurance.** Each party shall, upon reasonable request, furnish written evidence to the other party that the insurance required by this Agreement is in full force and effect. Each party shall provide the other with a minimum of thirty (30) days' prior written notice in the event insurance required by this paragraph is canceled or restricted. In addition, Public Health shall promptly notify Trillium in writing in the event any Public Health Provider is canceled from malpractice coverage for any reason. Public Health will provide proof of self-insurance in the required amounts to satisfy this section.

12.7 **Notice of Claims Involving Members.** Public Health shall promptly notify Trillium of any claim or demand involving any Member based on alleged malpractice or negligence of any person. Public Health and Public Health Providers shall notify Trillium of any settlement or judgment involving a Member within ten (10) days following execution or filing thereof.

13. Miscellaneous

13.1 **Confidentiality and Proprietary Information.** The parties agree to maintain the confidentiality of this Agreement and all documents, terms and conditions relating to reimbursement rates and methods and other proprietary information of the other party. Upon request, the parties agree to return all copies of documents containing the other party's proprietary information upon termination of this Agreement and to otherwise keep such proprietary information confidential.

13.2 **Amendment.** Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the parties.

13.2.1 The terms of this Agreement may be amended from time to time in writing signed by Public Health and Trillium.

13.2.2 **Intentionally Left Blank.**

13.3 **Dispute Resolution and Arbitration.** Except as otherwise provided in Section 13.3.1, any dispute, controversy, or claim arising out of the subject matter of this Agreement ("**Dispute**") will be settled by arbitration before a single arbitrator in Portland, Oregon. If the parties agree on an arbitrator, the arbitration will be held before the arbitrator selected by the parties. If the parties do not agree on an arbitrator, each party will designate an arbitrator and the arbitration will be held before a third arbitrator selected by the designated arbitrators. Each arbitrator will be an attorney knowledgeable in the area of business and healthcare law. The arbitration will be initiated by filing a claim with an arbitration service agreed to by the Parties and will be conducted in accordance with the then-current rules of such arbitration service. Each Party shall bear its own costs and attorneys' fees related to the arbitration except that the arbitration service's administrative fees, all arbitrator compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator(s), shall be borne equally by the Parties, and the arbitrator(s) shall not have the authority to order otherwise. The arbitrator(s) shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The Parties agree to and do hereby waive any right to pursue, on a class basis, any Dispute. The resolution of any dispute, controversy, or claim as determined by the arbitrator will be binding on the parties. Judgment on the award of the arbitrator may be entered by any party in any court having jurisdiction.

13.3.1. **Compelling Arbitration.** A Party may seek from a court an order to compel arbitration, or any other interim relief or provisional remedies, including equitable remedies to preclude a breach of the Agreement, pending an arbitrator's resolution of any Dispute. Any such action, suit, or proceeding will be litigated in courts located in Multnomah County, Oregon. For the purposes of the preceding sentence, each party consents and submits to the jurisdiction of any local, state, or federal court located in Multnomah County, Oregon. If a claim must be brought in a federal forum, then it shall be conducted solely and exclusively within the United States District Court for the District of Oregon.

13.3.2. **Dispute Resolution.** Any Dispute shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. Before a Party initiates arbitration regarding a Dispute, the Parties shall meet and confer in good faith to seek resolution of the Dispute. If a Party desires to initiate the procedures under this paragraph, the Party shall give notice (a "Dispute Initiation Notice") to the other Party providing a brief description of the nature of the Dispute, explaining the initiating Party's claim or position in connection with the Dispute, including relevant documentation, and naming an individual with authority to settle the Dispute on such Party's behalf. Within 20 days after receipt of a Dispute Initiation Notice, the receiving Party shall give a written reply (a "Dispute Reply") to the initiating Party providing

a brief description of the receiving Party's position in connection with the Dispute, including relevant documentation, and naming an individual with the authority to settle the Dispute on behalf of the receiving Party. The Parties shall promptly make an investigation of the Dispute, and commence discussions concerning resolution of the Dispute within 20 days after the date of the Dispute Reply. If a Dispute has not been resolved within 60 days after the Parties have commenced discussions regarding the Dispute, either Party may submit the dispute to arbitration subject to the terms and conditions herein. In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period.

13.4 **Assignment.** This Agreement shall be binding upon, and shall inure to the benefit of, the parties to it, and their respective heirs, legal representatives, successors and assigns. Notwithstanding the foregoing, neither Public Health nor Public Health Providers may assign any of their respective rights or delegate any of their respective duties hereunder without receiving the prior written consent of Trillium.

13.5 **Confidentiality**. The terms of this Agreement and in particular the provisions regarding compensation, are confidential and shall not be disclosed except as necessary to the performance of this Agreement or as required by law.

13.6 **No Third Party Beneficiary.** Except as expressly provided in paragraph 5.3 or a Plan Addendum, nothing in this Agreement, express or implied, is intended or shall be construed to confer upon any person, firm or corporation other than the parties hereto and their respective successors or assigns, any remedy or claim under or by reason of this Agreement or any term, covenant or condition hereof, as third party beneficiaries or otherwise, and all of the terms, covenants and conditions hereof shall be for the sole and exclusive benefit of the parties hereto and their successors and assigns.

13.7 **Notice.** All notices required by this Agreement shall be in writing addressed to the party to whom the notice is directed at the address of that party set forth below the signatures on this Agreement and shall be deemed to have been given for all purposes on the date the receiving party confirms receipt of the notice or communications. Any party may designate a different mailing address or a different person for all future notices by notice given in accordance with this paragraph.

13.8 **Attorney Fees.** In any proceeding to enforce or interpret this Agreement, seeking to enforce or invalidate an arbitration award, or otherwise arising out of or related to this Agreement, each party shall be responsible for its own attorneys' fees and costs.

13.9 **Integration.** This Agreement is the entire agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained in this Agreement. This Agreement shall supersede all prior communications, representations, and agreements, oral or written, of the parties.

13.10 **Interpretation.** The paragraph headings are for the convenience of the reader only and are not intended to act as a limitation on the scope or meaning of the paragraphs themselves. Both parties have had the opportunity to review and negotiate this Agreement and consult with such attorneys and advisors as they deemed appropriate prior to execution of this Agreement.

13.11 **Severability.** The invalidity of any term or provision of this Agreement shall not affect the validity of any other provision.

13.12 **Waiver.** Waiver by any party of strict performance of any provision of this Agreement shall not be a waiver of or prejudice any party's right to require strict performance of the same provision in the future or of any other provision.

13.13 **Governing Law**. This Agreement shall be interpreted and enforced according to the laws of the state of Oregon.

13.14 **Counterparts.** This Agreement may be executed in multiple counterparts, each of which together shall constitute one agreement, even though all parties do not sign the same counterpart.

13.15 **Exhibits.** All exhibits referred to in this Agreement are incorporated by reference.

13.16 **Required OHP Contract Language.** The contract provisions set forth in attached Exhibit 13.16 are specifically incorporated by this reference with respect to programs offered by the State of Oregon, Oregon Health Authority. In the event there is a conflict between the language in this Agreement and the contract provisions in Exhibit 13.16, then Exhibit 13.16 shall control.

13.17 **Required Medicare Contract Language.** The contract provisions set forth in attached Exhibit 13.17 are specifically incorporated by this reference in the event this Agreement applies to Medicare beneficiaries pursuant to a contract between Trillium and the Centers for Medicare and Oregon Health Plan Services (CMS). In the event there is a conflict between the language in this Agreement and the contract provisions in Exhibit 13.17, then Exhibit 13.17 shall control.

[SIGNATURE PAGE ON FILE AT TRILLIUM OFFICE

Authorized:

IN WITNESS WHEREOF, authorized representatives of the parties agree to the preceding terms and conditions of this Public Health Provider Agreement.

For: Clackamas County

Signature

Print Name

Title

Date

Address

Federal Employer Identification Number

OHA/DMAP Number

Medicare Number

NPI Number

For: Trillium Community Health Plan

Signature

Chris Hummer
Print Name

CEO
Title

Date

Approved as to form: Kathleen Rastetter 12/13/2021

EXHIBIT 2.1
Scope of Services

(Reference: paragraph 2.1)

Professional services within scope of licensure.

EXHIBIT 2.2
Provider Listing

(Reference: paragraph 2.2)

Please complete this page with a list of the providers that will be practicing under the terms of this Agreement.

Provider Name	Specialty	DMAP#	Medicare#	NPI#

Exhibit 7.1
Plan Addendum

(Reference: paragraph 7.1)

This Oregon Health Plan Addendum (the "Plan Addendum") is attached to and made a part of the Public Health Provider Agreement with Trillium (the "Agreement") and incorporates the terms and conditions of the Agreement by reference herein. Unless otherwise defined in this Plan Addendum, capitalized terms used in this Plan Addendum shall have the same meaning as those terms in the Agreement.

1. PLAN COVERED. The following Plan provided by Trillium to its Members is covered by this Plan Addendum.

1.1. **Oregon Health Plan.** Trillium is a coordinated care organization participating in the Oregon Health Plan (the "OHP"). Trillium has executed a written agreement ("OHP Contract") with the Oregon Health Authority ("OHA") under which Trillium is obligated to arrange for the provision of certain health care services to Members enrolled in the OHP. Provider agrees to provide Covered Services to Members enrolled in the OHP in accordance with the OHP Contract, OHA rules, applicable law and the Agreement.

1.2. **Term.** The term of this Plan Addendum shall begin on, February 1, 2022 and will remain in effect for an initial term ("Initial Term") of four (4) years, unless this Agreement is sooner terminated as provided in this Agreement.

1.3 **Compensation.** This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for professional Covered Services provided by Contracted Providers to Covered Persons enrolled in an Oregon Health Plan Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by Trillium as subject to this Compensation Schedule, Trillium shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for Covered Services is the lesser of: (i) Allowable Charges; or (ii) the "Contracted Rate" percentage by provider type as set forth below in ***Table 1 and Table 2***.

Table 1

This schedule establishes payment for services rendered to Trillium members who receive TB screening or STI/HIV/HCV screening for which reimbursement for services will be made per the fee schedule below.

Service Category	Coding	Contracted Rate
STI or TB Screening	99212	$31.44
• STI screening service (includes HIV/HCV screening) • Tuberculosis screening service • Services provided by, but not limited to, Community Health Workers, Disease Intervention Specialists, Licensed Practical Nurses, Registered Nurses and Physicians		
Other communicable disease screening: • COVID-19 (Coronavirus disease) screening	86328	$33.64
Immunizations	90471	$9.88
• Immunization administration for communicable disease • Services provided by, but not limited to, Community Health Workers, Disease Intervention Specialists, Licensed Practical Nurses, Registered Nurses and Physicians		

Fee Schedule Note: reimbursement per monthly invoice submitted by Provider. Trillium reserves the right to include additional FFS codes as approved by OHA that fall within the scope of county public health point of care services.

Table 2

This schedule establishes payment for services rendered to Trillium members who are actively receiving latent or active TB treatment from Provider.

Service Category	Coding	Contracted Rate
Tier 1 - Latent TB Treatment Diagnosis codes: R76.11 or R76.12t • Home and community visits related to latent TB treatment Services associated with ensuring compliance of treatment plan and • medication adherence	99201-99204, 99211-99214, 99384-99386, 99394-99396, 99401-99404	$250 monthly case rate
• Services provided by, but not limited to, Community Health Workers, Disease Intervention Specialists, Licensed Practical Nurses, Registered Nurses, and Physicians		
Tier 2 - Active TB Treatment Diagnosis codes: A15.x, A17.xx, **A18.xx,** or A19.xt	CPT Codes: 99201-99204, 99211-99214, 99384-99386, 99394-99396, 99401-99404	$500 monthly case rate
• Home and community visits related to active TB treatment • Services associated with ensuring compliance of treatment plan and medication adherence • Services related to TB treatment provided by, but not limited to, Community Health Workers, Intervention Specialists, Licensed Practical Nurses, Registered Nurses and Physicians		

Fee Schedule Note: reimbursement per monthly invoice submitted by Provider.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the

later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Trillium ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) sixty (60) days of being published in a final rule and becoming reasonably available to Trillium; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

3. Fee Sources. In the event CMS contains no published fee amount, alternate (or "gap fill") fee sources may be used to supply the fee basis amount for deriving fee amount (the "Alternative Fee Source Amount"). Payor will utilize such Alternative Fee Source Amount until such time that CMS publishes its own RBRVS value. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the Alternate Fee Source Amount. If there is no established payment amount on the current Medicare fee schedule or a gap fill fee source is not available for a Covered Service provided to a Covered Person, Payor may establish a payment amount to apply in determining the Allowed Amount. Until such time as Payor establishes such a payment amount, the maximum compensation shall be twenty five percent (25%) of Allowable Charges.

4. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

5. Billing.
    a. Provider. STI or TB screening and immunization services: Provider shall submit separate billing invoices without protected health information. Additionally, Provider will submit a separate report comprised of member information as listed below.
        i. The enrolled member report will be in Excel format and include the following elements:
            - Member Name
            - Member Medicaid ID #
            - ICD-10 Diagnosis Code
            - CPT code and unit of services performed

b. Trillium. STI or TB screening and immunization services: Trillium will make payment for enrolled members receiving STI or TB screening and immunization services according to Table 1 of this Exhibit within thirty (30) days following receipt of Provider invoices and required reports, or within the time period mandated by state and federal law, unless Provider is otherwise notified that additional information is necessary. If additional information is required before payment, Trillium will notify Provider within thirty (30) days of receipt of the validated monthly invoice with an explanation of the additional information needed to process and validate payment. Not later than thirty (30) days after receipt of additional information, Trillium will pay or deny invalidated services.

c. Trillium. TB treatment services: Trillium will make agreed upon case rate payments for enrolled members receiving TB tier 1 (latent) or tier 2 (active) treatment according to Table 2 in this Exhibit within thirty (30) days following receipt of Provider invoices and required reports, or within the time period mandated by state and federal law, unless Provider is otherwise notified that additional information is necessary. If additional information is required before payment, Trillium will notify Provider within thirty (30) days of receipt of the validated monthly invoice with an explanation of the additional information needed to process and validate payment. Not later than thirty (30) days after receipt of additional information, Trillium will pay or deny invalidated services.

d. Provider: TB treatment services: Provider shall submit separate billing invoices without protected health information. Additionally, Provider will submit a separate report comprised of member information as listed below for individuals receiving treatment for tier 1 (latent) or tier 2 (active) TB.

    i. The enrolled member report will be in Excel format and include the following elements:
        - Member Name
        - Member Medicaid ID #
        - ICD-10 Diagnosis Code
        - Service provided (screening, Tier 1 case management or Tier 2 case management)
        - Disposition (if providing Tier 1 or 2 case management), such as active treatment, suspended treatment, completed treatment
        - For members receiving treatment for active or latent TB the monthly invoice will only include members actively receiving treatment at least 15 days of the month. For members receiving treatment less than 15 days of the month, billing will commence the following month.

e. Provider. Provider shall submit monthly billing invoices without identifiable protected health information and required member reports as outlined in this Exhibit for payment of services to Trillium at the address listed below:

Trillium Community Health Plan
Attention: Accounts Payable
P.O. Box 11740
Eugene, OR 97440-3940

f. Provider: Provider shall additionally email a backup copy of above mailed billing invoices and required reports via secure and encrypted email to the Trillium Community Health Plan AP designated email. Instructions for email of monthly invoices and required reports:

i. Send invoices and required reports via secure and encrypted email to: Oregon_Market_AP@TrilliumCHP.com

g. With each emailed required report and invoice submission, include the following text and information: *I attest to the accuracy and completeness of the report submitted.*

6. Excluded Services. Services that are excluded from reimbursement under this agreement include:

a. Costs covered by state grants to support public health activities

b. Pharmaceutical costs

c. Point of care lab test costs

7. Included Services. Services covered under this contract are specifically for point of contact services provided by public health departments in accordance with ORS 414.153.

a. Immunizations

b. Sexually transmitted diseases: screening for STI including HIV and HCV for members with symptoms or high risk

c. Tuberculosis: screening and treatment for members with symptoms or high risk. Treatment for active or latent TB includes:

1. Directly observed therapy

2. Sputum collection

3. Home and community visits related to TB treatment

4. Services associated with ensuring compliance of treatment plan and medication adherence

5. Services related to TB treatment provided by, but not limited to, Community Health Workers, Intervention Specialists, Licensed Practical Nurses, Registered Nurses and Physicians

d. Other communicable diseases including COVID-19 (Coronvirus disease): screening for members with symptoms or high risk

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

4. **Payor** means entity (Trillium) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

EXHIBIT 13.16
OHP Specific Provisions

(Reference: paragraph 13.16)

TRILLIUM COMMUNITY HEALTH PLAN, Inc. ("Contractor") has entered into a Health Plan Services Contract, Coordinated Care Organization Contract with the State of Oregon, acting by and through its Oregon Health Authority ("OHA"), Division of Medical Assistance Programs ("DMAP") and Addictions and Mental Health Division ("AMH") to provide and pay for Coordinated Care Services (the "OHP Contract"). The OHP Contract requires that the provisions in this Exhibit be included in any subcontracts and contracts with Participating Providers. This Exhibit is incorporated by reference into and made part of the Public Health Provider Agreement (the "Agreement") with respect to goods and services rendered under the Agreement by Public Health (the "Subcontractor") to enrollees of Contractor who are enrolled in the Oregon Health Plan Oregon Health Plan managed care program ("Members"). In the event of a conflict or inconsistency with any term or condition in the Agreement relating to goods and services rendered to Members who are enrolled in the Oregon Health Plan Oregon Health Plan managed care program, this Exhibit shall control.

Subcontractor shall comply with the provisions in this Exhibit to the extent that they are applicable to the goods and services provided by Subcontractor under the Agreement; provided, however, that the Agreement shall not terminate or limit Contractor's legal responsibilities to OHA for the timely and effective performance of Contractor's duties and responsibilities under the OHP Contract. Capitalized terms used in this Exhibit, but not otherwise defined in the Agreement shall have the same meaning as those terms in the OHP Contract, including definitions incorporated therein by reference.

1. **OHA.** To the extent any provision in the OHP Contract applies to Contractor with respect to the Work Contractor is providing to OHA through the Agreement, that provision shall be incorporated by reference into the Agreement and shall apply equally to Subcontractor.

2. **Termination for Cause.** In addition to pursuing any other remedies allowed at law or in equity or by the Agreement, the Agreement may be terminated by Contractor, or Contractor may impose other sanctions against Subcontractor, if the Subcontractor's performance is inadequate to meet the requirements of the OHP Contract.

3. **Monitoring.**
   - 3.1 By Contractor. Contractor will monitor the Subcontractor's performance on an ongoing basis and perform at least once a year a formal review of compliance with delegated responsibilities and Subcontractor's performance, deficiencies or areas for improvement, in accordance with 42 CFR 438.230. Upon identification of deficiencies or areas for improvement, Subcontractor shall take the Corrective Action identified by Contractor.
   - 3.2 By OHA. Subcontractor agrees that OHA is authorized to monitor compliance with the requirements in the Statement of Work under the OHP Contract and that methods of monitoring compliance may include review of documents submitted by

Subcontractor, OHP Contract performance review, Grievances, on-site review of documentation or any other source of relevant information.

4. **Federal Oregon Health Plan Managed Care.** Subcontractor shall comply with the requirements of 42 CFR §438.6 that are applicable to the Work required under the Agreement.

5. **Hold Harmless**. Subcontractor shall not hold OHA nor a Member receiving services liable for any costs or charges related to Contractor-authorized Covered Services rendered to a Member whether in an emergency or otherwise. Furthermore, Subcontractor shall not hold a Member liable for any payments for any of the following: (a) Contractor's or Subcontractor's debt due to Contractor's or Subcontractor's insolvency; (b) Coordinated Care Services authorized or required to be provided under the OHP Contract and the Agreement to a Member, for which (i) OHA does not pay Contractor; or (ii) Contractor does not pay Subcontractor for Covered Services rendered to a Member as set forth in the Agreement; and (c) Covered Services furnished pursuant to the Agreement to the extent that those payments are in excess of the amount that the Member would owe if Contractor provided the services directly. Subcontractor may not initiate or maintain a civil action against a Member to collect any amounts owed by the Contractor for which the Member is not liable to the Subcontractor under the Agreement. Nothing in this paragraph 5 shall impair the right of the Subcontractor to charge, collect from, attempt to collect from or maintain a civil action against a Member for any of the following: (a) deductible, copayment, or coinsurance amounts, (b) health services not covered by the Contractor or the OHP Contact, and (c) health services rendered after the termination of the Agreement, unless the health services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination of the Agreement or unless the Subcontractor has assumed post-termination treatment obligations under the Agreement.

6. **Continuation.** Subcontractor shall continue to provide Covered Services during periods of Contractor insolvency or cessation of operations through the period for which CCO Payments were made to Contractor.

7. **Billing and Payment.** Subcontractor shall not bill Members for services that are not covered under the OHP Contract unless there is a full written disclosure or waiver on file signed by the Member, in advance of the service being provided, in accordance with OAR 410-141-0420.

8. **Reports**. Subcontractor shall provide timely access to records and facilities and cooperate with OHA in collection of information through consumer surveys, on-site reviews, medical chart reviews, financial reporting and financial record reviews, interviews with staff, and other information for the purposes of monitoring compliance with the OHP Contract, including but not limited to verification of services actually provided, and for developing and monitoring performance and outcomes.

9. **Quality Improvement.** In conformance with 42 CFR 438 Subpart E, Subcontractor shall cooperate with OHA by providing access to records and facilities for the purpose of an

annual, external, independent professional review of the quality outcomes and timeliness of, and access to, Services provided under the OHP Contract.

10. **Access to Records.** Subcontractor shall maintain all financial records related to the OHP Contract in accordance with generally accepted accounting principles or National Association of Insurance Commissioners accounting standards. In addition, Subcontractor shall maintain any other records, books, documents, papers, plans, records of shipment and payments and writings of Subcontractor, whether in paper, electronic or other form, that are pertinent to the OHP Contract (the "Records") in such a manner to clearly document Subcontractor's performance. Subcontractor shall provide timely and reasonable access to Records to: (a) OHA; (b) the Secretary of State's Office; (c) CMS; (d) the Comptroller General of the United States; (e) the Oregon Department of Justice Oregon Health Plan Fraud Control Unit; and (g) all their duly authorized representatives, to perform examinations and audits, make excerpts and transcripts, and evaluate the quality, appropriateness and timeliness of services performed. Subcontractor shall, upon request and without charge, provide a suitable work area and copying capabilities to facilities for such a review or audit. Subcontractor shall retain and keep accessible all Records for the longer of: (a) ten years following final payment and termination of the OHP Contract; (b) the period as may be required by applicable law, including the records retention schedules set forth in OAR Chapter 166; or (c) until the conclusion of any audit, controversy or litigation arising out of or related to the OHP Contract. The rights of access in this paragraph 10 are not limited to the required retention period, but shall last as long as the Records are retained.

11. **Clinical Records and Confidentiality of Member Records.** Subcontractor shall comply with Contractor's policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required by the Health Insurance Portability and Accountability Act, 42 USC 1320d et. seq., and the federal regulations implementing the Act ("HIPAA"), and complete Clinical Records that document the Coordinated Care Services received by the Members. Contractor shall regularly monitor Subcontractor's compliance with these policies and procedures and Subcontractor shall be subject to and comply with any Corrective Action taken by Contractor that is necessary to ensure Subcontractor compliance.

12. **Reporting of Abuse.** Subcontractor shall comply with all patient abuse reporting requirements and fully cooperate with the State for purposes of ORS 410.610 et.seq., ORS 419B.010 et.seq., ORS 430.735 et.seq., ORS 433.705 et.seq., ORS 441.630 et.seq., and all applicable Administrative Rules. In addition, Subcontractor shall comply with all protective services, investigation and reporting requirements described in OAR 943-045-0250 through 943-045-0370 and ORS 430.735 through 430.765.

13. **Fraud and Abuse.** Subcontractor shall comply with Contractor's fraud and Abuse policies to prevent and detect fraud and Abuse activities as such activities relate to the OHP, and shall promptly refer all suspected cases of fraud and Abuse to the Contractor and the Oregon Health Plan Fraud Control Unit ("MFCU"). Subcontractor shall permit the MFCU or OHA or both to inspect, evaluate, or audit books, records, documents, files, accounts, and facilities

maintained by or on behalf of Subcontractor, as required to investigate an incident of fraud and Abuse. Subcontractor shall cooperate with the MFCU and OHA investigator during any investigation of fraud and Abuse. Subcontractor shall provide copies of reports or other documentation regarding any suspected fraud at no cost to MFCU or OHA during an investigation

14. **Certification.** Subcontractor certifies that all Claims data submissions by the Subcontractor, either directly or through a third party submitter, is and will be accurate, truthful and complete in accordance with OAR 410-141-3320 and OAR 410-120-1280.

15. **Mental Health Services and Substance Use Disorder Services.**

15.1. Client Process Monitoring System Data. If Subcontractor provides Mental Health Services and/or substance use disorder services, Subcontractor shall provide to AMH within 30 days of Member admission or discharge all the information required by AMH's most current publication of "Client Process Monitoring System."

15.2. Community Services. If Subcontractor provides substance use disorder services, Subcontractor shall provide to Members, to the extent of available community resources and as clinically indicated, information and referral to community services which may include, but are not limited to: child care; elder care; housing; transportation; employment; vocational training; educational services; mental health services; financial services; and legal services.

15.3. Training. Where Subcontractor provides substance use disorder services and evaluates Members for access to and length of stay in substance use disorder services, Subcontractor represents and warrants that it has the training and background in substance use disorder services and working knowledge of American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (PPC-2R).

16. **State Provisions.** Subcontractor shall comply with all State and local laws, rules, regulations, executive orders and ordinances applicable to the OHP Contract or to the performance of Work under the Agreement, including but not limited to the following: (a) ORS Chapter 659A.142; (b) all other applicable requirements of State civil rights and rehabilitation statutes, rules and regulations; (c) OHA rules pertaining to the provision of prepaid capitated health care and services, OAR Chapter 410, Division 141; and (d) all other OHA Rules in OAR Chapter 410. These laws, rules, regulations, executive orders and ordinances are incorporated by reference herein to the extent that they are applicable to the OHP Contract and required by law to be so incorporated. Subcontractor shall, to the maximum extent economically feasible in the performance of the Agreement pertinent to the OHP Contact, use recycled paper (as defined in ORS 279A.010 (1) (gg)), recycled PETE products (as defined in ORS 279A.010 (1) (hh)), and other recycled products (as "recycled products" is defined in ORS 279A.010 (1) (ii)).

17. **Americans with Disabilities Act.** In compliance with the Americans with Disabilities Act of 1990, any written material that is generated and provided by Subcontractor under the OHP

Contract to Members, including Oregon Health Plan-Eligible Individuals, shall, at the request of such individuals, be reproduced in alternate formats of communication, to include Braille, large print, audiotape, oral presentation, and electronic format. Subcontractor shall not be reimbursed for costs incurred in complying with this provision.

18. **Information/Privacy/Security/Access.** If the items or services provided under the Agreement permits Subcontractor to have access to or use of any OHA computer system or other OHA Information Asset for which OHA imposes security requirements, and OHA grants Contractor access to such OHA Information Assets or Network and Information Systems, Subcontractor shall company with OAR 407-014-0300 through OAR 407-014-0320.

19. **Governing Law, Consent to Jurisdiction.** The OHP Contract shall be governed by and construed in accordance with the laws of the State of Oregon without regard to principles of conflicts of law. Any claim, action, suit or proceeding between the OHA (or any other agency or department of the State of Oregon) and Subcontractor that arises from or relates to the OHP Contract shall be brought and conducted solely and exclusively within the Circuit Court of Marion County for the State of Oregon; provided, however, if a claim must be brought in a federal forum, then it shall be conducted solely and exclusively within the United States District Court of the District of Oregon. In no event shall this paragraph 19 be construed as a waiver of the State of Oregon of the jurisdiction of any court or of any form of defense to or immunity from any claim whether sovereign immunity, governmental immunity, immunity based on the Eleventh Amendment to the Constitution of the Unites States or otherwise. **SUBCONTRACTOR, BY EXECUTION OF THE AGREEMENT, HEREBY CONSENTS TO THE IN PERSONAM JURISDICTION OF SAID COURTS.**

20. **Independent Contractor.**

20.1. Not an Employee of the State. Subcontractor represents and warrants that it is not an officer, employee, or agent of the State of Oregon as those terms are used in ORS 30.265 or otherwise.

20.2. Current Work for State or Federal Government. If Subcontractor is currently performing work for the State of Oregon or the federal government, Subcontractor by signature to the Agreement represents and warrants that Subcontractor's Work to be performed under the Agreement creates no potential or actual conflict of interest as defined by ORS Chapter 244 and that no statutes, rules or regulations of the State of Oregon or federal agency for which Subcontractor currently performs work would prohibit Subcontractor's work under the Agreement or the OHP Contract. If compensation under the Agreement is to be charged against federal funds, Subcontractor certifies that it is not currently employed by the federal government.

20.3. Taxes. Subcontractor shall be responsible for all federal and State of Oregon taxes applicable to compensation paid to Subcontractor under the Agreement, and unless Subcontractor is subject to backup withholding, OHA and Contractor will not withhold from such compensation any amount to cover Subcontractor's federal or State tax obligations. Subcontractor shall not be eligible for any social security,

unemployment insurance or workers' compensation benefits from compensation paid to Subcontractor under the Agreement, except as a self-employed individual.

20.4. Control. Subcontractor shall perform all Work as an independent contractor. Subcontractor understands that OHA reserves the right (i) to determine and modify the delivery schedule for the Work and (ii) to evaluate the quality of the Work Product; however, OHA may not and will not control the means or manner of Subcontractor's performance. Subcontractor is responsible for determining the appropriate means and manner of performing the Work delegated under the Agreement.

21. **Representations and Warranties**. Subcontractor represents and warrants to Contractor that: (a) Subcontractor has the power and authority to enter into and perform the Agreement; (b) the Agreement, when executed and delivered, shall be a valid and binding obligation of Subcontractor enforceable in accordance with its terms, (c) Subcontractor has the skill and knowledge possessed by well-informed members of its industry, trade or profession and Subcontractor will apply that skill and knowledge with care and diligence to perform the Work in a professional manner and in accordance with standards prevalent in Subcontractor's industry, trade or profession; and (d) Subcontractor shall, at all times during the term of the Agreement, be qualified, professionally competent, and duly licensed to perform the Work. The warranties set forth in this paragraph are in addition to, and not in lieu of, any other warranties provided.

22. **Assignment, Successor in Interest.** Subcontractor shall not assign or transfer its interest in the Agreement, voluntarily or involuntarily, whether by merger, consolidation, dissolution, operation of law, or in any other matter, without prior written consent of Contractor. Any such assignment or transfer, if approved, is subject to such conditions and provisions as Contractor and OHA may deem necessary, including but not limited to Exhibit B, Part 8, Section 14 of the OHP Contract. No approval by Contractor of any assignment or transfer of interest shall be deemed to create any obligation of Contractor in addition to those set forth in the Agreement. The provisions of the Agreement shall be binding upon and inure to the benefit of the parties, their respective successors and permitted assigns.

23. **Subcontracts.** Where Subcontractor is permitted to subcontract certain functions of the Agreement, Subcontractor shall notify Contractor, in writing, of any subcontract(s) for any of the Work required by the OHP Contract other than information submitted in Exhibit G of the OHP Contract. In addition, Subcontractor shall ensure that any subcontracts are in writing and include all the requirements set forth in this Exhibit that are applicable to the service or activity delegated under the subcontract.

24. **Severability.** If any term or provision of the OHP Contract, the Agreement or this Exhibit is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provision shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the OHP Contract, the Agreement or this Exhibit did not contain the particular term or provision held to be unlawful.

25. **Limitations of Liabilities.** Subcontractor agrees that OHA and Contractor shall not be held liable for any of Subcontractor's debts or liabilities in the event of insolvency.

26. **Compliance with Federal Laws.** Subcontractor shall comply with federal laws as set forth or incorporated, or both, in the OHP Contract and all other federal laws applicable to Subcontractor's performance relating to the OHP Contract or the Agreement. For purposes of the OHP Contract and the Agreement, all references to federal laws are references to federal laws as they may be amended from time to time. In addition, unless exempt under 45 CFR Part 87 for Faith-Based Organizations, or other federal provisions, Subcontractor shall comply with the following federal requirements to the extent that they are applicable to the OHP Contract and the Agreement:

26.1. Federal Provisions. Subcontractor shall comply with all federal laws, regulations, and executive orders applicable to the OHP Contract or to the delivery of Work under the Agreement. Without limiting the generality of the foregoing, Subcontractor expressly agrees to comply with the following laws, regulations and executive orders to the extent they are applicable to the OHP Contract and the Agreement: (a) Title VI and VII of the Civil Rights Act of 1964, as amended, (b) 45 CFR Part 84 which implements Title V, Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Executive Order 11246, as amended, (e) the Health Insurance Portability and Accountability Act of 1996, as amended, (f) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (g) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (h) all regulations and administrative rules established pursuant to the foregoing laws, (i) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, and (j) all federal law governing operation of community mental health programs, including without limitation, all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the OHP Contract and the Agreement and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 USC 14402.

26.2. Equal Employment Opportunity. If the OHP Contract, including amendments, is for more than $10,000, then Subcontractor shall comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

26.3. Clean Air, Clean Water, EPA Regulations. If the OHP Contract, including amendments, exceeds $100,000 then Subcontractor shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 USC 1251 to 1387), specifically including, but not limited to Section 508 (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under nonexempt federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to OHA, the U.S. Department of Health and Human

Services and the appropriate Regional Office of the Environmental Protection Agency. Subcontractor shall include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this subparagraph.

26.4. Energy Efficiency. Subcontractor shall comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 USC 6201 et seq. (Pub. L. 94-163).

26.5. Truth in Lobbying. Subcontractor certifies, to the best of the Subcontractor's knowledge and belief that:

a. No federal appropriated funds have been paid or will be paid, by or on behalf of Subcontractor, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Subcontractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

c. Subcontractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and Subcontractors shall certify and disclose accordingly.

26.6. HIPAA Compliance. Subcontractor acknowledges and agrees that Contractor is a "covered entity" for purpose of the privacy and security provisions of HIPAA. Accordingly, Subcontractor shall comply with HIPAA and the following:

a. Individually Identifiable Health Information ("IIHI") about specific individuals is protected from unauthorized use or disclosure consistent with the requirement of HIPAA. IIHI relating to specific individuals may be exchanged between Subcontractor and Contractor and between Subcontractor and OHA for purposes directly related to the provision of services to Members which are funded in whole or in part under the OHP Contract. However, Subcontractor shall not use or disclose any IIHI about specific individuals in a manner that would violate (i) the HIPAA Privacy Rules in CFR Parts 160 and 164; (ii) the OHA Privacy Rules, OAR 407-014-0000 et.seq., or (iii) the OHA

Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at: https://apps.state.or.us/Forms/Served/DE2090.pdf, or may be obtained from OHA.

b. Subcontractor shall adopt and employ reasonable administrative and physical safeguards consistent with the Security Rule in 45 CFR Part 164 to ensure that Member Information is used by or disclosed only to the extent necessary for the permitted use or disclosure and consistent with applicable State and federal laws and the terms and conditions of the OHP Contract and the Agreement. Security incidents involving Member Information must be immediately reported to the Contractor's privacy officer and to the Oregon Department of Human Services' ("DHS") Privacy Officer.

c. Subcontractor shall comply with the HIPAA standards for electronic transactions published in 45 CFR Part 162 and the DHS Electronic Data Transmission Rules, OAR 410-001-0000 through 410-001-0200. If Contractor intends to exchange electronic data transactions with OHA in connection with Claims or encounter data, eligibility or enrollment information, authorizations or other electronic transactions, Subcontractor shall comply with OHA Electronic Data Transmission Rules.

d. If Subcontractor reasonably believes that the Contractor's or OHA's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Subcontractor shall promptly consult Contractor or the OHA HIPAA officer.

26.7. Resource Conservation and Recovery. Subcontractor shall comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency.

26.8. Audits. Subcontractor shall comply with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations."

26.9. Debarment and Suspension. Subcontractor represents and warrants that it is not excluded by the U.S. Department of Health and Human Services Office of the Inspector General or listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension."

26.10. Drug-Free Workplace. Subcontractor shall comply with the following provisions to maintain a drug-free workplace:

a. Subcontractor certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in Subcontractor's workplace or while providing services to Members. Subcontractor's notice shall specify the actions that will be taken by Subcontractor against its employees for violation of such prohibitions;

b. Establish a drug-free awareness program to inform its employees about: the dangers of drug abuse in the workplace, Subcontractor's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;

c. Provide each employee to be engaged in the performance of services under the Agreement a copy of the statement mentioned in subparagraph 26.10.a above;

d. Notify each employee in the statement required by subparagraph 26.10.a that, as a condition of employment to provide services under the OHP Contract the employee will: abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

e. Notify OHA and Contractor within ten days after receiving notice under subparagraph 26.10.d from an employee or otherwise receiving actual notice of such conviction;

f. Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988;

g. Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs 26.10.a through 26.10.f;

h. Require any subcontractor to comply with subparagraphs 26.10.a through 26.10.g;

i. Neither Subcontractor, nor any of Subcontractor's employees, officers, agents or subcontractors may provide any service required under the Agreement while under the influence of drugs. For purposes of this provision, "under the influence" means: observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Subcontractor or Subcontractor's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Subcontractor or Subcontractor's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to Members or others. Examples of abnormal behavior include, but are not limited to: hallucinations, paranoia or violent outbursts. Examples of

impairments in physical or mental performance include, but are not limited to: slurred speech, difficulty walking or performing job activities;

j. Violation of any provision of this subparagraph 26.10 may result in termination of the Agreement and the OHP Contract.

26.11. Pro-Children Act. Subcontractor shall comply with the Pro-Children Act of 1994 (codified at 20 USC Section 6081 et. seq.).

26.12. Clinical Laboratory Improvements. Subcontractor and any laboratories used by Subcontractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438, which require that all laboratory testing sites providing services under the OHP Contract shall have either a Clinical Laboratory Improvement Amendments ("CLIA") certificate of waiver or a certificate of registration along with a CLIA identification number. Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

26.13. OASIS. To the extent applicable, Subcontractor shall comply with the Outcome and Assessment Information Set ("OASIS") reporting requirements and patient notice requirements for skilled services provided by Home Health Agencies, pursuant to the CMS requirements published in 64 FR 3764, 64 FR 3748, 64 FR 23846, and 64 FR 32984, and such subsequent regulations as CMS may issue in relation to the OASIS program.

26.14. Patient Rights Condition of Participation. To the extent applicable, Subcontractor shall comply with the Patient Rights Condition of Participation that hospitals must meet to continue participation in the Oregon Health Plan program, pursuant to 42 CFR Part 482. For purposes of this Exhibit, hospitals include short-term, psychiatric, rehabilitation, long-term, and children's hospitals.

26.15. Federal Grant Requirements. Subcontractor shall not expend any of the funds paid under the Agreement for roads, bridges, stadiums, or any other item or service not covered under the Oregon Health Plan ("OHP").

26.16. Title II of the Americans with Disabilities Act. Subcontractor shall comply with the integration mandate in 28 CFR 35.130(d), Title II of the Americans with Disabilities Act and its implementing regulations published in the Code of Federal Regulations.

27. **Marketing.** Subcontractor shall not initiate contact nor Market independently to potential Clients, directly or through any agent or independent contractor, in an attempt to influence an OHP Client's Enrollment with Contractor, without the express written consent of OHA. Subcontractor shall not conduct, directly, door-to-door, telephonic, mail, electronic, or other Cold Call Marketing practices to entice a Client to enroll with Contractor, or to not enroll with another OHP contractor. Subcontractor shall not seek to influence an Client's Enrollment with the Contractor in conjunction with the sale of any other insurance. Furthermore, Subcontractor understands that OHA must approve, prior to distribution, any written communication by Subcontractor that (a) is intended solely for Members, and (b) pertains

to provider requirements for obtaining coordinated care services, care at service site or benefits. Notwithstanding anything to the contrary in this paragraph 27, Subcontractor may post a sign listing all OHP Coordinated Care Organizations to which Subcontractor belongs and display Coordinated Care Organization-sponsored health promotional materials.

28. **Workers' Compensation Coverage.** If Subcontractor employs subject workers, as defined in ORS 656.027, then Subcontractor shall comply with ORS 656.017 and shall provide workers' compensation insurance coverage for those workers, unless they meet the requirements for an exemption under ORS 656.126(2).

29. **Third Party Resources.**

29.1. Provision of Covered Services. Subcontractor may not refuse to provide Covered Services to a Member because of a Third Party Resource's potential liability for payment for the Covered Services.

29.2. Reimbursement. Subcontractor understands that where Medicare and Contractor have paid for services, and the amount available from the Third Party Liability is not sufficient to satisfy the Claims of both programs to reimbursement, the Third Party Liability must reimburse Medicare the full amount of its Claim before any other entity, including Subcontractor, may be paid. In addition, if a Third Party has reimbursed Subcontractor, or if a Member, after receiving payment from a Third Party Liability, has reimbursed Subcontractor, the Subcontractor shall reimburse Medicare up to the full amount the Subcontractor received, if Medicare is unable to recover its payment from the remainder of the Third Party Liability payment.

29.3. Confidentiality. When engaging in Third Party Resource recovery actions, Subcontractor shall comply with federal and State confidentiality requirements, described in Exhibit E of the OHP Contract.

29.4. No Compensation. Except as permitted by the OHP Contract including Third Party Resources recovery, Subcontractor may not be compensated for Work performed under the OHP Contract from any other department of the State, nor from any other source including the federal government.

29.5. Third Party Liability. Subcontractor shall maintain records of Subcontractor's actions related to Third Party Liability recovery, and make those records available for Contractor and OHA review.

29.6. Right of Recovery. Subcontractor shall comply with 42 USC 1395y(b), which gives Medicare the right to recover its benefits from employers and workers' compensation carriers, liability insurers, automobile or no fault insurers, and employer group health plans before any other entity including Contractor or Subcontractor.

29.7. Disenrolled Members. If OHA retroactively disenrolls a Member at the time the Member acquired Third Party Liability insurance, pursuant to OAR 410-141-3080(2)(b)(D) or 410-141-3080(3)(a)(A), Subcontractor may not seek to collect from a Member (or any financially responsible Representative) or any Third Party

Liability, any amounts paid for any Covered Services provided on or after the date of Disenrollment.

30. **Preventive Care.** Where Subcontractor provides Preventive Care Services, all Preventive Care Services provided by Subcontractor to Members shall be reported to Contractor and shall be subject to Contractor's Medical Case Management and Record Keeping responsibilities.

31. **Accessibility.**

31.1. Timely Access, Hours. Subcontractor shall meet OHP standards for timely access to care and services, taking into account the urgency of the need for services as specified in OAR 410-141-3220. This requirement includes that Subcontractor offer hours of operation that are not less than the hours of operation offered to Contractor's commercial members (as applicable) and non-Members as provided in OAR 410-141-3220.

31.2. Special Needs. Subcontractor and Subcontractor's facilities shall meet the special needs of Members who require accommodations because of a disability or limited English proficiency.

32. **Member Rights.**

32.1. Treating Members with Respect and Equality. If Subcontractor is a Participating Provider, Subcontractor shall treat each Member with respect and with due consideration for his or her dignity and privacy. In addition, Subcontractor shall treat each Member the same as other patients who receive services equivalent to Covered Services.

32.2. Information on Treatment Options. If Subcontractor is a Participating Provider, Subcontractor shall ensure that each Member receives information on available treatment options and alternatives in a manner appropriate to the Member's condition and ability to understand.

32.3. Participation Decisions. If Subcontractor is a Participating Provider, Subcontractor shall allow each Member to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and decisions regarding coordination of follow up care.

32.4. Copy of Medical Records. Subcontractor shall ensure that each Member is allowed to request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45 CFR 164.524 and 164.526.

32.5. Exercise of Rights. Subcontractor shall ensure that each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Subcontractor, its staff, its subcontractors, its Participating Providers, or OHA treat the Member.

33. **Grievance System**. Subcontractor shall cooperate with DHS's Governor's Advocacy Office, the OHA Ombudsman and hearing representatives in all of the OHA's activities related to

Members' grievances, appeals and hearings including providing all requested written materials.

34. **Authorization of Service.** Subcontractor shall follow Contractor's procedures for the initial and continuing authorizations for services as defined in OAR 410-141-0000, which requires that any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's health or mental health condition or disease in accordance with 42 CFR 438.210. In addition, Subcontractor must obtain authorization for Covered Services from Contractor, except to the extent prior authorization is not required by OHP or elsewhere in the OHP Contract Statement of Work.

35. **Non-Discrimination.** Subcontractor shall not discriminate between Members and non-OHP persons as it relates to benefits and services to which they are both entitled.

36. **Record Keeping System.** If Subcontractor is a Participating Provider, Subcontractor shall, based on written policies and procedures, develop and maintain a record keeping system that: (a) includes sufficient detail and clarity to permit internal and external review to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the Member; (b) conforms to accepted professional practice; and (c) allows the Subcontractor to ensure that data submitted to Contractor is accurate and complete by: (i) verifying the accuracy and timeliness of reported data; (ii) screening the data for completeness, logic, and consistency; and (iii) collecting service information in standardized formats to the extent feasible and appropriate.

37. **Enrollment; Unique Provider Identification Number.** Each of Subcontractor's Physicians and other qualified providers, if any, shall be enrolled with OHA and have a unique provider identification number that complies with 42 USC 1320d-2(b).

38. **Accreditation.** If Subcontractor is a Participating Provider, all programs operated by Subcontractor shall be accredited by nationally recognized organizations recognized by OHA for the services provided, TJC, and/or be certified under OAR 309-012-0130 et.seq., or licensed under ORS Chapter 443 by the State of Oregon to deliver specified services including, OAR 309-032-0175 through 309-032-1565.

39. **Advocacy**. Except as provided in the OHP Contract, Contractor shall not prohibit or otherwise limit or restrict Subcontractor's Health Care Professionals acting within the lawful scope of practice, from advising or advocating on behalf of a Member, who is a patient of the professional, for the following : (a) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, that is Medically Appropriate even if such care or treatment is not covered under the OHP Contract or is subject to Copayment; (b) any information the Member needs in order to decide among relevant treatment options; (c) the risks, benefits, and consequences of treatment or non-treatment; and (d) the Member's right to participate in decisions regarding his or her health

care, including the right to refuse treatment, and to express preferences about future treatment decisions.

40. **Health Information Technology.** Subcontractor shall (a) be registered with a statewide or local Direct-enabled Health Information Service Provider, or (b) be a member of an existing Health Information Organization with the ability for providers on any electronic health record system (or with no electronic health record system) to be able to share electronic information with any other provider within the Contractor's network.

41. **No Actions**. To the extent Subcontractor is a Participating Provider, Subcontractor represents and warrants that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Subcontractor, including key management or executive staff, over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare or prescription drug services.

42. **Notice of Termination**. Subcontractor acknowledges and agrees that Contractor will provide written notice of the termination of Subcontractor's agreement with Contractor to provide Covered Services to Members, within 15 days of such termination, to each Member who received his or her primary care from, or was seen on a regular basis by, the Subcontractor.

EXHIBIT 13.17
CMS Specific Provisions

(Reference: paragraph 13.17)

Trillium Community Health Plan, Inc. ("Trillium") participates in the Medicare Advantage Plan ("MA Plan") as a Medicare Advantage Organization pursuant to a contract (the "MA Contract") with the U.S. Department of Health and Human Services ("HHS"), Centers for Medicare and Oregon Health Plan Services ("CMS") and may participate in other Medicare plans. In accordance with the MA Contract and MA Plan regulations the provisions in this Exhibit are included in any subcontracts or agreements with providers. This Exhibit is incorporated by reference into and made part of the Public Health Provider Agreement (the "Agreement") with respect to goods and services rendered under the Agreement by Public Health (the "Subcontractor") to members who are enrolled in Trillium's MA Plan (the "Contractor Plan"). In the event of any conflict or inconsistency with any term or condition in the Agreement relating to goods and services rendered to Contractor Plan members ("Members"), this Exhibit shall control. Subcontractor shall comply with the provisions in this Exhibit to the extent that they are applicable to the goods and services provided by Subcontractor under the Agreement.

1. **Compliance with Law.**
   1.1. **Medicare Program.** The Medicare Advantage program is governed by applicable statutes and regulations, including but not limited to 42 USC § 1395w-21 *et seq*. and 42 CFR Part 422, and the MA Contract. Trillium is ultimately responsible to CMS for complying with all terms and conditions of the MA Contract. However, Subcontractor agrees that it will comply with all applicable laws, regulations, CMS instructions and the MA Contract in providing services in connection with the Medicare Advantage program under the Agreement.

   1.2. **Other Laws.** Subcontractor agrees to comply with federal and state laws affecting the rights of Members. Applicable federal laws include, but are not limited to: (i) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164; and (ii) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse to include but not limited to applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 *et seq*.), and the anti-kickback statute (§1128B(b) of the Act).

2. **Access to Records; Audit.** Subcontractor agrees that HHS, the U.S. Comptroller General, Trillium, or their designees have the right to inspect, evaluate and audit any contracts, books, documents, papers, medical records, patient care documentation and records of the Subcontractor or its related entity(s), contractor(s), or subcontractor(s) involving transactions related to the MA Contract. This right of HHS, the Comptroller General, Trillium, or their designees to inspect, evaluate and audit any pertinent information for any particular contract period will continue for ten (10) years following (i) the date of termination of the Agreement; or (ii) completion of any audit commenced prior to termination of the Agreement, whichever is later, unless such ten year period is further extended for reasons specified in 42 CFR § 422.504(e)(4). Subcontractor agrees to maintain financial, Public Health, and other records pertinent to the Agreement to permit inspection, evaluation and audit of such

records as specified in this Section 2 and agrees to cooperate, assist, and provide information to HHS, the Comptroller General, Trillium, or their designees, as requested.

3. **Member Protections.**

3.1. **Hold Harmless.** Subcontractor agrees to hold Members harmless for the payment of fees that are the legal obligation of Trillium, for example, as a result of Trillium's insolvency, contract breach, or other financial difficulty.

3.2. **Medicare and Oregon Health Plan Eligible.** For all Members who are enrollees eligible for both Medicare and Oregon Health Plan, Subcontractor shall hold Members harmless for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Accordingly, Subcontractor shall accept Trillium's payment for services provided to Members as payment in full, or shall bill the appropriate State source.

3.3. **Continuation of Benefits.** As applicable, Subcontractor agrees to provide for continuation of health care benefits for all Members, for the duration of the contract period for which CMS payments have been made; and for Members who are hospitalized, on the date the MA Contract terminates, or in the event of Trillium's insolvency, through the date of the Member's discharge.

4. **Confidentiality and Member Records**. Subcontractor agrees to comply with all federal and state laws regarding confidentiality requirements of Member information. Subcontractor will use and disclose Member health information and enrollment information only in accordance with applicable federal or state law and agrees to safeguard Member privacy and confidentiality and assure accuracy of Member health records. Subcontractor will ensure that Members receive timely access to the records and information that pertain to them.

5. **Delegation**. With respect to all activities and responsibilities of Trillium under the MA Contract that are delegated to Subcontractor pursuant to the Agreement or otherwise, Subcontractor agrees to cooperate in ensuring that such delegation is clearly specified in writing, and that responsibility for reporting to CMS is clear. Any such delegated activities must be consistent and comply with the MA Contract. Performance of Subcontractor will be monitored by Trillium on an ongoing basis. In the event that either CMS or Trillium should determine that Subcontractor has not satisfactorily performed such delegated activities or reporting requirements, Trillium may at any time, revoke such delegation and requirements.

6. **Credentialing**. Where the Subcontractor or an affiliate performs provider credentialing for Trillium, all Trillium credentialing requirements, including all applicable Medicare Advantage credentialing requirements, must be met. The credentials of medical professionals providing services to Members will be either reviewed by Trillium or Trillium will review and approve, and audit on an on-going basis, the credentialing process.

7. **Subcontracts**. Subcontractor shall not subcontract or delegate any of Subcontractor's duties under the Agreement relating to the MA Contract without the prior written consent of Trillium. Trillium retains the right to approve, suspend, or terminate any such arrangement. Subcontractor will cause all services or activities performed by persons other than Subcontractor that relate to the Agreement or the provision of health care or administrative services for or with respect to the MA Plan or Members in the MA Plan ("Contract Providers")

to be subject to and performed in accordance with the terms and conditions of the Agreement, and to be consistent and comply with Trillium's obligations under the MA Contract. Subcontractor shall also cause each agreement with Contract Providers (the "Contract Provider Agreement") to contain all provisions required by applicable law to be in such agreement, or to otherwise satisfy such applicable law, including but not limited to those provisions required by 42 CFR 422.504(i). A Contract Provider Agreement includes every direct agreement between Subcontractor and a Contract Provider and every subcontract between two Contract Providers relating to the Agreement for or with respect to the MA Plan or Members in the MA Plan.

8. **Reporting Requirements**. Subcontractor will maintain and provide to Trillium data and information reasonably requested by Trillium to permit Trillium to comply with reporting requirements under the MA Contract, including but not limited to data and information necessary to (1) administer and evaluate the Medicare Advantage program, (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services, (3) allow Trillium to provide CMS data and information with respect to: the cost of its operations; the patterns of utilization of its services; the availability, accessibility and acceptance of its services; developments in the health status of Members; and fiscal soundness.

9. **Physical Premises**. Subcontractor agrees to allow HHS, the Comptroller General, or their designees to evaluate through inspection and other means the premises, physical facilities and equipment and records of the Subcontractor that pertain to Members and any additional information that CMS may require.

10. **Provider-Patient Relationship**. Subcontractor shall maintain the provider-patient relationship and nothing in the Agreement shall contain any provision that interferes with the provider-patient relationship.

11. **Prompt Payment**. Trillium agrees to provide prompt payment in accordance with the terms agreed to between Trillium and Subcontractor in the Agreement.

12. **Provider Selection**. If the Agreement provides for the selection of providers by the Subcontractor or its designee, then Trillium retains the right to approve, suspend, or terminate any such arrangement.

13. **Policies and Procedures**. Subcontractor agrees to comply with Trillium's policies and procedures that include Medicare Advantage-related provisions and provisions relating to Medicare Managed Care Manual, Chapter 11 – Medicare Advantage Application Procedures and Contract Requirements, Section 100.4. These Medicare Advantage related provisions include, but are not limited to, the following:
    13.1. Provide benefits to Members who permanently move into a "continuation area."
    13.2. Prohibition against discrimination based on health status.
    13.3. Pay for emergency and urgently needed services.
    13.4. Pay for renal dialysis for those temporarily out of a service area.
    13.5. Provide direct access to mammography and influenza vaccinations.

13.6. Not impose co-payments for influenza and pneumococcal vaccines.

13.7. Maintain written agreements with providers to demonstrate "adequate" access to benefits.

13.8. Provide or arrange for direct access to women's specialists for routine and preventive services.

13.9. Ensure services available 24hrs/day, 7days/week, when medically necessary.

13.10. Adhere to CMS marketing provisions.

13.11. Ensure services are provided in a culturally competent manner.

13.12. Maintain procedures to inform Members of follow-up care or provide training in self-care as necessary.

13.13. Document in a prominent place in the medical record if an individual has executed an advance directive.

13.14. Provide services in a manner consistent with professionally recognized standards of care.

13.15. Specify payment and incentive arrangements as necessary.

13.16. Make a good faith effort to notify all affected Members of the termination of a provider contract thirty (30) calendar days before the termination by Plan(s) or provider.

13.17. Submit complete and accurate risk adjustment data, as required by CMS, to Trillium.

13.18. Comply with medical policy, quality improvement programs, and medical management procedures.

13.19. Disclose to CMS and Trillium quality and performance indicators for plan benefits regarding (1) disenrollment rates for beneficiaries enrolled in the plan for the previous two years, (2) Member satisfaction and (3) health outcomes.

13.20. Prohibit use of excluded practitioners.

13.21. Adhere to appeals/grievance procedures.

14. **Part D**. Where Trillium is a Part D plan sponsor the following provisions also apply.

14.1. **Access to Records; Audit**. Subcontractor agrees that HHS, the U.S. Comptroller General, Trillium, or their designees have the right to inspect, evaluate and audit any pertinent contracts, books, documents, papers, and records of Subcontractor or related entity(s), contractor(s), or subcontractor(s) involving transactions related to CMS' Part D contract with Trillium ("Part D Plan Contract"). HHS', the Comptroller General's, Trillium's, or their designee's right to inspect, evaluate and audit any pertinent information for any particular contract period will exist for ten (10) years following (a) the date of termination of the Agreement or (b) completion of any audit commenced prior to termination of the Agreement, whichever is later, unless such ten year period is further extended for reasons specified in 42 CFR § 423.505(e)(4). Subcontractor agrees to maintain financial, clinical, and other records pertinent to the Agreement to permit inspection, evaluation and audit of such records as specified in this Section 14.1.

14.2. **Member Protections**. Subcontractor agrees to hold Members harmless for the payment of fees that are the legal obligation of Trillium.

14.3. **Delegation**. With respect to all activities and responsibilities of Trillium under the Part D Plan Contract that are delegated to Subcontractor pursuant to the Agreement or otherwise, Subcontractor agrees to cooperate in ensuring that such delegation is clearly specified in writing, and that responsibility for reporting to CMS is clear. Trillium maintains ultimate responsibility for compliance with the Part D Plan Contract and is required to monitor such delegated activities on an ongoing basis. Any such delegated activities must be consistent and comply with the Part D Plan Contract. In the event that either CMS or Trillium should determine that Subcontractor has not satisfactorily performed such delegated activities or reporting requirements, Trillium may at any time revoke such delegation if CMS or Trillium determines that Subcontractor has not performed satisfactorily.

14.4. **Subcontracts**. Subcontractor shall not subcontract or delegate any of Subcontractor's duties under the Agreement relating to the Part D Plan Contract without the prior written consent of Trillium. Trillium retains the right to approve, suspend, or terminate any such arrangement. Subcontractor will cause all services or activities performed by persons other than Subcontractor that relate to the Agreement to be subject to and performed in accordance with the terms and conditions of the Agreement, and to be consistent and comply with Trillium's obligations under the Part D Plan Contract.

Exhibit B-1: Pre-authorization and Prior Authorization

POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** UM Communication Services
PAGE: 1 of 3	**REPLACES:** CC.MEDM.UM.07.05 Precertification Admission Review Process (3/05)
APPROVED DATE: 3/06	**RETIRED:**
EFFECTIVE DATE: 3/06	**REVIEWED/REVISED:** 7/12; 7/13; 07/14; 08/14; 12/14; 06/15; 07/16; 09/17; 10/18; 10/19
PRODUCT TYPE: Medicaid, Medicare, Marketplace	**REFERENCE NUMBER:** CC.UM.03

SCOPE:

Medical Management Department

PURPOSE:

To provide consistent and easy access to Utilization Management (UM) staff for members and practitioners seeking information about the UM process and/or the authorization of care.

POLICY:

Members and practitioners can access UM staff through a toll-free number at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. Inbound and outbound communications may include directly speaking with practitioners and members, or fax, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Providers also have the capability to request authorizations or check status of an authorization via the website.

PROCEDURE:

A. Access to Staff

1. Toll-free phone lines are open for authorization requests and UM related questions and/or issues at minimum from 8am to 5pm, Monday through Friday, excluding holidays.

a. The member's treating provider or PCP may submit prior authorization requests by telephone, fax, or web (as applicable).

2. After normal business hours and on holidays, the 24 hour Nurse Advice Line is responsible for inbound calls to the UM toll-free number.

a. The Nurse Advice Line will notify the on-call, Prior Authorization Nurse or designee of after hour requests for hospital transfers, urgent/emergent prior authorizations and home health requests.

b. The company is responsible for providing a current on-call list to the Nurse Advice Line in a timely manner. The Nurse Advice Line is not a delegated UM entity and therefore does not make authorization decisions.

c. For Medicare requests, the Nurse Advice Line will follow the predefined processes in MCARE.MM.08.01.

3. Inbound faxes regarding UM issues are accepted 24/7. Use of secure application(s) for fax handling prevents exposure of protected health information (PHI).

4. Inbound authorization submissions via the web are accepted 24/7. Providers are able to access the web portal and enter a request for an authorization (excluding urgent or retro requests.) Note: Some service types may not be available for submission as determined by the company and/or state guidelines.

5. Communications regarding UM issues or requests for information about UM processes that are received after normal business hours are responded to on the next business day and communications received after midnight on Monday-Friday are responded to on the same business day. Authorization requests are handled per the timelines outlined in policy CC.UM.05.

6. When initiating or returning calls regarding UM issues, all UM staff will identify themselves by name, title and organization.

7. If Member Services receives a call regarding a specific UM case/issue (inquiries about decisions beyond the confirmation of approval or denial of care), the caller will be transferred to the appropriate UM staff/phone queue for direct access to UM staff about the UM decision or process.

8. TDD (Telecommunications Device for the Deaf) or TTY (Teletypewriter) services are available to assist the hearing impaired in obtaining and/or relaying information as needed. Company mailings provide documentation that these services are available via designated toll-free numbers (CC.MBRS.16 – *Hearing Impaired-Language Specific Interpreter Services,* CC.MBRS.17 – *Telecommunication Devices & Services,* EPC.NAL.MS.09 – *TDD Services (Nurse Advice Line).*

9. Interpretive services for languages other than English are provided free of charge via toll-free phone lines for UM related questions and/or issues. Language assistance for the Spanish speaking will be utilized via bi-lingual staff, and in the event an internal bi-lingual interpreter is not available, the designated Language

Interpreter Service vendor will be utilized (EPC.NAL.MS.07 – *Spanish Interpretation (Nurse Advice Line).*

10. Members may also call the Nurse Advice Line to access their medical triage phone service which provides healthcare assistance and advice (CC.UM.03.03 – Health Information and Symptom Member Calls).

REFERENCES / ASSOCIATED PROCESSES

UM.01– UM Program Description

UM.03.02 – Transfer of Phone Lines to Answering Service

UM.03.03 –Health Information and Symptom Member Calls

MBRS.16 – Hearing Impaired-Language Specific Interpreter Services

MBRS.17 – Telecommunication Devices & Services

MCARE.MM.08.01 – After Hours Monitoring for Medicare Authorization Requests

EPC.NAL.MS.07 – Spanish Interpretation (Nurse Advice Line)

EPC.NAL.MS.09 – TDD Services (Nurse Advise Line)

NCQA Health Plan Standards and Guidelines

Exhibit B-2: Claims Payment

POLICY AND PROCEDURE

DEPARTMENT: Claims Operations	**DOCUMENT NAME:** Claims Payment
PAGE: 1 of 4	**REPLACES DOCUMENT:**
APPROVED DATE: 7/16/2016	**RETIRED:**
EFFECTIVE DATE: 06/01/2016	**REVIEWED/REVISED: 6/12/2019; 7/10/2019; 10/22/2019; 5/26/2020**
PRODUCT TYPE: Oregon Health Plan	**REFERENCE NUMBER: OR.OPS.183**

SCOPE: Claims Operations

PURPOSE: To provide guidance regarding claims payment.

POLICY: Trillium provides claims payment according to guidelines set forth in Oregon Health Plan regulations.

PROCEDURE:

1. Claims submitted for payment by non-participating providers will be billed following the requirements of OAR 410-120-1280, 410-120-1295 and 410-120-1300.

1.1. Non-participating providers are paid for covered services consistent with the provisions of ORS 414.743, OAR 410-120-1340 and OAR 410-141-3565.

2. Trillium requires participating providers to submit all billings for members within 365 days of date of service.

2.1. Claims are date stamped when received in mail room.
2.2. Determines validity of claim within 30 days.
2.3. Trillium does not pend claims.
2.4. Trillium indicates on the claim, the date payment or remittance advise is mailed to the provider of service or member and the check number associated to the claim.
2.5. Trillium does not modify any claim.

3. All claims are reviewed for completeness and accuracy via the pre-adjudication validation process.

3.1. Incomplete or inaccurately completed claims will be rejected and returned to the provider.

3.1.1 Incomplete or inaccurate claims would be claims with incorrect or invalid information, missing information that would not allow claim to be validated for entry into the claim system.

3.1.2 This is done via a mailed letter with the rejection code and explanation of incomplete or inaccurate information that would need to be completed for claim to be accepted into the claim processing system.

3.2. Metrics are completed weekly to include percentage of rejected claims in determining overall accuracy and completeness of submitted claims.

3.3. This is done by calculating the total claims rejected divided by the total claims received to obtain the % of inaccurate claims.

4. General Edits – The system verifies that key information, diagnosis codes, procedure codes, modifiers, member number, provider number, etc. are valid data types configured in the AMISYS Advance system.

4.1. Member Eligibility – The system verifies that the group, division, contract, and member are eligible for coverage for the dates of service indicated on the claim. Member eligibility confirms that capitation has been received from the state for Medicaid members.

4.2. Provider Eligibility – The system determines provider eligibility and the provider's financial affiliation. An affiliation is an electronic record of the financial obligation between a provider and Centene (i.e., at what rate Centene will pay for the provider's services).

4.3. Authorization Requirements – The system determines authorization requirements, based on the contract loaded into AMISYS. If an authorization is required, AMISYS Advance obtains the authorization number for the service rendered from the authorization file and returns it to the claim entry screen. If no authorization is found, or the authorization does not match, the system denies the claim

4.4. Benefit Eligibility – The system verifies that the services rendered qualify for a benefit that is covered under the member's benefit package. AMISYS Advance determines if the service date falls within the effective date of the benefit.

4.5. Pricing – Payment amounts are determined and tracked through benefit limits, copayments and deductibles, provider discounts, and risk and fund allocations.

4.6. The final status of the claim is determined based upon the six steps described above. If one or more of the adjudication steps results in a pending status, referred to as a "pend," the entire claim will be reviewed by an analyst and then is reprocessed through the system.

4.7. If, in the above process, a claim pends, it is extracted out of AMISYS Advance and into our claims workflow system. Here the claim can be viewed for further investigations by dedicated Claims Processors who are extensively trained on state rules and who analyze the pended claims for final disposition. Typical "pended claims" situations are duplicate claim submissions, missing required data, high dollar thresholds, special pricing, etc. Once the pended issue is addressed, the claim is re-adjudicated in AMISYS using the six step process above.

5. Trillium will maintain a turn-around time of 90% of valid claims be processed in 30 days of receipts and a minimum of 99% of valid claims within 90 days of receipt

5.1. An initial determination is made on 99% of all claims submitted within 60 days of receipt.

6. Trillium pays any Indian Health Care providers for covered services provided to those members eligible to receive service from these providers.

6.1. Payment to Indian Health Care providers, follow the timeline standards above.
6.2. Trillium does not impose fees, premiums, or additional charges to members served by an Indian Health care provider or organization.

7. Trillium pays for Emergency Services from non-participating providers as per OAR 410-141-3840.

7.1. Urgent/emergent claims are reviewed prior to check run to ensure accuracy and to avoid any inappropriate denial.

8. Trillium pays certain contracts under a capitation agreement.

8.1. Claims processing under a Capitated agreement are reviewed prior to check run to ensure accuracy in processing.
8.2. All claims with the capitation agreement processing code are reviewed to ensure zero payment.

9. Trillium submits encounter data for services paid through all valid claims processed.

9.1. Encounter data is submitted weekly.
9.2. Any pended encounter data is reviewed and either reprocessed if system set up issues are corrected or recouped for provider to submit corrected claims.

10. Trillium does not make payment to a provider when a Provider Preventable condition, or Health Care-Acquired (HAC) condition is present or identified by:

10.1. Submission of HAC information on claim
10.2. Identified by the State upon review by qualified professionals
10.3. Has a negative consequence for the member
10.4. Is Auditable
10.5. HAC procedures include

10.5.1. Wrong surgical procedures performed on a member
10.5.2. Surgical procedure performed on the wrong body part,
10.5.3. Or a surgical procedure performed on the wrong member.

11. Trillium does not pay claims, other than emergency items and services, when:

11.1. When the individual provider or entity is excluded from participation under the Social Security Act

11.2. When an individual or entity to which there is a pending investigation of a credible allegation of fraud, unless OHA determines good cause to not suspend payment.
11.3. When services are excluded due to the Assisted Suicide funding restriction act.
11.4. Home health services by an agency that has not provided a surety bond specified in Section 1861 (o)(7) of the Social Security Act.

REFERENCES : OAR 410-120-1280, 410-120-1295, 410-120-1300, ORS 414.743, OAR 410-141-3840, Social Security Act,

REVISION LOG

REVISION	DATE
Revised to include verbiage per EQR Action Plan.	7/10/2019
Revised to add section 4. To 4.7.	10/22/2019
Updated OAR 410-141-3420 to OAR 410-141-3565 & OAR 410-141-3140 to OAR 410-141-3840.	5/26/2020

POLICY AND PROCEDURE APPROVAL

The electronic approval is retained in Archer

Director of Department: Approval on file

Vice President of Department: Approval on file

Exhibit B-3: Grievance System: Grievances, Appeals and Contested Case Hearings

POLICY AND PROCEDURE

DEPARTMENT: Quality Management and Improvement	**REFERENCE NUMBER: OR.QMI.111**
EFFECTIVE DATE: 6/6/2016	**POLICY NAME: Grievance System: Grievances, Appeals, Contested Case Hearings**
REVIEWED/REVISED DATE: 08/13/2020	**RETIRED DATE: N/A**

SCOPE:

Trillium Community Health Plan Quality Management (Trillium) (QM), Medical Management and Member Service departments.

PURPOSE:

To outline the Member Grievance and Appeals System that meets all Federal and State regulatory requirements, including a grievance and appeal process. It identifies how Trillium staff identifies, responds to, resolves, and reports member grievances and appeals. It includes procedures for the Contested Case Hearing (hearing) process if members feel the appeal finding is unacceptable regarding their care or service.

POLICY:

Trillium maintains a procedure for the receipt and prompt resolution of all grievances, appeals and hearings that complies with all applicable State and Federal laws. Trillium investigates and documents the content and substance of grievances and appeals, including all clinical care aspects involved, according to applicable statutory, regulatory, and contractual provisions and Trillium's policies and procedures. Trillium provides resolution and notification of such resolution as expeditiously as the member's condition warrants but no later than timeframes as outlined in this policy. Trillium does not structure compensation in a manner that incentivizes an individual or entity to deny, limit or discontinue medically necessary service to any member.

PROCEDURE

A. General Requirements

1. Upon enrollment, Trillium notifies Members of their rights to and the procedures for requesting, processing and resolving member grievances, appeals and hearings. The notification explains specific instructions about how to contact Trillium's Member Services Department.

2. The following individuals can be included as parties to a grievance or an appeal:

a. Trillium.
b. Member.
c. Member's representative.

i. If a Member would like an authorized representative, the Member must complete the Member Authorized Representative Designation Form or provide other written documentation authorizing the person to act on their behalf. If the Member chooses to elect an authorized representative, the Member's written consent is required before Trillium can process the request. Once the Authorized Representative Designation Form is received, the resolution time clock begins.

d. Legal representative of a deceased member's estate
e. Provider and/or provider's subcontractor, with member's written consent.

3. Trillium provides members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes, but is not limited to:
a. Assistance from qualified staff to participate in processes affecting the member's care and services.
i. Qualified staff includes but is not limited to: community health workers, qualified peer wellness specialists or personal health navigators.

b. Reasonable accommodations for members with disabilities.

4. Trillium provides members the following for filing a grievance or an appeal:

a. Toll-free numbers, including TTY/TTD.

b. Free interpreter services.

c. Documents in alternate formats and languages other than English.

d. Rules that govern representation at the hearing.

e. Right to have an attorney or member representative at the hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center.

5. Trillium and contracted providers do not do the following with regards to the grievance, appeal or hearing process:

a. Discourage a member from filing.
b. Encourage the withdrawal from the process.
c. Use the filing or resolution as a reason to retaliate against a member or to request member disenrollment.

6. Trillium, contracted provider offices, and subcontractors delegated appeals and grievances make available the Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

7. Trillium and contracted providers cooperate with OHA, CMS, the External Quality Review Organization, the Department of Human Services Governor's Advocacy Office, the Authority's Ombudsman and hearing representatives in all activities related to member appeals, hearing requests and grievances, including providing all requested written materials.

a. Requests for records are submitted to OHA's Contract Administrator within the following timelines:

i. Non Hearing related: no later than 14 days following receipt of the request,

ii. Expedited Hearing: within 24 hours; and,

iii. Non-expedited hearing: within 2 days.

8. Trillium meets the following requirements when handling grievances and appeals:

a. Resolve or acknowledge receipt of each grievance and appeal within 5 business days.

b. Document the substance of the grievance and appeal.

c. Investigate the substance of the grievance and appeal and obtain documentation regarding the facts of the case upon receipt, including any aspect of clinical care.

i. If a grievance could be a potential Quality Of Care (QOC) issue, the grievance case is investigated and resolved as a QOC grievance and a QOC referral is routed to the QI QM Department designee for investigation within 1 (one) business day of the grievance being received.

d. Document the actions taken to address the grievance and appeal.
e. Ensure that upon receipt of a grievance or appeal, it is forwarded to staff who are given authority to act upon the matter.
f. Ensure individuals who make decisions on grievances and appeals are:
i. Not involved in any previous level of review or decision-making and are not the subordinate of the person involved in the initial review or decision-making.

ii. Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

iii. Healthcare professionals with appropriate clinical expertise (same or similar specialty) in treating the member's condition for cases involving:

1. Appeal of a denial that is based on lack of medically appropriate services.

2. Grievance regarding denial of expedited resolution of an appeal.

3. Grievance or appeal that involves clinic issues.

iv. Taking into account all comments, documents, records and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial decision.

g. Ensure all written notices sent to members are culturally and linguistically appropriate, written in a format and language that may be easily understood by the member. Written notices include:

i. Nondiscrimination provisions.
ii. Information on how to receive language assistance.

B. Reporting and Logging Requirements

1. Trillium maintains records of grievances and appeals and reviews the information as part of Trillium's ongoing monitoring procedures as well as updates and revisions to the state quality strategy. The Quality Improvement Committee (QIC) reviews analyses of grievances, appeals and hearings and recommends opportunities for improvement. Analyses includes:

a. Compliance with applicable state, federal or other regulatory rules regarding turnaround times.

b. Top drivers.

c. Trends and improvement opportunities.

2. Trillium maintains a log for each grievance and appeal for ten years with the following requirements pertaining to each member's appeal or grievance:

a. Member's name, ID number, and date the member filed the grievance or appeal/date received.

b. Documentation of Trillium's review, resolution or disposition of the matter, including the reason for the decision and the date of resolution or disposition.

c. All evidence, testimony, or additional documentation provided by the member, the member's representative, or the member's provider as part of the appeal process.

d. Notations of verbal or written communications with the member.

e. Notations about appeals and grievances the member decides to resolve in another way, if Trillium is aware of this.

f. A general description of the reason for the appeal.

g. The log contains the number of actions and the categorization of the reasons for and resolutions or dispositions of appeals and grievances in aggregate by year.

3. Trillium maintains a complete record for each appeal and grievance included in the log for ten years.

4. Using the state approved grievance system report, Trillium submits documentation of all grievances and appeals to the state 45 days following the end of each calendar quarter and upon request.

a. Trillium staff reviews and monitors the log at least monthly for completeness and accuracy, which includes but is not limited to timeliness of documentation and compliance with regulations.

b. Trillium maintains a record, in a central location for each grievance and appeal included in the grievance forms for no less than 45 days. The record includes, at a minimum.

i. Member's name and ID number.
ii. Date of Notice.
iii. Date and nature of the review.
iv. Continuing benefits requested and provided
v. If filed in writing, the appeal or grievance.
vi. If a verbal filing was received, documentation that the grievance or appeal was received verbally.
vii. Records of the review or investigation.
viii. Date of resolution and notice of resolution of the grievance or appeal.
ix. All written decision and copies of all correspondence with all parties to the grievance or appeal.

c. Trillium submits to OHA Contract Administration Unit, with the Grievance and Appeal Log, 20 samples of Notices of Adverse Benefit Determination, and all Notices for ABA and Hepatitis C issued in the reporting quarter.

5. Trillium provides grievance system policies, procedures, and member notice templates to regulatory bodies annually and within 5 business days of request for review and approval. Upon any changes to the approved policies, procedures, and member notice templates Trillium resubmits the changes for approval.

a. Trillium revises and corrects any and, all deficiencies identified by CMS, OHA, or EQRO and resubmits corrected documentation within 30 days of notification or as outlined in administrative notice of such deficiency.

C. Protected Health Information

1. Trillium keeps all healthcare information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501, and include providing member assurance of confidentiality in all written, oral and posted material in grievance and appeal processes.

2. The following pertains to the release of member's information:

a. Trillium and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:

i. Resolving the matter; or,
ii. Maintaining the grievance or appeals log as specified in 42 CFR 438.416.

iii. If Trillium needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, Trillium shall obtain the member's signed release and retain the release in the member's record.

D. Delegation of Grievance System

1. When Trillium delegates grievances to a subcontractor, Trillium:

a. Ensures the subcontractor meets the requirements consistent with the grievance system regulations.

b. Monitors the subcontractor's performance on an ongoing basis.

c. Performs a formal compliance review at least annually to assess performance, deficiencies or areas for improvement and ensures subcontractor takes corrective action for any of these areas identified as deficient or needing improvement.

2. Trillium provides to providers and subcontractors, at the time they enter into a subcontract, the following grievance, appeal, and hearing procedures and timeframes:

a. Member's right to a hearing, how to obtain a hearing and representation rules at a hearing.

b. Member's right to file a grievance and/or appeal and their requirements and timeframes for filing.

c. The availability of assistance in filing.

d. The toll-free numbers, including TTY/TTD, and interpreter capabilities to file oral grievances and appeals.

e. Member's right to request continuation of benefits during an appeal or a hearing and, if the contractor's action is upheld in a hearing, the member may be liable for the cost of continued benefits.

f. Any state-determined provider appeal rights to challenge the failure of the organization to cover a service.

3. Trillium does not delegate adjudication of appeals.

E. Member Grievance Process

1. In compliance with Title VI of the Civil Rights Act and ORS chapter 659A, Trillium reviews and reports to the Authority grievances that raise issues related to racial or ethnic background, gender identity, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, violation of civil rights and other identity factors for consideration in improving services for health equity.

2. Trillium processes member grievances related to continuing benefits during their transition from one health plan to another to ensure continuity of care.

3. Grievances may be filed at any time orally or in writing by fax, mail or email with Trillium, OHA, or a delegated subcontractor of Trillium.

a. When Trillium receives grievances related to services provided by subcontractors who are delegated grievance processing, Trillium forwards the grievance to subcontractor upon receipt.

4. Trillium acknowledges verbal grievances upon receipt.
5. Taking into account the member's health condition, Trillium notifies the member of the grievance decision, addressing each aspect of the grievance and reason for the decision, within the following timeframes:
a. Within 5 business days from receipt date.
b. Extension: If additional time is needed to resolve the grievance, Trillium will acknowledge receipt of the grievance and notify the member within 5 business days that there will be a delay, including the reason additional time is necessary, and will provide resolution within 30 calendar days from receipt date. c. Grievances determined to be clinically urgent in nature, by an appropriately licensed professional, are resolved within 72 hours.
6. Trillium responds in writing to all grievances, including those received verbally.
7. Grievance resolution dispute rights are provided to members, as appropriate.

F. Grievance Resolution Dispute (Appeal)

1. Members unsatisfied with the resolution of their grievance may request a second review (also known as a grievance resolution dispute), if applicable.

a. Trillium must receive grievance resolution dispute requests within 60 calendar days from the grievance resolution notification.

i. Requests can be received verbally or in writing.
ii. Requests received more than 60 calendar days after the grievance resolution are be handled as a new grievance.
b. Trillium investigates and obtains any necessary documentation related to the issues of the case.

i. If grievance resolution dispute is clinical in nature, an appropriate health care professional is involved in the decision making.

c. Resolution of grievance resolution disputes follows the same timeliness standards as an initial grievance (outlined in section E.5 above).

d. Notice of grievance resolution dispute decision is provided to the member in writing and contains the decision, addressing each aspect of the grievance and reason for the decision. If Trillium cannot resolve a grievance within the timeframe stated in policy, or cannot notify the member of the final decision for legal or statutory reasons, Trillium notifies the member that the grievance was received and investigated.

e. The member is provided information on how to submit their grievance to the appropriate regulatory body for further review, if desired.

G. Additional Requirements

1. Member will be notified that they may present the grievance to Oregon Health Plan Client Services Unit (CSU) or Oregon Health Authority's (OHA) Ombudsman at any time.

2. Trillium cooperates with the investigation and resolution of the Grievance by CSU or OHA Ombudsman, including providing all requested records.

H. Appeals Process

1. Who can file an appeal:

a. Member.
b. Member's authorized representative.
c. Legal representative of a deceased member's estate.
d. Provider and/or provider's subcontractor acting on behalf of the member with the member's authorization and written consent.
e. The Oregon Health Authority (OHA) with a request to review an action that is in a hearing process.

2. Member may request an appeal verbally or in writing:

a. Trillium uses the verbal appeal receipt date to establish earliest possible filing date.

b. For verbal appeals, unless member requests expedited review, Trillium sends appeal request form OHP 3302 and advises the member that their request must be followed by a written, signed, and dated appeal.

3. Appeals must be filed within 60 calendar days from the date of the notice of adverse benefit determination.

a. Appeals filed untimely are invalid and dismissed for late filing.

4. For a standard appeal, Trillium sends an Appeal Acknowledgement letter within 5 business days of the receipt of the appeal request.

5. Members have only one level of internal appeal.

6. Members must exhaust internal appeal processes prior to requesting a State Fair Hearing.

7. Should Trillium fail to adhere to the notice and timing requirements within OAR and state contract, the member is deemed to have exhausted the internal appeal process and may initiate a State Fair Hearing.

8. Trillium ensures that:

a. Members are not discouraged from using any aspect of the appeal or hearing process;

b. Members are not encouraged to withdraw an appeal or hearing request already filed; and

c. Use of the filing or resolution of an appeal or hearing request is not used as a reason to retaliate against member or to request member disenrollment.

9. During the appeal review process, Trillium:

a. Provides the member reasonable opportunity, to present evidence and testimony and make legal and factual arguments in person as well as in writing.

i. In the case of an expedited appeal, Trillium informs the member of the limited time available for this sufficiently in advance of the resolution timeframe.

b. Upon request, provides the member or the member's authorized representative with the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon or generated by Trillium in connection with the appeal at no charge.

c. Documents the substance of the appeal to include the Member's reason for appealing the previous decision, and additional clinical or other information provided with the appeal request.

d. Fully investigates and documents the content of the appeal including all aspects of clinical care involved, without giving deference to the denial decision.

i. All information is taken into account regardless of whether the information was submitted or considered in the initial determination.

ii. Any additional information required to review the appeal request is requested at this time and that request is documented in the clinical documentation system. If no additional information is available, per the Provider or the Member, it is documented in the clinical documentation system.

iii. Trillium documents actions taken including but not limited to previous denial or appeal history, follow-up activities associated with the denial and conducted before the current appeal.

10. Trillium resolves the appeal, and provide 'Notice of Appeal Resolution' (OHP Form 2406), as expeditiously as the member's health condition requires and within the following timeframes:

a. Standard pre-service and post-service appeal resolution is within 16 calendar days from the date received.

b. Expedited appeal resolution within 72 hours from the date appeal was received.

i. Trillium provides oral notification to the member and the provider within the 72 hour timeframe.

ii. Written confirmation of decision is provided within 3 calendar days of the oral notification.

c. Extensions:

i. Trillium may extend the time frames, both standard and expedited, by up to 14 calendar days if:

1. The Member requests the extension; or 2. Trillium shows (to the satisfaction of OHA upon its request) that there is need for additional information and how the delay is in the Member's interest. ii. For any extension not requested by the member, Trillium:
1. Makes reasonable effort to give member prompt verbal notice of the reason for the delay;
2. Notifies the member in writing within 2 days of the reason for the decision to extend the appeal timeframe and inform the member of their right to file a grievance if they disagree with that

decision; 3. Resolves the appeal as expeditiously as the member's health condition requires but no later than the date the extension expires.

11. An expedited review process for pre-service appeals is available when Trillium determines the Member request or the Provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function. Post-service appeal requests are not eligible for expedited review.

a. Upon receipt of an expedited appeal request, Trillium acknowledges receipt of appeal orally and in writing within 1 business day, and determines if expedited request is granted or denied.

i. If granted, Trillium:

1. Informs the member of the limited time available for receipt of materials or documentation for the review.

2. Makes reasonable effort to call the member and the provider to tell them of the resolution, within 72 hours after receiving the request; and,

3. Mails written confirmation of the resolution within 3 days. 4. Informs the member of their right to request an expedited hearing in the event Trillium denies the requested services or items.

ii. If denied, Trillium:

1. Transfers the appeal to the 16-day timeframe for standard resolution.

2. Makes reasonable efforts to give the member and requesting provider prompt verbal notice of the denial and follow-up within two days with a written notice, to include Member right to file a grievance if they disagree with the decision.

b. Trillium's expedited review process ensures that punitive action is not taken against a provider who supports a member's appeal or requests an expedited appeal.

c. If Trillium fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe, the member may initiate a hearing.

I. Notice of Appeal Resolution

1. Trillium notifies members using the state approved Notice of Action/Adverse Benefit Determination when informing members of denied benefit determination.

a. Notices are written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and follow the process for doing so.

b. The Notice contains a complete explanation of the reason for the denial in plain language that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand.

2. Trillium Notice of Action/Adverse Benefit Determination informs members about:

a. The member or the member's authorized representatives rights and instructions on how to:

i. Request internal appeal.

ii. Request expedited appeal.

iii. Request hearing, including the right to request an expedited hearing, in the event that taking the time for standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

iv. Submit comments, documents or other information relevant to the appeal.

b. How to request an appeal extension.

c. How to request continued coverage of services pending the outcome of an appeal and/or hearing.

d. How to request an appeal/hearing representative.

3. All Notice of Appeal Resolution letters inform members about:

a. Results of the resolution process and date it was completed.

b. Titles and qualifications, including specialties, of individuals participating in the appeal review.

c. For appeals not resolved wholly in favor of the member:

i. Reason for the resolution and a reference to the particular benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.

ii. Right to request a hearing, including the state approved form and right to expedited hearing, and how to do so;

iii. Right to request continuation of benefits pending the outcome and how to do so;

iv. An explanation that the member may be held liable for costs of any continued benefits if adverse benefit decision is upheld.

J. Contested Case Hearing (Hearing) Process

1. Who can file an hearing request:

a. Member;

b. Member's representative;

c. Member's provider if the action affects the provider.

2. Include as parties to the hearing:

a. The member and representative

b. Trillium

c. Legal representative of a deceased member's estate

3. Filing guidelines

a. A hearing can only be requested after notification of an adverse appeal decision is received or if Trillium fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe.

b. A hearing request must be filed within 120 calendar days from date of Trillium's adverse appeal decision letter.

i. If untimely, the Authority determines if there is good cause for late filing.

c. The request can be filed with the Authority or Trillium.

i. If filed with Trillium, Trillium submits the date stamped request upon receipt to the Authority with the following information:

1. If case has already been appealed, Trillium submits to the Authority within two business days:

a. Notice of action/Adverse Benefit Determination;

b. Notice of appeal resolution;

c. All documents and records included in the file;

d. All other documents requested.

2. If an appeal review has not occurred, Trillium processes the appeal and submits to the Authority:

a. Notice of action/Adverse Benefit Determination and appeal receipt date, within two business days;

b. Notice of appeal resolution and all documents and records related to the review, within 16 days of receipt of the appeal request.

d. Member has the right to request an expedited hearing, in the event that taking the time for standard resolution of an appeal could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

i. Expedited hearings are requested using Authority form MSC 443 or other Division approved appeal or hearing request forms.

ii. If expedited hearing is requested:

1. Trillium submits all relevant documentation to Authority within two business days.

2. Authority determines if an expedited hearing will be granted within two business days from the date of receipt of the medical documentation.

3. If expedited request is denied, the Authority sends written notice within two calendar days and make reasonable effort to call the member.

4. Provider requests for a hearing with Authority:

a. Only requests regarding an action that affects the provider are permitted.

b. To be valid, the provider must have completed an appeal with Trillium, and requested a hearing no later than 30 days from the date of the notice of appeal resolution.

K. Effectuation of Hearing Decisions

1. The Authority provides Trillium with written notice resolving the hearing within 90 calendar days from the hearing receipt date, whichever comes first.

2. If the hearing judge reverses the appeal decision:

a. Trillium authorizes the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date that Trillium receives notice reversing the determination.
b. Trillium authorizes payment of the services within 30 calendar days, if services were already furnished.

L. Continuation of Benefits

1. A Member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or hearing is pending.
2. To be entitled to continuing benefits:

a. The member request for appeal or hearing was filed timely.
b. The request involves the termination, suspension, or reduction of a previously authorized service provided by an authorized provider.
c. The original authorization has not expired.
d. The requesting provider was notified of a decision to deny a service authorization request, or authorization for a service in an amount, duration, or scope that is less than requested.
e. The member's request to extend benefits is filed on or before the later of the following:

i. Within 10 calendar days of the Notice of Action or Notice of Adverse Benefit Determination; and,
ii. The effective date of the proposed action/adverse benefit determination.

3. During the appeal process, Trillium continues providing benefits when requested by a member until:

a. A final appeal resolution resolves the appeal, unless member requests a hearing with continuing benefits per guidelines listed below;
b. A final order resolves the hearing;
c. The time period or service limits of previously authorized service have been met; or,
d. The member withdraws the request for a hearing.

4. During the hearing process

a. Trillium continues to provide benefits until:

i. Member does not timely request a hearing;
ii. Member withdraws their hearing request;
iii. A hearing decision adverse to the member is issued; or,
iv. The original authorization expires or authorization service limits are met.
b. If hearing decision is to uphold Trillium's decision to deny, limit or delay services, Trillium may recover the costs of the services furnished while the hearing was pending to the extent that services were furnished solely because of the requirement to continue benefits during the process.

c. If hearing decision is to reverse Trillium's decision to deny, limit or delay services, Trillium pays for disputed services in accordance with State policy and regulations.

REFERENCES:

42 Code of Federal Regulations (CFR): 431.230, 438.10, 438.330, 438.358, 438.400 through 438.424

National Committee for Quality Assurance (NCQA) 2020 Health Plan Standards and Guidelines: ME 7, UM 8&9

Oregon Administrative Rule (OAR)

410-141-3580, 410-141-3585, 410-141-3835, 410-141-3875, 410-141-3880,

410-141-3885, 410-141-3890, 410-141-3895, 410-141-3900, 410-141-3905, 410-141-3910, 410-141-3915

OR.MRKT.102 Member Communication Translation/Alternate Format

DEFINITIONS:

Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service or the denial, in whole or part, of payment for a service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner, as defined by the State. The failure of the CCO to act within the timeframes provided in CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. For a resident of a rural area with only one CCO, the denial of a member's request to exercise his or her right under CFR 438.52(b)(2)(ii), to obtain services outside the network. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal: A formal review by the CCO of an Adverse Benefit Determination.

Clinically Urgent: Need for medical care or treatment with respect to which application of time periods for making non-urgent care decisions could result in serious jeopardy to life or health of member or member's ability to regain maximum function, based on a prudent layperson's judgment; or in opinion of practitioner with knowledge of member's medical condition would subject member to severe pain not adequately managed without care or treatment requested.

External Review: Formal request by a member for independent review of an adverse decision by Trillium, which are conducted by the OHA.

Expedited Appeal: Request for urgent review of an adverse determination.

Grievance: Any expression of dissatisfaction to the CCO or OHA about any matter other than an Adverse Benefit

Determination. Grievances may include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A Grievance may also include the member's right to dispute an extension proposed by the CCO to make an authorization decision.
Grievance Resolution Dispute: Request to change an adverse decision made regarding grievance, including denial of change of Practitioner, Provider, Clinical Specialist, Community Health Worker, or Behavioral Health Care Coordinator. Request to change a denial of access to; Complex Case Management Program, Clinical Specialist, Community Health Worker, or Behavioral Health Care Coordinator. NCQA defines this as an appeal to a grievance.
Member: Person insured or otherwise provided coverage by Trillium. For purpose of this procedure, a reference to member means a member, member's representative, or representation of a deceased member's estate.
Member Representative: A person with legal authority to make healthcare decisions on behalf of the member.
Oregon Health Authority: State of Oregon government agency that oversees Oregon Health Plan.
Pre-Service Appeal: A request to change an adverse determination for medical or behavioral healthcare or services requiring approval, in whole or in part, in advance of member obtaining care or services.
Post-Service Appeal: Request to change an adverse determination for medical or behavioral healthcare services already received by the member.
Same-or-Similar Specialist: A clinical peer who holds an active, unrestricted license to practice medicine, or a health professional who is board-certified, if applicable, and who is of the same-or-similar health care profession and has similar credentials and licensure and appropriate training and experience as those who typically treat the condition or health problem in question in the appeal.

To be considered same or similar specialist, the reviewing specialists training and experience must meet the following criteria: Includes treating the condition; Includes treating complications that may result from the service or procedure; Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate. Pharmacists are not considered same or similar specialists for the purpose of deciding appeals.

REVISION	DATE:
Procedure B.2.a. added "date received" Procedure E.6. added "including those received verbally" Updated Adverse Benefit Determination definition Updated Grievance definition	8/13/2020
Corrected grammar and formatting Updated Same-or-similar specialist definition Procedure A.4.c. added "in alternate formats and" Procedure A.4.e. added "through Legal Aid Services and Oregon Law Center" Procedure A.8.c. added "I" additional QOC process information Procedure B.5. added "within 5 business days" Updated OARs and Policies in Reference section	3/31/2020
Updated formatting and organization of text. Corrected OAR and NCQA references. Updated text in Procedure A.1. added "their rights to and the procedures". Procedure: B.5. to include correction process of OHA identified documentation deficiencies. Procedure H.12.a. added "acknowledges receipt,"	2/18/2020
Revised and updated to reflect new OAR and clarified NCQA language re: including medical director information in the decision letter.	10/8/2019
Removed duplication language; reorganized policy; removed language re: member ability to request a hearing at the same time they request an appeal for urgent situations; clarified definitions.	7/18/2019
Updated language, revisions for grammatical errors, addition of regulation language clarified by NCQA and OHA, updated reference.	6/20/2019
Update and added additional information which reflects clarification in language.	2/15/2019
Review and update to revised OARs.	2/23/2018
Revisions including minor grammatical errors and addition of regulation language clarified by CMS ensure individuals who make decision on grievances and appeals take into account information provided by member.	2/21/2017
Mid-year revision; minor grammatical changes	10/31/2016

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

Exhibit B-4: Monitoring and Evaluation of Access to Services

DEPARTMENT: Provider Network Management	**DOCUMENT NAME:** Monitoring and Evaluation of Access to Services
PAGES: 5	**REPLACES DOCUMENT:** OR.QMI.104
APPROVED DATE: 6/6/2019	**RETIRED:**
EFFECTIVE DATE: 6/6/2019	**REVIEWED/REVISED:** 6/5/2019; 7/10/2019; 1/16/2020; 2/3/2020
PRODUCT TYPE: Trillium OHP	**REFERENCE NUMBER:** OR.PNM.100

SCOPE:

This policy applies to Trillium's Provider Network Management, Quality Improvement and Vendor Management departments.

PURPOSE:

This policy outlines the standards and process for monitoring and measuring member access to primary care, behavioral health, specialty care and dental care services.

POLICY:

Trillium measures appointment accessibility to primary care, high-volume and high-impact specialty care, and behavioral health and dental care services at least annually. Trillium takes into account NCQA Accreditation, CCO Contract obligations and Special Health Care Needs (SHCN) members in

establishing its accessibility standards. Standards are measured against the results of the CAHPS® Survey, member appeals and grievances and a practitioner survey.

SHCN members are defined as D-SNP members and those receiving Complex Care Management.

Trillium directs provider's to prioritize access for pregnant women and children ages birth through 5 years to health services through the Provider Handbook.

PROCEDURE:

At least annually, Trillium evaluates its accessibility standards to comport with necessary regulations, benchmarks and/or policy changes. Established accessibility standards are communicated via the Member Handbook, Provider Manual, and related communications to members, network providers and other applicable groups.

1. Primary Care Appointment Access Standards

Trillium has established quantifiable and measurable standards for primary care practitioner (PCP) appointment access. Standards are for, primary care regular/routine care appointments, urgent/sick appointments, and after-hours care.

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Appointment Type	Access Standard	Compliance Rate
Routine/regular care appointment	30 calendar days	90%

SHCN Routine/regular care appointment	21 calendar days	90%
Adult Urgent/Sick Visit	72 hours	90%
Pediatric Urgent/Sick Visit	72 hours	90%
After-Hours	• By medical staff directly; • By an answering service that could reach an on-call provider within 30 minutes; • By a recorded or automated message, or that has both emergency instructions and a way to reach medical staff.	90%

2. Behavioral Health Appointment Access Standards

Trillium has established quantifiable and measurable standards for Behavioral Health appointment access. Standards are for, non-life-threatening emergencies, urgent care, initial visits for routine care, and follow-up routine care appointments.

Appointment Type	Access Standard	Compliance Rate
Non-life-threatening emergency care	Directed to a crisis center or ER Within 6 hours if care with a behavioral health practitioner is not available	90%
Urgent care	48 hours	90%
Initial visit for routine care	10 business days	90%
Follow-up Routine Care	Non-prescribers: within 14 calendar days Prescribers: within 90 calendar days	90%

3. Specialty Care Appointment Access Standards

Trillium has established quantifiable and measurable standards for high-volume and high-impact Specialty Care appointment access. Trillium identifies high-volume practitioner specialists through an analysis of the number of visits based on claims volume by Specialty type.

Appointment Type	Access Standard	Compliance Rate
Routine/regular care appointment	45 calendar days	90%
SHCN Routine/regular care appointment	45 calendar days	90%

4. Dental Care Appointment Access Standard

Trillium has established quantifiable and measurable standards for Dental Care appointment access.

Appointment Type	Access Standard	Compliance Rate
Routine/regular care appointment	Eight weeks	100%
Emergency Care	24 hours or referred to ER	100%
Urgent Care	One week	100%

5. Monitoring and Evaluation of Appointment Access

To monitor and evaluate member appointment access, Trillium analyzes the results from the CAHPS® survey, member appeals and grievances and a site-specific practitioner survey.

a. For the CAHPS® survey, results are compared against Trillium's goal of at least 75% of members who report they always or usually obtained routine appointments as soon as they needed it, including:

i. Percent of members who report they "always" or "usually" obtained regular or routine care as soon as they needed/wanted it;

ii. Percent of members who report they "always" or "usually" obtained urgent appointments as soon as they needed/wanted it;

iii. Percent of members who report they "always" or "usually" obtained a specialist appointment as soon as they needed/wanted it.

b. Member appeals and grievances about access to specific practitioners, groups or geographic areas. On an annual basis, Trillium compiles a report of all access-related issues documented during the prior 12-month period.

Results are compared against Trillium's goal of member complaints about appointment access at less than 5.0 per 1000 members per year.

c. Trillium hires an outside vendor annually to conduct an appointment and after-hours survey based on Trillium's access standards, using the following steps:

i. Trillium approves telephone survey scripts used prior to start of the survey.

ii. Trillium Analytics (Analytics) provides practitioner files to the vendor. The vendor then conducts a telephone survey at facility-level by using unique facility phone number and calling to verify practitioners at the listed number.

iii. The vendor documents responses, time/date of the call, time/date of appointment given and scores pass and fail based on established standards.

iv. Trillium reviews verbatim responses and makes final pass/fail determination.

v. The vendor prepares a final report of the results, and shares the applicable verbatim responses with Trillium.

vi. Trillium will identify non-compliant providers, and re-survey them within 30 days. If the provider remains out of compliance for more than 90 days a corrective action plan will be developed for the provider.

6. Practitioner Access Analysis Report

PNM performs an analysis and prepares an annual report on practitioner access measured against Trillium's standards. The report follows the Centene Corporate template – NET 2 Accessibility of Services, which includes monitoring and evaluation results and compared to Trillium's standards by appointment and practitioner type. The report also includes:

a. In addition to the quantitative results, a qualitative analysis to determine if there are access barriers for members.

b. Planned actions to address any identified access barriers

On an annual basis, the report is shared with Trillium's Quality Committee, who can ask for further analysis, clarifications and/or inform action items to address access

barriers. Interim quarterly reports may also be reported to the Quality Committee at the Committee request.

7. Provider Communication

At least annually, Trillium will send out a provider communication reminding providers of their contractual obligation in meeting the above availability standards.

REFERENCES: OAR 410-123-1060
ATTACHMENTS:
DEFINITIONS: CAHPS® - Consumer Assessment of Healthcare Providers and Systems; NCQA - National Committee for Quality Assurance

REVISION LOG

REVISION:	DATE:
Added 7. Provider Communication section	7/10/2019
Updated urgent care standard from 48 hours to 72 hours to match CCO Contract	1/16/2020
Added Vendor Management under Scope	2/3/2020
Changed Dental Routine/regular care appointment from 30 days to Eight weeks	2/3/2020
Changed Dental Urgent Care from 72 hours to 1 week	2/3/2020
Updated Dental Emergency Care to include referral to ER	2/3/2020
Changed compliance rate for all Dental standards from 90% to 100%	2/3/2020

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer, Centene's P&P management software, is considered equivalent to a signature.

Exhibit B-5: Pharmaceutical Management

DEPARTMENT: Pharmacy	**REFERENCE NUMBER:** OR.PHAR.17
EFFECTIVE DATE: 4/12/19	**POLICY NAME:** Pharmaceutical Management
REVIEWED/REVISED DATE: 5/7/19, 12/20/19, 2/24/2020	**RETIRED DATE: N/A**
PRODUCT TYPE: Medicaid, Oregon Health Plan (OHP)	**PAGE:** 1

SCOPE:

Trillium Community Health Plan

PURPOSE:

To ensure that Trillium Community Health Plan and Envolve Pharmacy Solutions, to whom limited pharmaceutical management has been delegated, develop and annually review and update policies and procedures for pharmaceutical management, using sound clinical evidence.

POLICY:

Trillium Board of Directors through Quality Committee delegates Trillium Oregon Health Plan Pharmaceutical Management to Trillium's Pharmacy and Therapeutic (P&T) Committee.

All policies and procedures utilized by Trillium Community Health Plan or Envolve Pharmacy Solutions, related to pharmaceutical management, consider guidance recommended by the Pharmacy Solutions Group and adopted by the Centene Pharmacy and Therapeutics Committee. Pharmacy decisions are

made using input from National Pharmacy Standards Organizations including, but not limited to, the Academy of Managed Care Pharmacy, Center for Drug Evaluation and Research, Food and Drug Administration, Facts and Comparisons, Clinical Pharmacology, and the governing bodies of medical specialties. Current medical and pharmaceutical literature is researched for relevant clinical studies and nationally recognized clinical guidelines (e.g. JNC VII, ATP III, TMAP, NHLBI, NIH, NCEP, AAP, peer reviewed journals etc.) are utilized. Centene health plans adjust these policies and procedures to comply with state regulations as needed, reporting these changes to the Corporate Pharmacy Department. Policies and procedures are reviewed and approved by both the Corporate and health plan Pharmacy and Therapeutics (P&T) committees. The members of these committees include community practitioners, medical specialists, and pharmacists.

When pharmaceutical management is delegated to Envolve Pharmacy Solutions, Trillium Community Health Plan maintains responsibility for ensuring the functions are being performed according to the expectations outlined in this policy. In the event that the responsibility for pharmacy management has been retained by the State or other external entity, this policy does not apply.

Coverage criteria are subject to approval by OHA and must be submitted for administrative review and approval by OHA upon request.

PROCEDURE:

I. Pharmaceutical Management

A. P&T voting membership comprises panel physicians including specialists and practicing Clinical Pharmacists in addition to non-voting staff Medical Directors and Clinical Pharmacists.

B. P&T Committee is responsible for developing, maintaining, and following policies and procedures for the Preferred Drug List (PDL) management activities, including objective evaluation, review, guidance, and clinical recommendations for therapeutic use of drugs contained within formularies.

1. Trillium Oregon Health Plan has a closed, mandatory generic formulary (PDL) with UM criteria for prior authorization, step-therapy, and quantity limitations. Therapeutic interchange is not part of Trillium's Pharmaceutical Management procedure.

2. Trillium dual members (members insured by both Medicare Part D and Trillium Oregon Health Plan) are eligible for coverage of drugs based on Trillium Oregon Health Plan's PDL with UM criteria for drugs excluded from member's Medicare Part D PDL.

3. Except as otherwise provided in the CCO contract, prescription drugs are a covered service for funded conditions, and Trillium will pay for prescription drugs. Trillium will provide covered prescription drugs in accordance with OAR 410-141-3855. Prescription drugs and drug classes covered by Medicare Part D for Fully Dual Eligible members are not a covered service. OHA will continue to cover selected drugs that are excluded from Medicare Part D coverage, pursuant to OAR 410-120-1210.

4. To ensure FBDE Members receive appropriate medications necessary for treatment of physical or Behavioral Health conditions, Trillium will coordinate with FBDE Members MA and DSNP Plans or Part D Plans to ensure Members are connected to Medicare medication management services.

a. Trillium can only coordinate medications for FBDE Members when the members are enrolled in Trillium Medicare as their Part D plan.

C. P&T Committee reviews, updates, and approves changes (by vote) to Pharmaceutical Management policies, procedures, and PDL, including reviewing UM requirements annually or more frequently, as needed. Updates are made to respond to any practitioner, member, or pharmacist request, and to address new drug approvals or information.

D. PDL review is by therapeutic class and staggered throughout the year. Decisions are based on strength of scientific evidence, practice standards, utilization, and cost.

1. Trillium does not make PDL decisions for drug classes 7 and 11; coverage for these drugs are carved out and determined at state level.

2. OHA reserves the right to require Trillium to align, for all or some drug classes, its Preferred Drug List with OHA's approved Fee-For-Service Preferred Drug List, including identical preferred and non-preferred drugs and identical criteria for Prior Authorization. OHA shall provide Contractor's Contractor Administrator with Administrative Notice of any and all such alignment requirements.

3. On or before January 15, 2020 and again within five (5) Business Days of any change, Trillium shall provide to OHA, via Administrative Notice, in a format required by OHA, the following:

a. PDLs for all classes; and

b. Prior Authorization criteria for all drug classes.

II. Pharmaceutical management policies include the following:

A. The criteria used to adopt pharmaceutical management procedures. In particular, criteria used when constructing the preferred drug list or preferred status, shows how decisions are made about:

1. Classes of pharmaceuticals
   a. Classes preferred or covered at any level
   b. Any exception processes available to members for obtaining non-covered pharmaceuticals
   c. Considerations regarding limiting access to drugs in certain classes
2. Within each class of pharmaceuticals
   a. The pharmaceuticals preferred or covered at any level
   b. The criteria for prior authorization of any pharmaceutical
   c. Any exceptions process available to members
   d. Substitutions made automatically or with physician permission
   e. Each class includes at least one over-the- counter drug, if available
   f. Efficacy: Evidence showing how preferred-status pharmaceuticals can produce similar or better results for a majority of the population as compared to other pharmaceuticals in the same class
   g. Decisions to add non-PDL generics to formularies based on
      i. Established therapeutic equivalence to brand name
      ii. Pricing which is competitive to similar products in class or which have minimal impact on overall costs
      iii. Compliance with existing pharmaceutical contracts
   h. Dose and route of administration: When a given pharmaceutical is available in different dosages or formulation, only certain dosages or formulations may be included on the PDL (e.g., the same active ingredient available in dissolvable tablets, capsules, regular tablets, etc.).

B. A process that uses clinical evidence from appropriate external organizations. This evidence includes relevant findings of the Food and Drug Administration, Centers for Drug Evaluation

and Research, drug manufacturer dossiers, the Academy of Managed Care Pharmacy, and others. In addition, clinical review using peer-reviewed journals, medical specialty guidelines, and authoritative compendia is performed for determination of pharmaceutical coverage positioning.

C. Adoption or creation of a system for point of dispensing communications to identify and classify by severity, drug-drug interactions. Envolve Pharmacy Solutions, as the delegated PBM, uses a Medispan database as the source of drug interactions, which are classified by severity. Envolve Pharmacy Solutions uses a passive point-of-service (POS) communication to dispensing pharmacies designed to avoid interference with prescribed drug therapy and to complement network pharmacy applications.

D. Trillium will maintain policies to prevent unnecessary delay in treatment of patients being prescribed non-PDL or restricted medications upon discharge from a hospital or ambulatory surgical center.

E. Trillium will arrange to provide medication, as covered under Trillium's global budget, to nursing or residential facility and group or foster home residents in a format that is reasonable for the facility's delivery, dosage and packaging requirements and Oregon law.

F. Identification and notification of members affected by a Class I recall are notified in 14 business days. Class II recalls, Class III recalls, or other equivalent severity safety alerts must be completed within 30 days of receiving the FDA notice.

1. Exceptions include:
    a. Withdrawals unrelated to safety issues
    b. Recalls that do not pose serious health hazards
    c. Recalled or withdrawn pharmaceuticals for which the Plan or PBM is unable to identify affected members from the batch or lot numbers
    d. Wholesale-only drug recalls and withdrawals
2. Notification of drug recalls and voluntary market withdrawals:
    a. Trillium collaborates with PBM to promptly identify and notify members and prescribing practitioners affected by Class I or II drug recalls. PBM daily scans the FDA website for patient safety notices.
    b. PBM informs Trillium about recently announced product recalls and market withdrawals within five (5) calendar days of public notice, including the following information:
        (i) Manufacturer name.
        (ii) Distributor name, if applicable.
        (iii) National Drug Code (NDC) numbers.
        (iv) Lot numbers and expiration dates, if applicable.
3. Following PBM notice of drug recall or market withdrawal:
    a. Trillium or PBM immediately removes products and pharmaceuticals under Class I recall from Trillium's drug formularies.
    b. Trillium or PBM notifies affected members and prescribers by mail as soon as possible, but not exceeding (14) fourteen days after the FDA posts Class I recall.
    c. Trillium or PBM notifies affected members and prescribers by mail as soon as possible, but not exceeding (30) thirty calendar days after the FDA posts Class II recall, market withdrawal, or safety alert on FDA website.
    d. Notification letter contains pertinent product recall information including an action plan for members and practitioners.

G. Exception policies and procedures that describe the process for:

1. Making an exception request based on medical necessity
2. Obtaining medical necessity information from prescribing practitioners, including notifying prescribers for a request for additional information to support medical necessity.
3. Using appropriate pharmacists and practitioners to consider exception requests
4. Timely request handling
5. Communication the reason for a denial and an explanation of the appeal process when it does not approve an exception request.
6. Trillium PDL exceptions are based on medical necessity and include consideration of the following:
    a. UM criteria (e.g., prior authorization, step-therapy, quantity limits) changes for a drug member is already taking.
    b. Intolerance or allergy to drugs on approved PDL list.
    c. Inadequate or inappropriate response to drugs on approved PDL list.
    d. PDL drug cannot be supplied or was withdrawn from market by manufacturer. Or the drug is no longer available in sufficient quantity to adequately meet member needs.
7. Consideration of practitioner and member exception requests:
    a. Members and their prescribing practitioners may request exceptions when PDL does not adequately accommodate a member's clinical needs.
    b. Members may request an exception by phone, in person, in writing, or by completing an authorization form request on Trillium's website.
    c. Prescribing practitioners may request an exception by phone, electronic portal, or fax.
    d. For member and prescribing practitioner requests, Trillium requires the prescribing practitioner to provide clinical information to support medical necessity, establishing:
        (i) The requested drug therapy is evidence-based and generally accepted medical practice, and:
        (ii) A reasonable number of similar drugs on the PDL have been tried, with an adequate dose and duration of therapy, and were not tolerated or not effective; or
        (iii) Reasonable clinical evidence confirms PDL drugs are inappropriate for member.
    e. For Oregon Health Plan, a Trillium Clinical Pharmacist reviews exception requests, with consultation by a physician reviewer, as appropriate.
        (i) Non-PDL requests are approved if two (or as stated in criteria or policy) PDL options have been tried or there is a documented contraindication. If there is only one PDL alternative option available, only one option needs to be tried.
        (ii) A pharmacist may recommend a non-PDL medication if determined appropriate.
        (iii) The pharmacist will list in the denial letter the number of options a member must try prior to the approval of a non-PDL medication.
    f. Oregon Health Plan exceptions are responded to in a timely manner.
        (i) Urgent care requests are decided and responded to within 24 hours of receipt.
        (ii) Pre-service requests are decided and responded to within 24 hours of receipt.
        (iii) Post service requests are decided and responded to within thirty (30) calendar days of receipt.
        (iv) Trillium notifies member and member's requesting practitioner of exceptions approved.
        (v) Trillium notifies member and member's requesting practitioner of exceptions denied.

(vi) Denial notification letters include reason(s) for denial, explanation of appeal process, and peer-to-peer process.
(vii) If Trillium first provides verbal notification of denial, PBM on behalf of Trillium sends written confirmation by the next business day.

III. The preferred drug list (PDL) and pharmaceutical management edits are posted on Trillium's website. Trillium notifies members using the Member Handbook. The Member Handbook is mailed to new members and on request. Providers are notified via newsletter through the mail. This information is also available on the Trillium website. Members and providers can contact Trillium to request materials found online be mailed, if they do not have fax, email or internet access. Major changes in drug coverage and pharmaceutical management edits are communicated to providers and members by direct mail (e.g. fax, email, mail) as needed.

The PDL includes restrictions and preferences, and addresses:

A. How to use the pharmaceutical management procedures
B. An explanation of any limits or quotas
C. An explanation of how prescribing practitioners must provide information to support an exception request
D. The process for generic substitution, therapeutic interchange, and step-therapy protocols

PDL information posted on Trillium's website includes:

A. A list of pharmaceuticals, including restrictions. Prior authorization criteria.
B. Explanation of limits and quotas.
C. How to use pharmaceutical management procedures for generic substitution, step-therapy, and quantity or other limits if applicable.
D. Other requirements, restrictions, limitations, or incentives applying to use of certain pharmaceuticals.
E. Information practitioners must provide to support PDL exceptions request.

An updated PDL will be posted on Trillium's website within thirty (30) days of change.

A. The PBM provides the plan with a monthly PDL file in both a PDF and JSON (machine readable) format.
B. For negative Oregon Health Plan PDL changes:
    1. Trillium notifies members by mail, and their practitioners via fax or mail, at least 30 calendar days prior to removal from the PDL.

REFERENCES:

CFR 438.10(i)(3) Information requirements
CMS Chapter 6: Chapter 6: Part D Drugs and Formulary Requirements
2019 State CAK Contract #156276-1
2020 State CCO Contract #161766
NCQA UM 11, MEM 2 D

Oregon Administrative Rule (OAR): 410-121-0111, 410-120-1210, 410-141-3855, 410-141-3885, 410-141-3915
USC 42 U.S.C. 1396r–8 Payment for covered outpatient drugs

ATTACHMENTS:

DEFINITIONS:	
Closed Formulary	If an organization covers some drugs but not others, the formulary is considered closed, regardless of number of drug classes affected.
Criteria	Systematically developed, objective and quantifiable statements used to assess appropriateness of specific healthcare decisions, services, and outcomes.
Generic Substitution	A bioequivalent copy of a pioneer (innovator) name-brand pharmaceutical whose patent has expired; typically less expensive and sold under the common or generic name for name-brand pharmaceutical.
FBDE	Medicare & Medicaid Full Benefit Dual Eligible (FBDE).

REVISION LOG

REVISION:	DATE:
Reviewed and updated per 2019 CCO & CAK Contract Assessment. Per CCO Contract - ExhB.P2:2. Provision of Covered Service e. added the following verbiage to create the 4th paragraph of the definition of the policy, "Coverage criteria are subject to approval by OHA and must be submitted for administrative review and approval by OHA upon request."	5.7.19
Reviewed and updated references to reflect changes to Oregon Administrative Rules (OARs) effective 1/1/2020; CCO Contract-Ex. B, Part 2, Sec. 7, Para. D. Added procedure steps D2 and D3.	12.20.19
Updated per 2020 CCO Contract. Added verbiage under Procedure as I, B, 4. Added definition for FBDE.	2.24.2020

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

Exhibit B-6: Drug Utilization Review

DEPARTMENT: Pharmacy	**REFERENCE NUMBER:** OR.PHAR.19
EFFECTIVE DATE: 1.1.2019	**POLICY NAME:** Drug Utilization Review
REVIEWED/REVISED DATE: 2/24/2020	**RETIRED DATE:**
PRODUCT TYPE: Medicaid, Oregon Health Plan (OHP)	**PAGE:**

SCOPE:

This policy applies to Trillium Community Health Plan's (Trillium) Pharmacy Department.

PURPOSE:

To define Trillium Community Health Plan's (Trillium) Drug Utilization Review Policy (DUR).

POLICY: Trillium partners with the Envolve Pharmacy Solutions Clinical Programs Team (EPS) to complete Drug Utilization Review (DUR). The drug utilization management programs are developed in accordance with evidence based practices based upon peer-reviewed, clinical literature and evidence-based practice guidelines from national and/or international professional organizations and in accordance with 42 CFR 438.3(s)(4)-(5). Trillium operates a Drug Use Review (DUR) program that meets the definition and standards in 42 CFR §438.3 and 42 CFR Part 456, Subpart K.

Per EPS Drug Utilization Review Policy, EPS.PHARM.05, all EPS DUR program activities will be reviewed and approved by the Centene Corporate P&T Committee who will ensure compliance with program activity requirements and predetermined standards. The Centene Corporate P&T Committee serves as the company's DUR board and meets the following standards: at least one-third licensed and practicing physicians (but not more than 51%) and at least one-third licensed and practicing pharmacists. Activities approved shall aim to enhance safety, appropriateness, and cost effective use of prescription medications. All activities will be developed utilizing appropriate clinical protocols, FDA approved labeling, and evidence-based guidelines for prescription drug use. Pre-determined standards for utilization will be disclosed to pharmacists and physicians upon request.

DUR program activities will consist, at a minimum, of prospective, concurrent, and retrospective medication reviews, targeted educational interventions when appropriate, and other activities as requested by the plan sponsor. Residents in nursing facilities shall not be excluded from these DUR program activities. All Envolve Pharmacy Solutions DUR functions shall be performed in conjunction with or under the direction of Trillium Health Plan DUR program managers'.

The results of the EPS drug utilization reviews will be communicated to the Health Plan, physician, and/or member based upon the type of activity conducted. Any errors of clinical significance will be disclosed to

the consumer directly by the Health Plan. Any errors that are identified during the drug utilization review process will be monitored and reported to the QIC Committee.

Envolve Pharmacy Solutions in conjunction with its claim processors and pharmacy network administrator, ensures pharmacies comply with patient consultations and DUR standards through network contracts and the corresponding provider manual which includes requirements on patient consultation and prospective DUR.

As noted in the CVS/Caremark provider manual, pharmacy services include those services as mandated by state and federal law and the counseling of Eligible Persons, which may consist of information about the proper storage, dosing, side effects, potential interactions and use of the medication dispensed; the monitoring of appropriate drug use; and the implementation of drug utilization review programs and other clinical programs and services.

Envolve Pharmacy Solutions shall not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, sections 261 to 264, Centene Corporate policies, and other applicable laws and administrative regulations.

Trillium Pharmacists will conduct monthly secondary review of EPS DUR activity and conduct clinically appropriate member or provider outreach activities per internal procedures when deemed professionally appropriate.

Trillium shall revise Drug Utilization Policies if notified by Oregon Health Authority (OHA) that they have determined the plan to be out of compliance with applicable state or federal laws in accordance with the current CCO contract.

PROCEDURE:

DUR Objectives:

Drug utilization review goals include:

- Improving cost-effectiveness and quality of members' health care.
- Identification and analyzing of utilization patterns that impact prescribing, dispensing, and overall drug utilization practices.
- Identification and intervention with high-risk members, prescribers, and pharmacies to improve safety and long-term health care.
- Enhancing education and communication between prescribers, pharmacists, health plans, and members to improve health outcomes.
- Improving prescribing trends by alerting prescribers and pharmacists to potential medication problems.

- Improving overall quality of care by providing monthly, quarterly, and annual reports to health plans.

Prospective Drug Utilization Review (ProDUR):

ProDUR activities occur prior to a prescriber providing a drug, or before a member receives a prescription. ProDUR activities reduce improper drug selection by supplying providers with tools to assist selection of an appropriate drug regimen for each patient. EPS and Trillium utilize ProDUR tools such as, but not limited to:

- Preferred Drug or Formulary Lists and Portals – these lists and portals assist providers in choosing drug regimens that are safe, effective, and economical for members. Providers may reference each plan-specific website or portal for a current Preferred Drug List (PDL) or Formulary. Categories of review include, but are not limited to:
    - Over and underutilization
    - Generic use
    - Therapeutic interchange
    - Drug-drug or drug-allergy interactions
    - Drug dosage
    - Duration of treatment
    - Clinical abuse or misuse
    - Drug-age precautions
    - Drug-gender precautions
    - Drug-pregnancy precautions
    - Regulatory limitations
    - Benefit Design

- Prior Authorization Review– A medication evaluation process allowing prescribers to work in conjunction with the Trillium Pharmacy Department to determine the most appropriate regimen for a member. Prior authorization reviews often target high-risk and/or high-cost medications that may require additional therapy considerations. Part of the Prior Authorization process may include the use of clinical guidelines and protocols designed to maximize patient benefit. Pharmaceutical management policies are delegated to the pharmacy and therapeutics committee as described in OR.PHAR.17.
- Any PDUR reports obtained from the claims processors and made available to Trillium health plan will be reviewed monthly.

Concurrent Drug Utilization Review (CDUR):

As a part of CDUR, Envolve Pharmacy Solutions will utilize an electronic claim adjudication process incorporating ‘edits’ designed to detect, flag, and stop inappropriate prescribing and utilization. CDUR will occur at the prescription point-of-sale (POS) and include real-time ‘edits’ and provider messages to assist dispensing pharmacists and allow them to communicate information to the patient.

Envolve Pharmacy Solutions CDUR plan is managed by an outside vendor and may be supplemented with other CDUR activities or tools that include, but are not limited to:

- Alerts from Medi-Span – A clinical drug information database, containing up-to-date and comprehensive medication information capable of alerting pharmacists of drug-

related issues. Health Plan-specific therapy considerations supplement the database to ensure clinical appropriateness and safety of a member's therapy. Alerts triggered may include, but are not limited to those regarding:

- − Evaluation of therapeutic appropriateness in conjunction with the pharmacist's clinical judgment
- − Availability of therapeutic interchanges
- − Availability of generic utilization
- − Over and under utilization
- − Excessive doses/high dosages of therapy
- − Dose optimization
- − Duplicate therapy
- − Drug-disease contraindications
- − Drug-age precautions
- − Drug-pregnancy precautions
- − Drug-drug interactions
- − Drug-gender alerts
- − Drug-allergy interactions
- − Inappropriate durations of therapy
- − APAP overuse screening
- − Clinical abuse or misuse
- − Regulatory limitations
- − Benefit design

- Therapeutic Interchange Program – POS messaging to alert pharmacists of a prescription claim outside the Preferred Drug Lists or Formularies. Messages will suggest an appropriate, preferred, and cost-effective drug alternative to allow pharmacists and prescribers to coordinate care for optimal drug therapy.
- Clinical Drug Restrictions – benefit design restrictions programmed to prevent unsafe and inappropriate use of medications. Restrictions will promote drug safety, cost-effective medication use, and help to prevent inappropriate utilization and prescribing. Restrictions may not be overridden at the pharmacy POS and will require further review, prescriber action, and coordination of care with managed care specialists (i.e. prior authorization pharmacist, health plan medical directors, etc.).
- CDUR reports sent to Trillium monthly are reviewed for noteworthy trends and stored in an electronic reporting folder.

Retrospective Drug Utilization Review (RetroDUR)

Envolve Pharmacy Solutions provides a retrospective DUR program for ongoing periodic examination (no less frequently than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and beneficiaries, or associated with specific drugs or groups of drugs. This examination involves pattern analysis, using predetermined standards, of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies. Categories of review include, but are not limited to:

a. Therapeutic appropriateness
b. Overutilization and underutilization
c. Appropriate use of generic products
d. Therapeutic duplication
e. Drug-disease contraindication
f. Drug-drug interaction
g. Drug-age precautions
h. Drug-gender precautions
i. Drug-pregnancy precautions
j. Incorrect drug dosage
k. Incorrect duration of drug treatment
l. Clinical abuse or misuse
m. Regulatory limitations
n. Benefit design

RetroDUR reports will be provided monthly. Report summaries including a chronic user's report will be provided quarterly. RetroDUR will evaluate claims data on individual members, physicians, and pharmacy dispensing. Review allows for evaluation of therapeutic appropriateness, cost-effectiveness, quality of care, fraud and abuse, over/underutilization, adverse drug events, prescribing errors of clinical significance, and outcomes management, and will guide initiatives to improve medication use outcomes. Activities resulting from RetroDUR may include, but are not limited to:

- Outreach Letters and Programs – Communications via letter or other medium focused on improving medication utilization practices at the member, provider, or health plan level. This intervention is performed by either Envolve Pharmacy Solutions or the individual Health Plans.
- Outreach to affected members or providers regarding FDA drug alerts and recalls that may include communication through letters, phone calls, or other methods per OR.PHAR.17.
- Member Lock-In Programs – In collaboration each health plan, this member focused intervention restricts members to using one prescriber, one pharmacy, or both for obtaining a narcotic prescription(s). Lock-ins are generally applied to members at high-risk of medication abuse or misuse are often locked in, making their benefit only available when using the designated prescriber or pharmacy. OR.PHAR.300.
- Envolve Pharmacy Solutions will pull various overuse reports and make them available to the plan for review and possible intervention. Centene's Special Investigation Unit (SIU) will refer cases to Envolve Pharmacy Solutions to work up as necessary.
- Revision of prospective and concurrent DUR screens. Based on findings from quarterly or monthly retrospective DUR reviews, Trillium DUR pharmacists may recommend implementing changes to existing prospective/concurrent DUR edits to remedy apparent misuse/overuse. Recommendations may include but not limited to: formulary changes, quantity limits, prior authorization, hard blocks, and use of electronic step therapy.

Educational Outreach Programs

Envolve Pharmacy Solutions, when delegated, will provide quarterly educational outreach programs based on the findings from ongoing periodic examination of claims data, which will identify areas of concern that should be addressed with the health care community, including physicians and pharmacists. Programs may include but are not limited to sending or posting written communications for providers or holding face-to-face discussions, webinars, or teleconferences. All educational programs will be approved by the Centene P&T Committee upon recommendation from Envolve Pharmacy Solutions' Clinical Pharmacy Services. A quarterly assessment of these interventions will be conducted to review the impact on the quality of care.

Annual Survey

Trillium shall complete an annual CMS DUR survey during the specified reporting period. Report will be completed in full and submitted to the OHA Contract Administrator prior to the submission deadline.

DUR Program Handbook

In connection with the DUR program, Trillium maintains a DUR Program Handbook that sets forth Trillium's written policies and procedures that comply with Section 1927 of the Social Security Act and 42 CFR, part 456, subpart (K) and, without limiting the foregoing, must address coverage criteria, which are developed in accordance with Evidence-Based practices based upon peer-reviewed, clinical literature, and Evidence-Based practice guidelines from national and/or international professional organizations. As required under 42 CFR 438.3(s)(5) Trillium will annually provide OHA, via Administrative Notice, with its DUR Program Handbook, which will be subject to review and approval by OHA. OHA will provide Trillium's Contract Administrator with Administrative Notice of its approval or disapproval of Trillium's DUR Program Handbook within thirty (30) days of receipt. It is Trillium's responsibility to ensure its drug utilization review program complies with all Applicable Laws. In the event OHA determines that Trillium's DUR Program Handbook does not comply with the terms and conditions of the Contract, Trillium will, in order to remedy the deficiencies in the Handbook, follow the process set forth in Ex. D, Sec. 5 of the Contract.

REFERENCES:

- Evaluation of Drug Utilization Review Programs:
  Robert Berringer, Ellen Friedla, and Karen Rich
  JAMA. 2004;291:184-185
- URAC PBM Accreditation Standards
- EPS.COMP.06
- EPS.PHARM.05
- 42 CFR § 423.153(b)(1)(2); (c)(2)(i-vi); (c)(3)
- 42 CFR § 456.700 *et seq.*
- 42 CFR § 438.3.
- 42 CFR § 438.3(s)(4)-(5).
- 42 CFR Part 456, Subpart K
- 45 CFR § 156.122
- 19 USC 1927(g)
- Section 1927 of the Social Security Act
- Prescription Drug Benefit Manual: Chapter 7 Quality Assurance Requirements:
  - Section 20.3 Concurrent Drug Utilization Review;
  - Section 20.4 Retrospective Drug Utilization Review.
- Health Insurance Portability and Accountability Act, Subtitle F, sections 261 to 264
- OR.PHAR.17
- 2020 State CCO Contract #161766
- State CAK Contract #156276-1

DEFINITIONS:

• **Overutilization** - use of a drug in a quantity, strength, or duration that is greater than necessary to achieve a desired therapeutic goal or that puts the beneficiary at risk of a clinically significant undesirable effect, or both.
• **Underutilization** - use of a drug by a beneficiary in insufficient quantity, strength, or duration to achieve a desired therapeutic goal or that puts the beneficiary at risk of a clinically significant undesired effect, or both.
• **Soft Edits** – Drug restrictions that can be over-turned by the pharmacist at point-of-sale.
• **Hard Edits** – Drug restrictions that cannot be over-turned without prior authorization approval.

REVISION LOG

REVISION:	DATE:
Created policy per 2019 CCO & CAK Contract Assessment. Per CCO Contract & CAK Contract – ExhB.P2:2. Provision of Covered Service e. included the following verbiage in the first paragraph of the Policy section, "The drug utilization management programs are developed in accordance with evidence based practices based upon peer-reviewed, clinical literature and evidence-based practice guidelines from national and/or international professional organizations and in accordance with 42 CFR 438.3(s)(4)-(5)." Also included the following sentence as the 9th paragraph under the Policy section, "Trillium shall revise Drug Utilization Policies if notified by Oregon Health Authority (OHA) that they have determined the plan to be out of compliance with applicable state or federal laws in accordance with the current CCO contract." Per CCO Contract - ExhB.P2: 4. Covered Service Components q.(1)-(2) included the following sentence in the first paragraph of the Policy section, "Trillium operates a Drug Use Review (DUR) program that meets the definition and standards in 42 CFR §438.3." Also included the following verbiage under the Annual Survey section under the Procedure section, "Trillium shall complete an annual CMS DUR survey during the specified reporting period. Report will be completed in full and submitted to the OHA Contract Administrator prior to the submission deadline."	05.15.19
Annual review. Updated per 2020 CCO Contract. Updated References section.	2.24.2020

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.

Exhibit B-7: Eligibility Verification

DEPARTMENT: Member and Provider Services	**DOCUMENT NAME:** MMIS-Adding and Removing Access
PAGE: 1 of 4	**REPLACES DOCUMENT:**
APPROVED DATE: 6/21/2017	**RETIRED:**
EFFECTIVE DATE: 6/21/2017	**REVIEWED/REVISED:** 4/3/2018;7/12/19; 8/24/2020
PRODUCT TYPE: Trillium Oregon Health Plan	**REFERENCE NUMBER: OR.OPS.190.01**

SCOPE:

Trillium Community Health Plan work process for adding and removing MMIS access.

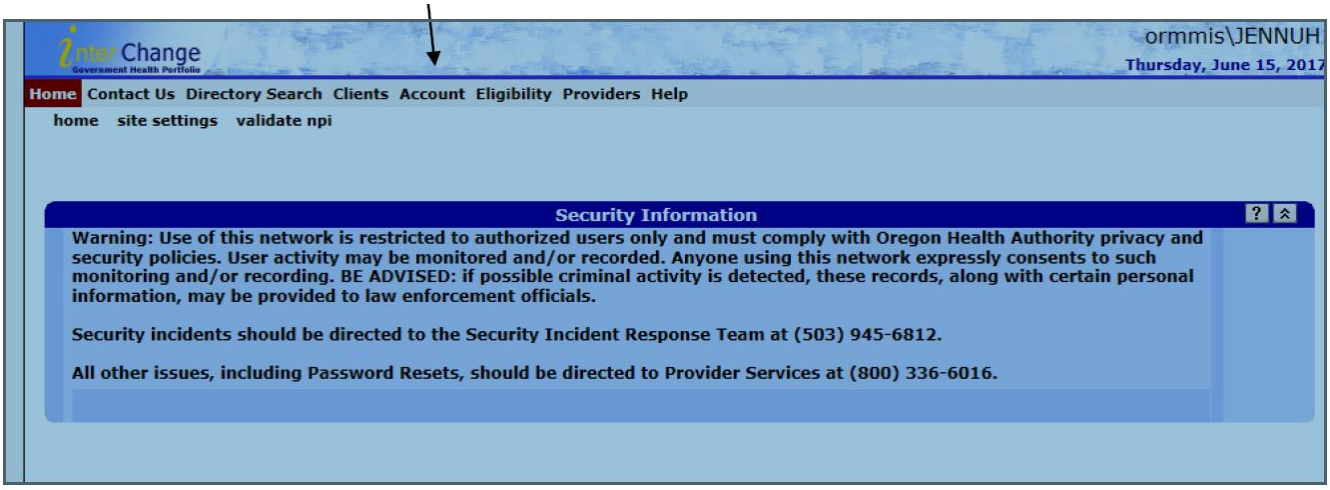
PROCEDURE:

1. Account Administrator logs into MMIS

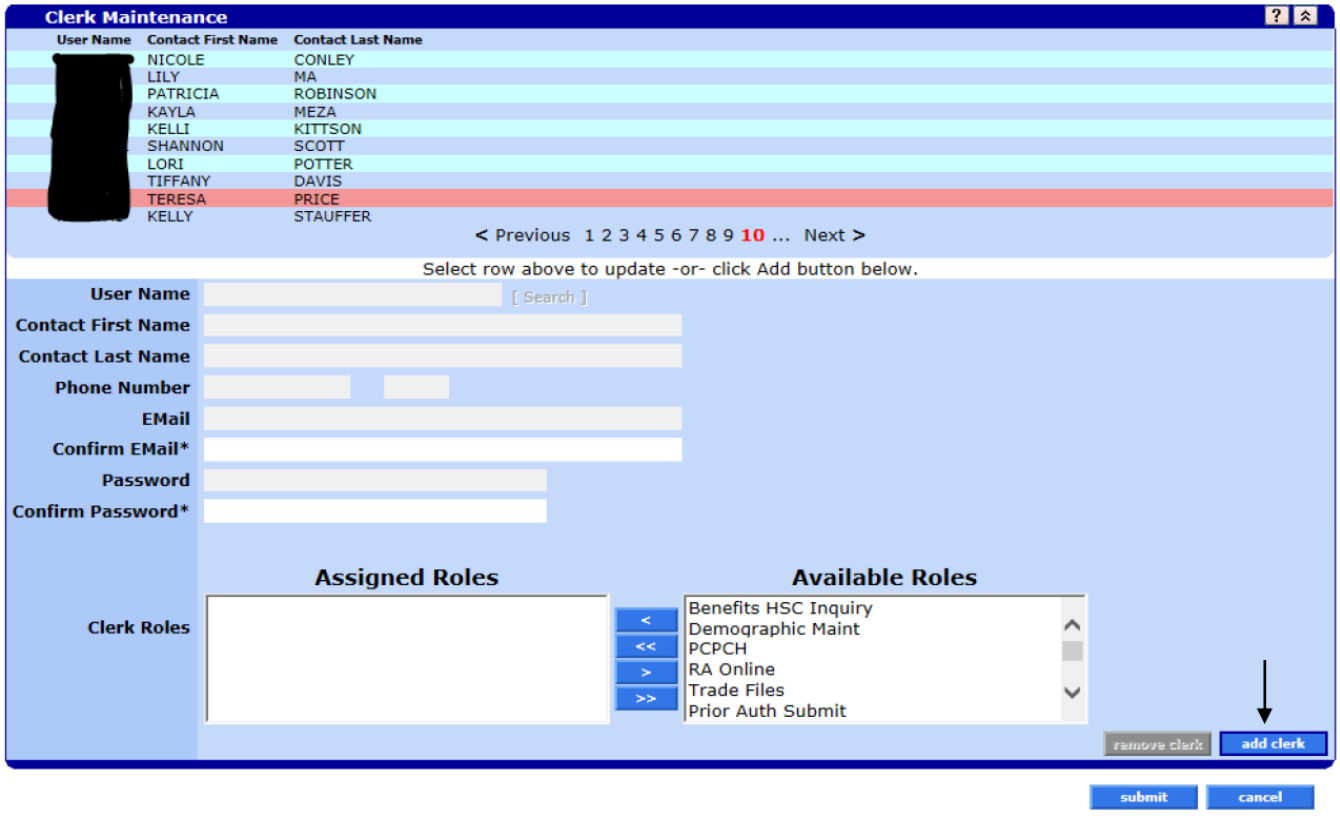
https://www.or-medicaid.gov/ProdPortal/Account/Secure%20Site/tabid/63/Default.aspx

2. Adding MMIS Access

2.1. After logging into MMIS select Account, then Clerk Maintenance.

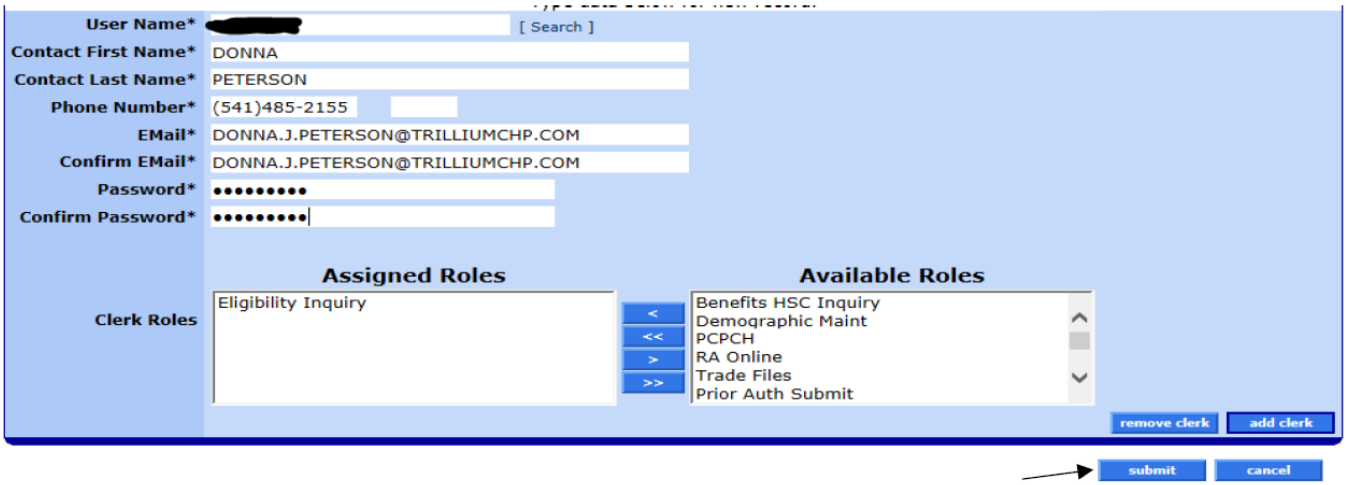


2.2. When the Clark Maintenance screen appears, select the add clerk button.



2.3. Once the add clerk button is selected you will be able to populate the listed fields. Staff user name is the first 3 letters of their first name and first 3 letters of their last name with a 1. Phone number used is Trillium's Oregon Health Plan number at 541-485-2155. Email address is staff members Trillium email address. As a temporary password, use Password1. Of the available roles, we select Eligibility Inquiry.

2.4. Once you have completed this information, select the submit button.



2.5. After submit is selected, the staff member will now have MMIS access. Email staff member with their log in information and temporary password. Once they log in they will be prompted to change their password.

Hi Donna,

The link to the State of Oregon Eligibility (MMIS) is:
https://www.or-medicaid.gov/ProdPortal/Account/Secure%20Site/tabId/63/Default.aspx

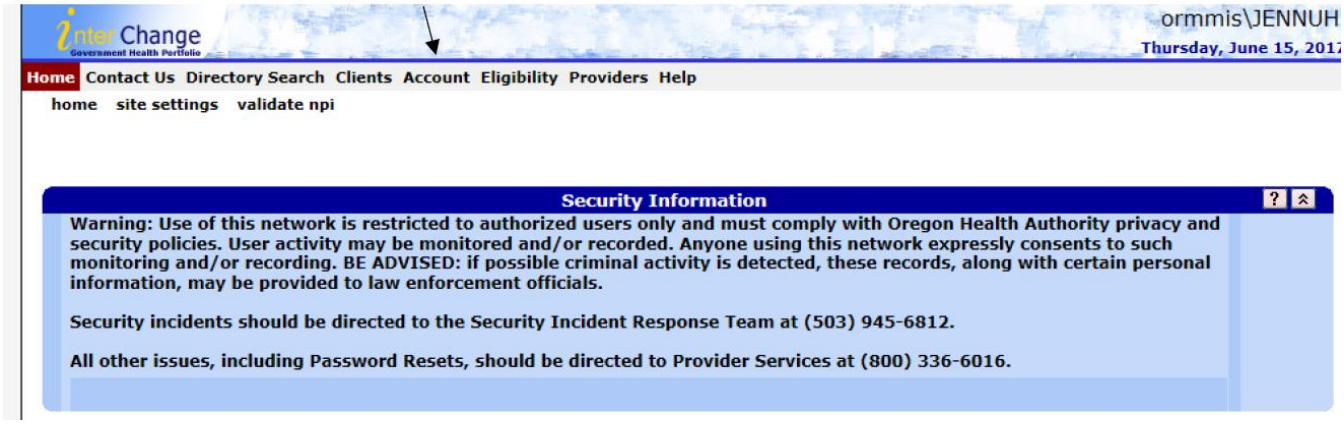
1. Your User ID is: [redacted]
2. Temporary password is **Password1** (capital P) after you enter that password It automatically asks you to change your password. MMIS requires a Number and a capital letter, for example, Mom2steven12 or Trillium11
3. You'll get a pop up box saying "set up now complete" say OK
4. You will be required to confirm your email address.
5. then set up 2 questions and answers, hint, keep your questions and answers all lowercase

Something to keep in mind. If you forget your password and you try it 3 times you will be locked out and will have to call Providers services at the state (800-336-6016, option 2).
They will ask for our Medicaid ID, it is 218756. IF they ask for an NPI tell them you are the CCO, not a provider office.
Note to self…if your password in wrong 2 times, just go ahead and click on "forgot password" and reset. You don't want to be sitting on HOLD with the state!

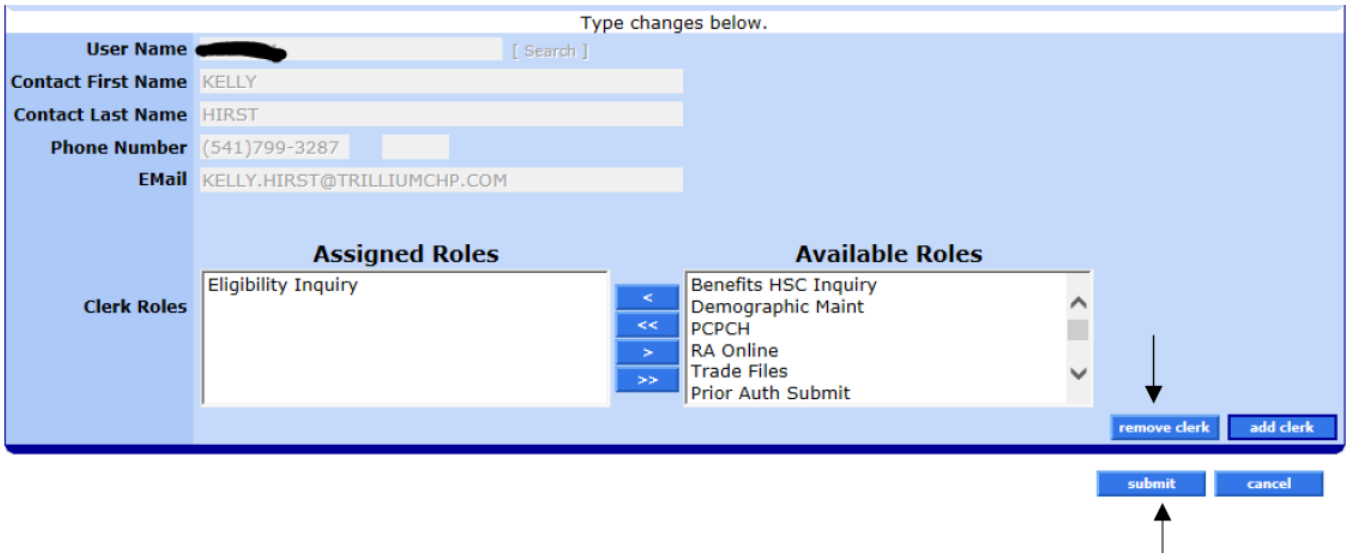
3. Removing MMIS Access

3.1. Upon a staff member's termination, MMIS access will be removed.

3.2. After logging into MMIS select Account, then Clerk Maintenance.



3.3. Select staff member who needs to be removed, then select the remove clerk button, after selecting the remove clerk button, select the submit button. The terminated staff member's access will be removed at that time.



REFERENCES:
OR.OPS.190 MMIS Call Center

ATTACHMENTS:

DEFINITIONS:

REVISION LOG

REVISION:	**DATE**
Updated wording to Oregon Health Plan	4/3/2018
Annual Review, no updates required	7/12/2019
Annual Review, no updates required	8/24/2020

Exhibit B-8: Practitioner Credentialing and Recredentialing

DEPARTMENT: Corporate Credentialing and Provider Data Management	**DOCUMENT NAME:** Practitioner Credentialing & Recredentialing
PAGE: Page 1 of 107	**REPLACES DOCUMENTS:** See Revisions detail dated 8/6/16.
APPROVED DATE: 08-28-2014	**RETIRED:**
EFFECTIVE DATE: 08-28-2014	**REVIEWED/REVISED: 4/2019; 6/2019; 7/2019; 11/2019; 12/2019; 2/2020; 3/2020; 6/2020; 8/2020**
PRODUCT TYPE: All	**REFERENCE NUMBER:** CC.CRED.01

SCOPE:

Centene Corporate Credentialing ("Credentialing") and the Provider Data Management Department ("PDM") on behalf of Centene Health Plans (the "Plan"). Plan Provider Relations, Network Contracting, and Quality Improvement Departments. Plan-specific requirements are included in the Appendices.

PURPOSE:

To ensure the Plan develops and maintains a network of professional practitioners who are qualified to meet the health care needs of covered members in an efficient, compliant, safe, and effective manner.

POLICY:

Centene has established standards for conducting the functions of practitioner selection and retention. These standards include practices for practitioner credentialing, recredentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for

Quality Assurance (NCQA), and Plan requirements to the extent that those standards do not conflict with other laws of the state [1].

Network Participation: For consideration to participate in the Plan network, all individual practitioners who have an independent relationship with the Plan must complete an application for participation, submit copies of applicable supporting documentation, meet minimum administrative requirements, and meet the credentialing qualifications of the Plan [2].

Exclusion from federal procurement activities is non-compliant with minimum administrative requirements and results in exclusion from payment, except as permitted under 42 CFR 1001.1801 and 1001.1901. For currently participating practitioners, exclusion results in immediate termination of network participation.[3] [4] [5]

It is the sole responsibility of the applicant to produce all necessary information and documentation in a timely manner; as required to conduct a thorough examination. Failure to provide the necessary information within thirty (30) calendar days from the initial application date may result in termination of the process. If the practitioner ever seeks to join Plan in the future once the process has been terminated, he/she must begin the process from inception.

Types of Practitioners: The credentialing/recredentialing processes apply, but are not limited to, the following practitioner types:

- Medical doctors (MD);
- Nurse Practitioners (NP);
- Oral surgeons (DDS/DMD);
- Chiropractors (DC);
- Osteopaths (DO);
- Podiatrists (DPM);
- Behavioral Health Service Providers [6]; and

[1] Magnolia Health Plan requires the use of credentialing and recredentialing standards set forth by the National Committee for Quality Assurance (NCQA) and EQRO recommendations.

[2] In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in the Next Level Health provider network, Next Level Health will verify that provider is enrolled in IMPACT. As stated in Contract item 5.9.4, Next Level Health is prohibited from requiring providers to undergo additional credentialing processes that are not part of the contract

[3] Any excluded individuals and entities discovered as a result of screening for Fraud, Waste and Abuse during the provider application, credentialing and recredentialing processes for Coordinated Care Health Plan must be reported to HCA within five (5) business days of discovery. Credentialing staff will report identified excluded individual/entities to the Compliance Department, who will report to HCA using HCA PIR006- WA Excluded Individual Template.

[4] Absolute Total Care will report to SC DHHS any excluded individuals and entities discovered as a result of screening for fraud, waste and abuse during the provider application, credentialing or recredentialing process. Credentialing staff will report to the Compliance Department, who will submit the report to the SC DHHS and other regulatory agencies as necessary.

[5] Louisiana Healthcare Connections will report to LDH those participating providers who have been terminated due to exclusion within three (3) business days.

[6] Licensed Mental Health Practitioners for Louisiana Healthcare Connections for the Healthy Louisiana contract.

- Mid-level practitioners (non-physician)[7] [8].

Completion of the credentialing/recredentialing process is not required when the Plan does not select or direct its members to see a specific practitioner or group of practitioners and for non-participating practitioners. This includes practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility. These practitioners may include, but are not limited to the following specialties:

- Anesthesiology,
- Emergency Medicine,
- Neonatology,
- Pathology,
- Radiology, and
- Telemedicine.

A locum tenens practitioner who does not have an independent relationship with the Plan and who is covering for a participating provider does not require credentialing.

Practitioner Rights: All practitioners are notified of their right to review information obtained by the Plan and/or Credentialing to evaluate their credentialing or recredentialing application upon receipt of a written and signed request submitted to the Credentialing Department. These rights do not include the right to review references, personal recommendations, or other information that is peer review protected.

Practitioners also have the right to receive the status of their credentialing or recredentialing application at any time by contacting the Plan Provider Relations and/or Contracting Department.

Should the practitioner believe any of the credentialing information to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner, he/she has the right to correct any erroneous information submitted by another party.

New practitioners who are denied participation for non-administrative reasons have the right to request a reconsideration of the decision within thirty (30) calendar days of the date of receipt of the denial letter.

Notification of these rights may occur via individual correspondence, in the provider manual, and/or on Plan's web site.

Provisional Credentialing: Credentialing and the Plan may determine the need to occasionally make practitioners available to members prior to the completion of the entire initial credentialing process. The option for provisional credentialing is only available to practitioners who are

[7] Physician Assistants shall not be approved for credentialing as a primary care physician for CeltiCare Health Plan

[8] Maryland Physicians Care does not include Physician Assistants in their credentialing program. This mid-level practitioner type must be under the direct supervision of a physician and is not eligible for independent practice.

applying for the first time to the Plan practitioner network. A practitioner may only be provisionally credentialed once and for a time-period no longer than 60 calendar days.[9] [10] [11]

Recredentialing: Credentialing formally recredentials practitioners at least every thirty-six (36) months.[12] [13] The recredentialing cycle begins with the date of the initial credentialing decision.

Practitioners who are terminated or voluntarily withdraw from the network and subsequently seek to be reinstated must complete the initial credentialing process if the break in service is more than thirty (30) calendar days or if it has been more than thirty-six (36)[14] months since they were last credentialed.

If Credentialing is unable to recredential a practitioner due to military leave, maternity leave or sabbatical, the contract remains in place and the practitioner will be recredentialed upon his/her return. Credentialing will document the reason for this delay in the practitioner's file. At a minimum, the recredentialing must be completed within 60 calendar days of when the practitioner resumes practice. [15]

Professional Competence: For health care practitioners, verification of applicable education and training upon initial credentialing and maintenance of valid professional licensure for practitioner's field of practice upon recredentialing, which includes requirements for Continuing Medical Education, are accepted as evidence of maintenance of knowledge and ability in practice area(s) for health care practitioner.

Binding Nature of Credentialing Decisions: The Plan has the right to make the final determination about which practitioners may participate within its network. Practitioners who are denied initial participation may reapply for admission into the network no earlier than one (1) year following the initial denial or end of the reconsideration process [16].

PROCEDURES:

[9] Louisiana Healthcare Connections utilizes Provisional credentialing to meet the requirement to process expedited and temporary credentials.

[10] Arizona Medicaid Health Plan utilizes the option of Provisional credentialing when necessary to increase the available network of providers in medically underserved areas, whether rural or urban. This also includes providers in a Federally Qualified Health Center (FQHC), FQHC Look-Alike Center, and hospital employed physicians (when appropriate). A decision regarding provisional credentialing is rendered within 14 calendar days from receipt of complete application

[11] Maryland Physicians Care does not utilize the provisional credentialing option.

[12] IlliniCare Health Plan requires recredentialing of practitioners at least every 3 years based on the last digit of their social security number. A recredentialing cycle cannot occur more than once in this 3 year cycle.

[13] Celticare Health Plan requires recredentialing of practitioners every twenty-four (months).

[14] Number of months to align with the Health Plan's required recredentialing timeframe.

[15] Coordinated Care Health Plan allows active duty military service providers a period of at least one hundred twenty days to complete the recredentialing process after return to civilian status. The one hundred twenty days will begin no earlier than the date the provider's period of active duty ends.

[16] Practitioners who are denied initial participation for Maryland Physicians Care may reapply for admission into the network at any time following the initial denial.

I. Application Received

A. Plan contracting secures first-signature contracts, provider applications[17] [18] [19] [20] [21] [22] [23] [24] [25] [26] [27] [28] [29], and associated documents from applicant practitioners and forwards to PDM.

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[17] CeltiCare Health Plan is required to accept and utilize the Integrated Massachusetts Application for Initial Credentialing and Recredentialing

[18] Magnolia Health Plan is required to accept and utilize the Mississippi Participating Physician Form for the credentialing application.

[19] Louisiana Healthcare Connections will accept and utilize the Louisiana Standardized Credentialing Application or the CAQH Application for the credentialing application

[20] IlliniCare Health Plan will accept and utilize the Illinois Health Care Professional Credentialing and Business Data Gathering Form or the CAQH Application for the credentialing application

[21] Home State Health Plan will accept and utilize the CAQH Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180 (as amended), as the credentialing application for all practitioner credentialing in compliance with section 2.18.8c of the contract.

[22] Coordinated Care will utilize the Washington Practitioner Application to process credentialing for all practitioners that require credentialing

[23] Kansas Sunflower State Health Plan will accept and utilize the Kansas Standard Credentialing Application/CAQH to process credentialing for all practitioners that require credentialing

[24] Absolute Total Care accepts the SC Uniform Managed Care Provider Credentialing Application or CAQH.

[25] Maryland Physicians Care accepts the Maryland Uniform Credentialing form or CAQH. Plan Contracting will return incomplete applications to provider at the address listed on the application within ten (10) days after the date application was received, and will indicate to provider what information is needed to make application complete. Within thirty (30) days of receipt of completed application, Maryland Physicians Care shall send to the provider at the address listed in the application written notice of the intent to continue to process the Provider's application to obtain necessary credentialing information or rejection of the provider for participation in the Maryland Physicians Care provider panel. If Maryland Physicians Care provides notice to the provider of its intent to continue to process the provider's application, Maryland Physicians Care, within 120 days after the date notice is provided, shall: accept or reject the provider for participation; or send written notice of the acceptance or rejection to the provider at the address on the application. Maryland Physicians Care will track the date of the application so that dates of credentialing can be calculated.

[26] In accordance with the State Uniform Credentialing and Recredentialing MMIS Policy, Kansas Sunflower State Health Plan will accept and utilize the State of Kansas Standard Credentialing Application/CAQH to process credentialing for all providers/practitioners that require credentialing.

[27] Carolina Complete Health, Inc. accepts only the North Carolina DOI's 'Uniform Application to Participate as a Health Care Practitioner' and does not require an applicant to submit information not required by the application. This is in accordance with North Carolina General Statute 58-3-230. Applications will be processed within the following timelines: **Complete App at time of Receipt:** (b) Within 60 days after receipt of a completed application and all supporting documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision. If, by the 60th day after receipt of the application, the carrier has not received all of the information or verifications it requires from third parties, or date sensitive information has expired, the carrier shall issue a written notification to the applicant either closing the application and detailing the carrier's attempts to obtain the information or verification, or pending the application and detailing the carrier's attempts to obtain the information or verifications. If the application is held, the carrier shall inform the applicant of the length of time the application will be pending. The notification shall include the name, address and phone number of a credentialing staff person who will serve as a contact person for the applicant. **Incomplete App at time of Receipt:** (c) Within 15 days after receipt of an incomplete application, the carrier shall

B. PDM verifies existence of sufficient information needed for enrollment:

2. Completed Provider Data Form or Provider Roster;

3. Completed Provider Application signed and dated not more than 150 calendar days prior to enrollment;

4. Applicable W-9(s);

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notify the applicant in writing of all missing or incomplete information or supporting documents, in accordance with the following procedures: (1) The notice to the applicant shall include a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person for the applicant. (2) Within 60 days after receipt of all of the missing or incomplete information or documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision, in accordance with paragraph (b) of this rule. (3) If the missing information or documents have not been received within 60 days after initial receipt of the application or if date-sensitive information has expired, the carrier shall close the application or delay final review, pending receipt of the necessary information. The carrier shall provide written notification to the applicant of the closed or pending status of the application and where applicable, the length of time the application will be pending. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person to the applicant.

[28] New Hampshire Granite State Health Plan's Contracting team will conduct outreach to prospective Participating Providers within ten (10) business days after receiving notice of the Provider's desire to enroll, and will concurrently work through the Health Plan's and the DHHS contracting and credentialing processes with Providers in an effort to expedite the Provider's network status.

[29] Ambetter of Tennessee shall notify the health care provider of the results of the provider's clean CAQH credentialing application and shall notify the health care provider as to whether or not the health insurance entity is willing to contract with that provider within ninety (90) calendar days after receipt of the completed application (this notification is provided by the Contracting Department.A clean CAQH application means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing.

Ambetter of Tennessee shall provide to any medical group practice with which there is an existing contract a list of all information and supporting documentation required for a credentialing application of a new provider applicant to be considered complete pursuant to subsection (f) of the Tenn Code Ann. 56-7-1001. **(A)** Ambetter Contracting Department will notify a new provider applicant in writing of the status of a credentialing application no later than five (5) business days of receipt of the application. The notice shall indicate if the application is complete or incomplete, and, if the application is incomplete, the notice shall indicate the information or documentation that is needed to complete the application. **(B)** If the application is incomplete and the new provider applicant submits additional information or documentation to complete the application, Ambetter shall comply with the requirements of subdivision (f)(2)(A) upon receipt of the additional information or documentation.**(C)** Ambetter shall notify a new provider applicant of the results of the new provider applicant's credentialing application within ninety (90) calendar days after notification from the Ambetter Contracting Department that the application is complete.**(D)** If a new provider applicant fails to submit a complete credentialing application to Ambetter within thirty (30) calendar days of notice of an incomplete application, then the application is deemed incomplete and credentialing is discontinued. If a new provider applicant fails to submit a complete network participation enrollment form, including signature evidencing intent to participate with the group and any other required documentation, to Ambetter within thirty (30) calendar days of notice of an incomplete application, then the new provider applicant is ineligible to receive the payment set out in (f)(3)(A)

5. Query of the National Plan & Provider Enumeration System (NPPES) to confirm that the practitioner has a current, valid unique National Provider Identifier (NPI) for every provider type, to the extent such provider is not an atypical provider as defined by CMS;[30] [31] [32]

6. Current Disclosure of Ownership/Interest Form, signed and dated [33];

a) PDM provides Disclosure forms to the Corporate Compliance department for monitoring of exclusion checking and ongoing monitoring as specified in CC.COMP.27. [34] [35]

b) Upon notification from the Corporate Compliance department of a verified exclusion status of an individual or entity with an ownership or controlling interest in the provider or a managing employee of the provider, PDM will initiate the appropriate actions specified in each Health Plan's contract, up to and including termination of the contracting process or participation status.

7. In conjunction with the enrollment process, if state requirements specify, PDM also performs additional reviews to ensure compliance to requirements in the provider contract.

[30] California Health and Wellness - All providers of Medi-Cal managed care services must have a valid National Provider Identifier (NPI) number.

[31] Home State Health Plan will require each that ordering and referring professional providing services to Home State Health Plan members have a national provider identifier (NPI) in accordance with 45 CSR 162.410 in accordance with Sections 2.2.6 and 3.9.6w of the contract. Home State Health Plan will query the National Plan & Provider Enumeration System at the time of initial and recredentialing to confirm that the practitioner has a current, valid NPI

[32] Absolute Total Care recognizes that some 'atypical' Provider types may not have NPI.

[33] Trillium requires Ownership and Disclosure information to be submitted on OR Form 3974

[34] ITC follows process outlined in IA.COMP.27

[35] Disclosure of Ownership is not required for submission for any ATC product.

8. Eligibility to become a Medicaid provider is verified as part of enrollment, as applicable per Plan requirements[36] [37] [38] [39] [40] [41] [42] [43] [44] [45] [46] [47] [48] [49];

C. If any of the required items needed for enrollment are missing or insufficient, PDM notifies Plan Contracting or Provider Relations to secure needed items.

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[36] Magnolia shall ensure that all providers are enrolled as a Medicaid Provider and that all active network providers are enrolled using the same National Provider Identifier (NPI) numbers. Acceptable source for confirmation Medicaid enrollment shall be a review of a file of participating Medicaid providers supplied by the Department of Medicaid.

[37] IlliniCare Health Plan shall ensure all providers are enrolled as a Medicaid Provider. Acceptable source for confirmation shall be a review of a file of participating Medicaid providers supplied by the Department of Medicaid.

[38] Coordinated Care shall ensure that all providers are enrolled in Washington as a Medicaid Provider. Acceptable source for confirmation shall be a review of the Provider One website.

[39] Sunflower Health Plan shall ensure that all providers approved as an HCBS/Autism waiver provider are Medicaid enrolled, have submitted documentation declaring their intent to become an HCBS/Autism waiver provider, and complete the State approved curriculum (prior to or within six (6) months of receiving notification of being an approved Medicaid provider).

[40] Nebraska Total Care will confirm the provider has a valid Medicaid Identification number. Acceptable source for confirmation shall follow MLTC requirements. Providers who have submitted an application as a Medicaid provider but have not yet been approved will be allowed to go through the credentialing process and, if necessary, network participation may be pended until the Medicaid provider application is approved or denied. Once approved, confirmation that a valid Identification number has been issued is performed and the network status may change from pending to participating.

[41] New Hampshire Healthy Families shall ensure that all providers are enrolled as New Hampshire Medicaid.providers, they must have a NH Medicaid identification number..

[42] Absolute Total Care shall ensure all providers are enrolled in South Carolina Medicaid.

[43] Nevada SilverSummit shall ensure all providers are enrolled in Nevada Medicaid (this does not preclude the option to enter into a single case agreement with non-Medicaid providers if needed).

[44] Trillium Community Health Plan will apply for DMAP when necessary. Practitioners who have submitted a credentialing application for Medicaid participation, but have not yet been approved by Medicaid, will be allowed to go through the credentialing process. Network participation will be pended until the Medicaid approval has been received and confirmed.

[45] Effective 1/1/2018, all California Health & Wellness network providers must enroll in the Medi-Cal Program. California Health & Wellness relies on the enrollment and screening results conducted by DHCS and will access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers.

[46] PA Health & Wellness reviews applications for the MAID number issued by DHS, however will not delay processing of Provider applications which do not contain the MAID number. Network participation will be pended until the Medicaid approval has been received and confirmed.

[47] Western Sky Community Care, Inc (New Mexico) requires Medicaid product Contract providers to be enrolled with New Mexico Medicaid as a managed care provider.

[48] In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in the Next Level Health provider network, Next Level Health will verify that provider is enrolled in IMPACT. As stated in Contract item 5.9.4, Next Level Health is prohibited from requiring providers to undergo additional credentialing processes that are not part of the contract.

[49] Sunflower Health Plan confirms that the provider has a valid KMAP ID prior to submitting for enrollment.

D. PDM completes enrollment into the Provider Data Management system utilizing the Provider submitted information as referenced above in Section B. This includes but is not limited to demographic information, NPI, licenses, Practice/service location information including accessibility as required by federal, state and local laws, and standards adopted by the Plan, associated groups, education/training, specialty, board certifications, cultural competency training, Panel information, etc. and forwards documentation to Credentialing. Discrepancies identified during the credentialing process regarding licenses, education/training, specialty, board certifications or other information verified by Credentialing is updated by Credentialing prior to completion of the credentialing cycle. Credentialing staff updates the Provider record to reflect the Credentialing Committee decision, PDM staff performs a review of the Provider record for practice/service location and associated group information, and identified discrepancies will be updated prior to changing the status from non-participating to participating in the network. Once made par, the record is fed to both the online directory, the call center system, and the eligibility system for member cards and enrollment.

II. Verification of Items Requiring Primary Source Verification (PSV)

Credentialing verifies using primary sources the elements included in this section. Primary sources may include oral, written, and/or internet sources. Any sources used are NCQA accepted.

Query images and other documentation reviewed (including those retrieved via oral sources) during PSV are saved, date stamped, initialed, and placed in the applicant's file prior to the credentialing decision. For calculating timeliness requirements on Internet and electronic verifications, the date generated by the source when the information is retrieved is used. If the source does not generate a date, the staff person verifying the credential should note the date of receipt of verification in the credentialing file via date stamp.

The minimum verification elements needed for Provisional Credentialing are noted in the section below.

A. Current, unrestricted state license to practice, if license is required to practice [50] [51] (*required for Provisional Credentialing*).

   i. Validation that the practitioner has a current and valid license at the time of credentialing decision is required in all states where practitioner provides care to Plan members, and is verified directly from the state license or certification agency (or it's website).
   ii. Verification for state sanctions, restrictions on licensure and limitations on scope of practice is performed for all active state licenses and is performed through a query of the National Practitioner Data Bank or with the applicable State Licensure Board or the applicable State Certification

[50] Nebraska Total Care recognizes the licensure for Provisional Licensed Mental Health Practitioners (PLMHP) and Provisional Licensed Alcohol and Drug Abuse Counselors (PLADC) as active and unrestricted.

[51] New Hampshire Healthy Families requires all practitioners to be licensed or certified in accordance with the laws of New Hampshire.

Board or State Agency. Verification of the most recent five year period available through the data source is performed.

B. Education and Training.

i. Credentialing verifies the highest of the three levels of education and training obtained by the practitioner (graduation from medical school, residency, or board certification).

ii. Because medical specialty boards verify education and training, verification of board certification fully meets the requirement for verification of education and training, unless otherwise noted.

a. Credentialing queries the current version of the ABMS Directory of Medical Specialists via CertiFacts or other NCQA-approved service.

iii. Other approved primary sources for verifying education and training include:

Practitioner Type	**Primary sources for verifying education and training**
Physicians	**<u>Graduation from Medical School</u>** • Confirmation from the medical school • Entry in the AMA Physician Master File • Entry in the AOA Official Osteopathic Physician Profile Report or AOA Physician Master File • Confirmation from the Educational Commission for Foreign Medical Graduates for international medical graduates licensed after 1986 (ACFME is not an acceptable substitute). • Confirmation from an association of schools of health professions if the association performs primary-source verification. At least annually, Corporate Credentialing must obtain written confirmation from the association that it performs primary source verification of graduation from medical school. • Confirmation from the state licensing agency, if the state agency performs primary source verification. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification.. • Sealed transcripts, if submitted in the institution's sealed envelope with an unbroken institution seal. • Confirmation from AMA that the physician's education was completed through the AMA's Fifth Pathway Program.

Practitioner Type	Primary sources for verifying education and training
	Completion of Residency Training • Confirmation from the Residency training program • Entry in the AMA Physician Masterfile • Entry in the AOA Official Osteopathic Physician Profile Report or AOA Physician Masterfile • Confirmation from an association of schools of health professions if the association performs primary-source verification. At least annually, Corporate Credentialing must obtain written confirmation from the association that it performs primary source verification of residency training. • Confirmation from the state licensing agency, if the state agency performs primary source verification of residency training. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of residency training. • FCVS for closed residency programs.
Chiropractors	• Confirmation from a chiropractic college whose graduates are recognized as candidates for licensure by the regulatory authority issuing the license. • Confirmation from the state licensing agency, if the state agency performs primary source verification of graduation from chiropractic college. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of graduation from chiropractic college.
Oral Surgeons	**Completion of Residency** • Training programs in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA) • Confirmation from the appropriate specialty board if the board performs primary source verification of graduation from a CODA accredited training program. At least annually, Corporate Credentialing must obtain written confirmation from the specialty board that it performs primary source verification of

Practitioner Type	**Primary sources for verifying education and training**
	graduation from a CODA accredited training program. • Confirmation from the state licensing agency, if the state agency performs primary source verification of graduation from a CODA accredited training program. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the CODA accredited training program or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of graduation from a CODA accredited training program.
Mid-level Practitioners	• Verification from the college or university of the highest level of education. • Confirmation from the state licensing agency, if the state agency performs primary source verification of the highest level of education. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of education and training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of the highest level of education.
Other Non-physician health care professionals	• Confirmation from professional school. • Confirmation from the state licensing agency, if the state agency performs primary source verification of professional school training. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification of professional school training directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of professional school training. • Confirmation from a specialty board or registry, if the board or registry performs primary source verification of professional school training. At least annually, Corporate Credentialing must obtain written confirmation from the specialty board or registry that it performs primary source verification of professional school training.
Podiatrists	• Confirmation from the residency training program • Appropriate specialty board, if the board performs primary source verification of completion of residency. At least annually, Corporate

Practitioner Type	Primary sources for verifying education and training
	Credentialing must obtain written confirmation from the podiatry specialty board that it performs primary source verification of completion of residency. • Confirmation from the state licensing agency, if the state agency performs primary source verification of the completion of residency. Corporate Credentialing must maintain a copy of the state statute that requires the licensing board to obtain verification completion of residency directly from the institution or must annually obtain a written confirmation from the state licensing agency that it performs primary source verification of completion of residency.

C. Board Certification

i. Unless specified by Plan requirements[52] [53] [54] [55], Board certification is not required for network participation. However, if a physician level practitioner claims to be board certified, Credentialing verifies current board certification.

a. The expiration date of the board certification is documented in the credentialing file.

b. If the practitioner's board certification does not expire, a lifetime certification status is verified and documented.

c. If the medical board does not provide the expiration date, Credentialing verifies that the board certification is current and documents the date of verification.

D. Report(s) of malpractice settlement(s) (*required for Provisional Credentialing*).

i. National Practitioner Data Bank (NPDB) is queried and reviewed.

[52] CeltiCare Health Plan requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10.

[53] Absolute Total Care Health Plan requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10.

[54] Granite State Health Plan requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10

[55] Louisiana Healthcare Connections requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10

ii. Credentialing reviews of the history of all settled malpractice claims against a practitioner within the past five (5) years from date of report, or as defined by the unique Plan look back period.[56] [57]

E. Medicare/Medicaid-specific exclusions (*required for Provisional Credentialing).*

i. OIG LEIE will be queried through the Office of Inspector General's website.

F. State Specific Exclusion Lists, as applicable.[58] [59] [60] (*required for Provisional Credentialing*)

G. Determination if a practitioner has been debarred, suspended, or otherwise excluded from participating in federal procurement activities (*required for Provisional Credentialing*)

i. The System for Awards Management (SAM) website shall be queried.

H. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members, as applicable per Plan requirements.[61]

I. Social Security Administration's Death Master File must be queried for determination if practitioner has deceased, a possible indicator of fraud.

J. CMS Preclusion list is queried.

III. Verification of Items where PSV is Not Required

The elements below may be verified via secondary sources to support completion of an application and to show eligibility of practitioner to participate in the Plan network. Documentation reviewed during verification is saved, date stamped, initialed, and placed in the applicant's file prior to the credentialing decision. Secondary sources of information are acceptable for the below credentialing requirements.

The minimum verification elements needed for Provisional Credentialing are noted.

A. Complete application form is signed and dated by the applicant and must include attestation for correctness and completeness of the application. Attestation elements must include (*required for Provisional Credentialing):*

[56] CeltiCare Health Plan requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.

[57] Arizona Medicaid Health Plan requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.

[58] The South Carolina (SC) Excluded Providers Listing and the Termination for Cause List on the SC DHHS website shall be queried.

[59] The Louisiana LDH Adverse Actions List shall be queried

[60] The Medicaid MS Sanctioned Provider List shall be queried.

[61] Per requirements applicable to Absolute Total Care, Granite State Health Plan and IlliniCare, to ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

i. Reasons for any inability to perform the essential functions of the position, with or without accommodation;

ii. Physical or mental health problems that may affect the provider's ability to provide health care;

iii. Lack of present/current illegal drug use;

iv. History of chemical dependency/substance abuse;

v. History of loss or limitation of license and/or felony convictions;

vi. History of loss or limitation of clinical privileges and/or disciplinary actions; and

vii. Current malpractice insurance coverage;

B. Current valid federal DEA certificate(s) in each state where practitioner provides care to Plan members (as applicable)

i. Credentialing verifies through one of the following methods: Current Certificate, the DEA Diversion website, NTIS, or an AMA Profile.

ii. In cases where a practitioner may not possess a valid DEA certificate, an attestation of DEA Coverage Plan with name of covering practitioner may be verified [62].

C. Current valid State Controlled Substance registration in each state where practitioner provides care to Plan members (as applicable)

i. Corporate Credentialing verifies through one of the following methods: Current Certificate or through the issuing state agency. For example: CSR, CDS.

ii. Plan-specific requirements may exist and are included in the Appendices.[63] [64] [65] [66]

D. Hospital privileges from the primary hospital as indicated on the credentialing application are verified. [67]

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[62] Maryland Physicians Care requires a copy of the DEA certificate, and does not accept a DEA Coverage Plan in lieu of this requirement.

[63] CeltiCare Health Plan requires verification of the MA CSR, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement. The document does not contain an expiration date. The certificate is valid for three (3) years from date of issuance for physicians and one (1) year for non-physician mid-level practitioners.

[64] Louisiana Healthcare Connections requires verification of the LA controlled dangerous substance certificate, if applicable. A current copy of the certificate is considered a valid source for meeting the requirement or primary source verification.

[65] Home State Health Plan requires verification of Bureau of Narcotics and Dangerous Drugs issued by the Missouri Department of Health & Human Services, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement. Alternately, this may be verified on line.

[66] Maryland Physicians Care requires verification of the MD CDS, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement.

[67] Absolute Total Care requires hospital privileges or alternate admitting arrangements at an in network hospital.

i. This requirement supports patient access to a hospital setting and accurate directory information.

ii. Credentialing may verify using one of the following acceptable sources. Plan-specific requirements may include PSV of hospital admitting privileges.[68] [69] [70]

a. application attestation;

b. letter from facility;

c. roster from facility;

d. verbal confirmation from the facility; or

e. Copy of online directory information provided by the hospital's website specifying admitting privileges.

iii. If the practitioner does not have privileges, a statement (written or verbal) is obtained regarding the practitioner's alternate admitting arrangements through one of the following acceptable sources:

a. the use of a hospitalist program or

b. admitting through a colleague.

E. Proof of professional liability coverage

i. Credentialing verifies existence, currency, and amount using one of the following acceptable sources. Plan-specific requirements may exist.[71]

a. A current malpractice facesheet, application attestation or primary source verification from the carrier. Coverage must be in an amount not less than $1,000,000 per occurrence/ $3,000,000 per aggregate, or as otherwise set forth by the Plan;[72] [73] or

b. Federal coverage through the Federal Torts Claims Act may be confirmed by a copy of the Federal Tort letter or an attestation from practitioner of Federal Tort coverage. The application does not need to contain the current amount of malpractice insurance coverage; or

[68] CeltiCare Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application.

[69] Magnolia Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application, if applicable.

[70] New Hampshire Granite State Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application.

[71] Magnolia Health Plan verification sources for Malpractice Insurance coverage include current copy of insurance certificate, Federal Tort letter or primary source verification document with the Carrier.

[72] Kansas Sunflower State Health Plan accepts the State minimum insurance of $200,000/$600,000 per Kansas State Statute.

[73] Nebraska Total Care accepts the State minimum insurance limits of $500,000 per occurrence and $1,000,000 aggregate per policy period. For hospitals the required limits are $500,000 per incident and $3,000,000 aggregate per policy period. The Nebraska Excess Liability Fund then provides coverage for any damages exceeding those amounts but falling below the applicable damage cap.

c. Evidence of compliance with state regulations.

F. Work history review is performed and the results of the review, including gaps, are documented within the credentialing file.

i. Relevant work history is obtained through the practitioner's application or Curriculum Vitae (CV). Relevant experience includes work as a health professional.

ii. Work history must be submitted in a month/year format for at least the preceding five (5) years.

a. If a practitioner has had continuous employment for five (5) years or more with no gap, providing the year only is acceptable.

iii. Work history is reviewed for gaps;

a. Each gap in employment exceeding six (6) months is clarified either verbally or in writing and documented in the credentialing file.

b. Each gap that exceeds one year will be clarified in writing.

iv. If the practitioner has practiced fewer than five (5) years from the date of verification of work history, the time frame starts at the time of initial licensure. Experience practicing as a non-physician health professional within the five (5) years should be included.

G. Evidence of CLIA Certificate or Waiver for the provision of laboratory services, as applicable per Plan requirements.[74] [75] [76] [77] [78] [79] [80] [81]

H. For non-physician mid-level practitioners, proof of collaborative agreement, protocols, or other written authorization (as required by state law or Plan

[74] Magnolia is required to ensure all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include a current copy of certificate or waiver, or information obtained directly from CLIA.

[75] Sunflower State Health Plan shall obtain copies of the valid CLIA certificates from the laboratories and/or all entities providing laboratory services funded by Title XIX and Title XXI of the Social Security Act at credentialing and recredentialing. Per state, when a copy of CLIA is unavailable, a screen shot of CLIA certification via CMS website is acceptable. Sunflower State Health Plan shall provide a listing to the State of all laboratories and/or entities providing laboratory services and shall certify to the State that the laboratories and/or entities providing laboratory services are CLIA certified. Kansas Sunflower State Health Plan shall update the listing and certification as laboratories and/or entities providing laboratory services are added to or dropped from the list.

[76] New Hampshire Granite State Health Plan is required to ensure all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include application attestation, current copy of certificate or waiver, or information obtained directly from CLIA.

1. [77] California Health and Wellness Plan shall ensure that all contracted laboratory testing sites for use in Medi-Cal managed care have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

[78] Absolute Total Care shall ensure that all offices with laboratory services have Clinical Laboratory Improvement Act (CLIA) certificates or waivers. Certificates or waivers may be primary source verified or a copy of the certificate or waiver is acceptable.

[79] Nebraska Total Care shall ensure that all clinical laboratories provide verification of CLIA licensure (including the CLIA identification number) or Certificate of Waiver and is a minimum administrative requirement for participation in the network.

[80] Nevada SilverSummit shall ensure that all laboratory testing sites providing services under this contract have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate or a waiver of certificate of registration, a CLIA identification number, and comply with CLIA regulations as specified by 42 CFR Part 493. Nevada SilverSummit shall provide to the DHCFP, on request, copies of certificates of any laboratories with which it conducts business.

[81] Trillium/HealthNet Oregon shall and shall ensure that any Laboratories used by Contractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories, which require that all laboratory testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

requirements[82] [83] [84] [85] [86] [87]) with a licensed physician who is participating with the Plan, sets forth the manner in which the mid-level practitioner and licensed physician cooperate, coordinate, and consult with each other in the provision of health care to patients and may be secondary source verified utilizing:

i. Form completed by supervising physician;

ii. Copy of authorization or arrangements; or

iii. Copy of protocols.

I. An onsite review may be required of PCPs and OB/GYNs as defined by market-specific requirements. [88] [89] [90] Verification process includes review of documentation from Plan staff of completion of assessment with passing score and may be in the form of:

i. Documented on Provider Data Form;

ii. Logged in CRM system;

iii. Credentialing staff review of documented site assessment results from the Plan; or

iv. Other confirmation communicated verbally or in writing from Plan staff.

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[82] For CeltiCare Health Plan non-physician mid-level practitioners a copy of the physician collaborative agreement is obtained for the credentialing file.

[83] Magnolia Health Plan will verify that Nurse Practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility. Nurse Practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting as PCPs.

[84] Arizona Medicaid Health Plan will include the name of the Supervising Physician for Physician Assistants in the Committee review materials.

[85] Absolute Total Care will verify that Nurse Practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility.

[86] PA Health & Wellness will ensure that mid-level practitioners functioning as part of the PCP team are doing so within the scope of his or her license via collection and review of the collaborative agreement, protocols or other written authorization.

[87] Carolina Complete Health, Inc. requires Nurse Practitioners and Physician Assistants to provide a copy of their physician collaborative agreement.

[88] The California Health and Wellness Plan shall conduct Facility Site, Medical Record, and Facility Site Physical Accessibility reviews on all Primary Care and high volume provider sites. These site visits shall consist of initial surveys and subsequent periodic site inspections conducted at least every three (3) years. The initial full scope site review survey can be waived by a plan for a pre-contracted provider site if the provider has documented proof that a current full scope survey with a passing score was completed by another plan within the past three years.

[89] The Magnolia Health Plan shall conduct site visits for all providers in accordance with the process outlined in Policy and Procedure MS.CONT.03 Site Assessments for New Provider Contracts.

[90] Maryland Physicians Care conducts an initial site visit of primary care practitioners, and primary care obstetricians to ensure that the practitioners' offices and medical record keeping practices meet Maryland Physicians Care standards and compliance with the ADA. Site audits are performed for practitioners with a new location and/or not part of an existing group.

IV. Recredentialing follows the same process as initial credentialing, with the following differences:

A. Credentialing team is responsible for collection of the Provider Application[91] and associated documentation needed for the recredentialing process (Plan Contracting team is responsible for collection of this documentation for initial credentialing process);

B. Credentialing secures an updated copy of the Disclosure of Ownership/Interest Form, signed and dated (Plan Contracting team is responsible for collection of this document for initial credentialing process);

C. Review of work history is not required;

D. Verification of education and training is not required, unless one of more of the following exceptions exist:

i. If additional education has been obtained to change specialty affecting the contractual agreement with the Plan, Credentialing will verify additional education.

ii. If a physician level practitioner states he/she is board certified, Credentialing will verify current board certification status from the primary source.

E. The recredentialing process consider provider-specific performance data such as those collected through the quality improvement program, the utilization management system, the grievance/complaint system, satisfaction surveys, and other activities of the organization, and that includes an attestation to the correctness and completeness of the new information. The credentialing designee gathers applicable performance data from the QI Department designee for inclusion in the recredentialing file.

V. Cases of Information Variance

In cases where information obtained from primary sources varies from information provided by the practitioner, Credentialing contacts the applicant by phone and/or letter to alert the applicant to the variance and request a response.

A. At least three (3) outreach attempts are made by Credentialing. Each attempt is documented and included in the practitioner's credentialing file.

i. Notification sent to the practitioner includes the time frame for submitting a correction or explanation.

ii. Notification also includes the contact information for submitting the correction/explanation, including the name and phone number of the Credentialing representative, address, and fax number.

B. The practitioner must provide a written explanation detailing the error or the difference in information to Credentialing on or before the due date stated on the notification to the practitioner. The Plan Credentialing Committee includes this information as part of the credentialing/recredentialing process.

C. If requested by the practitioner, a representative of Credentialing contacts the practitioner's office to confirm receipt of the practitioner's written explanation.

[91] Practitioners are allowed to submit the CAQH or the OPRA (Oregon Practitioner Recredentialing Application) for processing.

Credentialing representatives only speak directly to the practitioner, or a designee authorized by the practitioner, to ensure the confidentiality of information.

VI. If no response is received by the stated due date in the notification to the practitioner, Credentialing, on behalf of the Plan, assumes the practitioner does not dispute the accuracy of the information collected, and the file is presented to the Credentialing Committee. Information received after the due date, but prior to the next Credentialing Committee meeting, may be **Complete Application Criteria**

A "complete application" contains all of the information needed for credentialing review, including:

A. the practitioner's correctly and fully completed application;

B. submission of all required and current credentialing documents;

C. current application attestations, aged not more than 180 days from anticipated credentialing decision, and

D. associated attestation supporting statements.

State-specific regulations may allow for determination of the "complete application" date to also include verifications obtained from third-party sources.[92] [93] [94] [95]

The application must be considered complete for credentialing review to occur. The date the application is deemed complete is recorded within the Provider Data Management system.

VII. Process to Secure Missing and/or Expired Information

Missing and/or expired information must be secured before an application can be considered complete.

A. Credentialing staff and/or the Plan staff contact the practitioner and/or relevant third party to secure missing and/or updated documentation (in cases of expired

[92] Applicable to Louisiana Healthcare Connections, per Louisiana State Act 358, complete application is the date on which the managed care organization has received all the information needed for credentialing, including the health care provider's correctly and fully completed application and attestations and all verifications or verification supporting statements required by the managed care organization. "Verification" or "verification supporting statement" means the documentation confirming the information submitted by an applicant for a credentialing application from a specifically named entity or a regional, national, or general data depository providing primary source verification including but not limited to a college, university, medical school, teaching hospital, health care facility or institution, state licensing board, federal agency or department, professional liability insurer, or the National Practitioner Data Bank.

[93] Per New Hampshire Medicaid Care Management Contract, the complete application start time begins when all necessary credentialing materials have been received by the managed care organization

[94] Per Section 2.2.4 of Kansas Contract - Provider Credentialing and Re-credentialing, the complete application start time begins when all necessary credentialing materials have been received by the managed care organization

[95] South Carolina MCO Contract defines a complete application to include all necessary documentation and attachments, and a signed Provider Agreement.

or soon-to-be-expired) information[96]. At least three (3) outreach attempts are made to secure needed information. [97]

B. If information is not secured within twenty one (21) calendar days of first outreach attempt for initial credentialing applications or prior to recredentialing due date for recredentialing applications, Credentialing and the Plan determine course of action up to and including termination of the application process[98].

C. If application is terminated, notification is sent to the practitioner.[99]

VIII. Minimum Administrative Requirements

Certain minimum requirements must be met for credentialing committee/Medical Director review to occur; if these requirements are not met, termination of the process results and is referred to as "administrative" termination of the application process.

A. Minimum administrative requirements that must be met include:

i. Contains the minimum elements required for verification as described in Sections II-IV of this document;

ii. Application is signed and dated not more than 180 calendar days prior to anticipated credentialing decision;

iii. Contains primary and/or secondary source verification information collected not more than 120 calendar days prior to placing into the "Ready for Committee" status in the credentialing system of record. And, not more than 180 calendar days at the time of credentialing decision;

iv. As applicable to Plan requirements,[100] does not contain information that practitioner has opted-out of receiving Medicare funds;

v. Does not contain information that the practitioner has been excluded from participation in the Medicare and/or Medicaid program or state-specific exclusions; and

vi. Does not contain information that the practitioner has been identified as being included on the Social Security Administration's Death Master File.

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[96] Magnolia Health Plan shall notify a practitioner within five (5) business days of any missing or invalid information that would impede completion of credentialing and/or contracting.

[97] For any provider submitting new or missing information for it's credentialing application, New Hampshire Healthy Families will act upon the new or updated information within ten (10) business days.

[98] For Maryland Physicians Care if missing or expired information can not be secured within 21 calendar days of the first outreach attempt for initial credentialing but the Letter of Intent has gone out the application will proceed through the credentialing process as an Unclean File.

[99] Louisiana Healthcare Connections will send termination notice via certified mail, effective fifteen (15) days from the date of the notice. Claims will be paid for services delivered prior to the termination date.

[100] Per requirements applicable to Absolute Total Care, New Hampshire Healthy Families, and IlliniCare, to ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

vii. Does not contain information that the practitioner has been excluded from participation in the federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

B. Credentialing notifies the practitioner via certified mail of the administrative termination of the application process.

i. A copy of the letter is retained in the practitioner's closed file and maintained in the Credentialing Department for future reference.

C. When administrative requirements (iv), (v) and/or (vi) are not met, Credentialing notifies the Plan and PDM to ensure appropriate actions are taken:

i. As applicable, PDM modifies Provider Data Management system to prohibit payment to practitioners under these programs.

ii. If practitioner is found listed on the Social Security Administration's Death Master File and Credentialing reasonably suspects potential fraud, Credentialing engages Centene's Special Investigations Unit (SIU).

iii. Plan Compliance ensures applicable State notifications are completed.[101] [102] [103] [104]

IX. Determination and Review of Clean Files

Applicants who meet the participation criteria and are determined to have a "clean file" are approved for Plan participation following review by the Corporate or Plan Medical Director or chair of the Credentialing Committee.

A. Plan defines a "clean file" as one that meets the following criteria, unless otherwise noted in Plan-specific attachments to this policy:

i. No past or present suspensions or limitations of state licensure within a five (5) year look back period;

ii. No past or present suspensions or limitations of DEA or state controlled substance registration within a five (5) year look back period;

iii. Current Malpractice coverage in the amount required by Plan;

iv. No past or present Federal or State sanction activity including Medicare/Medicaid sanctions;

a. At the discretion of the Credentialing Manager or Medical Director, sanctions over the five (5) year look back period may be presented

[101] Magnolia Health Plan shall notify the Division within ten (10) calendar days of the denial of a Provider credentialing application either for program integrity-related reasons or due to limitations placed on the Provider's ability to participate for program integrity-related reasons

[102] Effective 2/1/2015, Louisiana Healthcare Connections shall notify DHH of denial of a Provider credentialing application for program integrity-related reasons or otherwise limits the ability of Providers to participate for program integrity-related reasons

[103] Any type of provider who is denied credentialing or recredentialing by Absolute Total Care, regardless of the reason, will be reported to the SC Division of Program Integrity/SUR and SC DHHS. Credentialing staff will notify the Compliance Department, who will provide the notification.

[104] If Nevada Silver Summit decredentials, terminates or disenrolls a provider, Nevada Silver Summit will inform DHCFP Provider Enrollment Unit within five (5) business days.

to the Committee if the practitioner has recent sanctions and the older history may provide more information regarding an appropriate decision

v. Absence of information that practitioner has opted-out of receiving Medicare funds, as applicable to Plan requirements[105];

vi. No malpractice claims that resulted in a settlement or a verdict in favor of the plaintiff (claims ruled in favor of the defendant are acceptable for a clean file) in a five (5) year look back period[106] from date of settlement;[107] [108]

a. At the discretion of the Credentialing Manager or Medical Director, malpractice claims over the five (5) year look back period may be presented to the Committee if the practitioner has recent aberrant malpractice claims and the older history may provide more information regarding an appropriate decision.

vii. No gaps in relevant (as a health professional) work history of one (1) year or more within a five (5) year look back period. Each gap in employment history exceeding six (6) months is clarified either verbally or in writing. Gaps over one (1) year in work history must be documented in writing and reviewed by Committee. If the practitioner has practiced fewer than five (5) years from the date of credentialing, the work history starts at the time of initial licensure;

viii. No current hospital membership or privilege restrictions and no history of hospital membership or privilege restrictions within a five (5) year look back period;

ix. No history of or current use of illegal drugs or alcoholism;

x. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

xi. No criminal/felony convictions, including a plea of no contest.

xii. No involuntary terminations from an HMO or PPO.

xiii. For those practitioners for whom site visit is required, site visit score meets appropriate threshold for passage.

xiv. No "yes" answers on attestation/disclosure questions, with exceptions of the following which do not trigger a full Committee review:

[105] Per requirements applicable to Absolute Total Care, Granite State Health Plan, and IlliniCare, to ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

[106] CeltiCare Health Plan requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.

[107] Pennsylvania Health and Wellness Clean File eligibility criteria is expanded to include a defined threshold for applicants with previous history of limitation of licensure, malpractice claims, or privilege actions based upon an expanded level of review and determination by the Medical Director.

[108] Maryland Physicians Care Clean File eligibility criteria is expanded to include malpractice claims with settlement amount under $49,999.99.

a. Investment or business interest in ancillary services, equipment or supplies;

b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;

c. Voluntary surrender of state license related to relocation or nonuse of said license;

d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that is over five (5) years old from date of report, or as defined by the unique Plan look back period;

e. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);

f. Previous failure of a certification exam in a provider who is currently board certified or who remains in the five (5) year post residency training window;

g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion; and/or

h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

B. In cases of recredentialing:

i. Issues, judgments, or settlements previously reviewed do not have to be resubmitted during the current phase of recredentialing; and

ii. Issues, judgments, or settlements since prior credentialing must be considered in the determination of whether a file is considered clean.

C. If a file is determined to be clean, the practitioner is presented to the Corporate or Plan Medical Director or chair of the Credentialing Committee on a summary listing containing, at minimum, practitioner name, NPI and specialty.

i. Information is typically presented via email, but may also be presented in person.

ii. Approvals received via email are from a secure system with a unique electronic identifier with appropriate controls to ensure that only the designated medical director or qualified physician can access and use as an electronic signature.

D. If approved for network participation, a letter of acceptance is mailed to the applicant within sixty (60) calendar days of the determination, unless otherwise specified by Plan requirements.[109]

i. Notification of acceptance is not provided for recredentialing applications.

[109] CeltiCare Health Plan applicants must be notified of the credentialing committee decision on an initial application within four (4) business days. The notice shall include the committee decision and the decision date.

X. Committee Review of Unclean Files

Credentialing and/or recredentialing application files that do not meet criteria for clean file review are brought to the Credentialing Committee for review. The Credentialing Committee has been delegated the responsibility from the Plan Quality Improvement Committee to review the qualifications of each applicant presented and make approval or rejection determinations[110]

A. The following grid summarizes file criteria and when Credentialing Committee review is required:

Credentials	Criteria	Committee Review
NPDB Profiles	NPDB Reports within five (5) years of the resolution date, per report to the committee decision/date.	Yes
	Example: Committee Date 01/2007 *NPDB Report 1 Resolution 1/2009*	*Yes*
	NPDB Report 2 Resolution 10/1991	*No*
Restricted License Adverse Activity Disciplinary Limited Supervision	State Licensure documentation within five (5) years of date of final action/order to the committee decision/date. *Please see the NPDB example for date compliance.*	Yes
Malpractice History	All Open, Pending, Discovery Claims *Committee cannot make a recommendation on these types of issues until a final judicial outcome. The Credentialing Committee will review the final outcome during the recredentialing or ongoing monitoring process.*	No [111]
	All Closed or Dismissed Claims Claims that resulted in a settlement or judgement for the plaintiff	No Yes
Federal, State Sanctions, Financial	State, Medicare/Medicare Sanctions, Fines, Discipline activity within five (5) years. Review dates for determination.	Yes
	Current Medicare/Medicaid Exclusions File will be administratively declined for participation.	No

[110] MPC Credentialing Committee determinations for Unclean Files are presented to the MPC Board of Directors who hold the authority for making final determinations.

[111] Files with History of Malpractice claims settled for over $50,000.00, and all Open, Pending and Discovery Claims are designated as unclean and require review by Maryland Physicians Care Credentialing Committee and Board of Directors.

Credentials	Criteria	Committee Review
Work History Gap	Gaps over 1year in work history must be documented in writing and reviewed by committee.	Yes
Specialty Issues Board Certification Clinical Education Training Program	Any discrepancies found through the verification process with a final order or judgment within 10 years of the credentialing committee decision/date.	Yes
Relinquish privileges, licensure, certification	Relinquish state clinical license or certificates, malpractice insurance coverage, clinical or staff privileges, appointments, board status etc. Also any state, local, or federal agencies.	
	*Under Investigation	Yes
	Not Under Investigation – *Credentialing Manager review to determine committee file review.*	Yes or No
Quality Indicators Recredentialing Only	During recredentialing the practitioner or facility have unsatisfactory Quality indicators, which can be one or more of the following: quality of care, over/under utilization, inadequate medical records, accessibility issues, and inappropriate volume of member complaints.	Yes

* It is expected that these findings will be discovered for currently participating practitioners through ongoing sanction monitoring. Practitioners with such findings will be individually reviewed and considered by the Credentialing Committee at the time the findings are identified. These practitioners will be identified (off cycle) when they are presented to the Credentialing Committee.

C. The Credentialing Committee may utilize an exception process should it be necessary to credential certain practitioners given the needs of its membership [112].

i. When there are extenuating circumstances that preclude the practitioner from meeting minimum participation criteria, but do not preclude the practitioner from providing quality care and service for Plan members, the Medical Director/Credentialing Committee Chair /Credentialing Committee may decide to utilize an exception process to extend an offer of participation.

ii. A complete discussion of this decision is reflected in the Credentialing Committee meeting minutes.

iii. If such a need exists, each criterion for selection is examined on an individual basis taking into account the following:

a. If there is a history of drug or alcohol abuse, the applicant must be involved in a credible program to correct impairment with

[112] Maryland Physicians Care Credentialing Committee/Board of Directors doesn't utilize an exception process.

concurrent and present monitoring by the medical society or state board. There should be no evidence of recidivism.

b. Previous sanction activity: the nature of the sanction and remedy.

c. Office site visit: a plan to remedy any deficiencies with provisional approval until the remedy is achieved, if Plan requires site visits.

d. Additional exceptions are granted and reviewed on an individual basis by the Credentialing Committee.

D. The Credentialing Committee and/or Quality Improvement Committee has the authority to require an applicant to undergo an evaluation of his/her physical and/or mental status prior to further consideration of the application or in order to retain active status within Plan.

E. If the Credentialing Committee requires additional information prior to making a determination, application may be pended and information is obtained and file presented to Credentialing Committee at a future meeting.

F. The Credentialing Committee may determine that corrective action is necessary in order to credential a practitioner. The Committee decision includes a description of the steps necessary to fulfill compliance with the required action. If necessary, a work process will be created to document the specific step-by-step detail of how to complete the required tasks. Provider application should be pended and a future date set for re-review.

G. The applicant is sent notice of his/her status in writing within sixty (60) calendar days of the Credentialing Committee decision, unless otherwise required by Plan.[113]

XI. Denial of Initial Credentialing/Recredentialing Application

A. Corporate or Plan Medical Director or Credentialing Committee may decide not to extend or continue to extend participation status to a practitioner.

B. The Credentialing Committee Chair or designee notifies the practitioner via certified mail of the Credentialing Committee denial decision within sixty (60) calendar days of the Credentialing Committee's decision.[114]

i. A letter of denial includes the reason and information on the practitioner's right to view and/or correct erroneous information. [115] [116] [117]

ii. A copy of the letter is retained in the practitioner's closed file and maintained in the Credentialing Department for future reference.

iii. If the practitioner's current participation status is being suspended, restricted or terminated based on issue of quality of care or service, Plan offers and informs the practitioner of the appeal process in accordance with the associated policies, CC.CRED.07 - Practitioner Disciplinary Action and Reporting, and CC.CRED.08 - Practitioner Appeal Hearing Process.

[113] CeltiCare Health Plan applicants must be notified of the credentialing committee decision on an initial application within four (4) business days. The notice shall include the committee decision and the decision date.

[114] For those practitioners reviewed by Committee for recredentialing and denied continued participation, Louisiana Healthcare Connections will send a termination notice effective fifteen (15) days from the date of the notice via certified to the last mailing and email address submitted by the provider.

[115] Nebraska Total Care will include a description of appeal rights in the denial letter for Initial credentialing applications.

[116] Maryland Physicians Care letter of denial includes reason and right to view and/or correct for currently participating providers only.

[117] When an adverse credentialing decision is rendered, PA Health & Wellness will provide written notice which will include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors.

C. In order to support compliance with specific Plan requirements, Credentialing notifies Plan Compliance of Credentialing Committee denials as soon as reasonably possible after the committee proceedings conclude. [118] [119] [120] [121]

XII. Practitioner Requests for Status of Credentialing/ Recredentialing Application

A. Practitioner contacts Plan Provider Relations Department to request status.

B. Upon receiving such request, the Plan Provider Relations Representative obtains information from Credentialing as needed, and provides practitioner with information such as the application approval date, status of any requests for additional information, the expected date the practitioner's file will go to the Credentialing Committee, etc.

C. Plan Provider Relations Department relays status information to requesting Practitioner.

XIII. Practitioner Requests to Review Information Obtained During Credentials Verification

A. Practitioner submits a written and signed request for access to information obtained during the credentialing and/or recredentialing process.

B. Requested information is secured and sent to the practitioner via Restricted Delivery Certified Mail within fourteen (14) days of the receipt of the request from the practitioner.

i. If Credentialing is unsure of the type of information that can be released, Corporate Counsel is immediately notified.

C. The written request from the practitioner and the information provided by Credentialing is documented in the provider's credentialing file.

XIV. New Practitioner Requests Reconsideration

A. A practitioner who is denied participation for non-administrative reasons requests a reconsideration of the decision [122].

i. If the request is received within thirty (30) calendar days of the date of receipt of the denial letter and includes additional supporting documentation in favor of the applicant's consideration for network participation, reconsideration will occur.

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[118] Per South Carolina Managed Care Policy and Procedure Guide, any type provider who is denied credentialing or recredentialing, regardless of the reason(s), must be reported to the MCO's Program Manager the same day (or within 24 hours) of the denial

[119] Magnolia Health Plan shall notify the Division within ten (10) calendar days of the denial of a Provider credentialing application either for program integrity-related reasons or due to limitations placed on the Provider's ability to participate for program integrity-related reasons

[120] Home State Health Plan will notify the state agency of any denial of provider credentialing or re-credentialing in a timely manner and will report provider terminations as part of its quarterly fraud and abuse report following the State provided forms

[121] Arizona Medicaid Health Plan will report adverse credentialing actions to the AHCCCS Clinical Quality Management Unit within one business day.

[122] Request for reconsideration of non-administrative denials by new (non-participating) practitioners is not applicable to Maryland Physicians Care.

ii. The request is presented to the Credentialing Committee at the next regularly scheduled meeting but in no case later than sixty (60) calendar days from the receipt of additional information. The Credentialing Committee may recommend:

a. Support of the original denial recommendation by the Credentialing Committee and closure of the file; OR

b. Support of the applicant's ability to meet the Plan minimum participation criteria and approval of the applicant for inclusion in the Plan practitioner network.

iii. The Medical Director/Credentialing Committee Chair, or designee, notifies the applicant in writing within sixty (60) calendar days of the Credentialing Committee decision.

XV. Once credentialing is complete, PDM performs a quality check and makes the provider "par" (i.e. participating) in the Provider Data Management system[123]. Once made par, the record is fed to both the online directory, the call center system, the claims system[124], and the eligibility system for member cards and enrollment.

REFERENCES:
Current NCQA Health Plan CR Standards and Guidelines CMS Medicare Managed Care Manual Chapter 6 "Relationships with Providers" State and Federal regulations for Credentialing and Recredentialing including: 42 C.F.R. § 438.214, 455.104, 455.105, 455.106, 455.107, 1001.1801, 1001.1901, 1002.3(b) Current South Carolina Medicaid Managed Care Program- Policy and Procedure Guide for MCOs Arizona Health Care Cost Containment System (AHCCCS) Mississippi Department of Insurance Regulation 98-1 State of Oregon: OAR 410-120-1280 and OAR 410-141-3120

ATTACHMENTS:

A. CeltiCare Health Plan Unique Credentialing Requirements
B. Magnolia Health Plan Unique Credentialing Requirements
C. Louisiana Healthcare Connections Unique Requirements for Credentialing
D. IlliniCare Health Plan Unique Requirements for Credentialing
E. Home State Health Plan Unique Requirements for Credentialing
F. Coordinated Care Unique Requirements for Credentialing
G. Kansas Sunflower State Health Plan Unique Requirements for Credentialing

[123] Arizona Medicaid Health Plan will ensure the practitioner is listed as participating within thirty (30) calendar days of Credentialing Committee approval.

[124] Magnolia Health Plan will load provider information into it's claims processing system within thirty (30) calendar days of provider contract approval.

H. New Hampshire Healthy Families Health Plan Unique Requirements for Credentialing
I. California Health and Wellness Plan Unique Requirements for Credentialing
J. Absolute Total Care Plan Unique Requirements for Credentialing
K. Michigan Complete Care Unique Requirements for Credentialing
L. Trillium/HealthNet Oregon Unique Requirements for Credentialing
M. Arizona Complete Health Unique Requirements for Credentialing
N. Pennsylvania Health and Wellness Unique Requirements for Credentialing
O. Nebraska Total Care Unique Requirements for Credentialing
P. Maryland Physicians Care (MPC) Unique Requirements for Credentialing
Q. Nevada SilverSummit Unique Requirements for Credentialing
R. Arkansas Health and Wellness Unique Requirements for Credentialing
S. Western Sky Community Care, Inc (New Mexico); and Ambetter of Western Sky Community Care Unique Requirements for Credentialing
T. Carolina Complete Health, Inc. Unique Requirements for Credentialing
U. Next Level Health (IL Medicaid) Unique Requirements for Credentialing
V. Iowa Total Care Unique Requirements for Credentialing
W. Ambetter of Tennessee Unique Requirements for Credentialing
X. Ambetter of Virginia Unique Requirements for Credentialing
Y. MHS Health Wisconsin Unique Requirements for Credentialing
Z. Ascension Joint Venture Unique Requirements for Credentialing
AA. ICNF (Integrated Care Network of Florida) Unique Requirements for Credentialing

DEFINITIONS:

REVISION LOG

REVISIONS	DATE
Added provisions for Louisiana Healthcare Connections RFP effective 2/1/2015, including – 30-day turnaround time to completely process a provider application and that MCO must notify DHH upon denials or limitations for program integrity reasons	09/15/2014
Revised language for Magnolia Health Plan Site Visit requirements.	10/31/14
Revised language for Kansas Sunflower Health Plan Unique Requirements to specify CLIA validation at credentialing and recredentialing. Revised language for Louisiana Healthcare Connections Unique Requirements to include query of Louisiana Exclusion Database (LED)	12/4/14
Revised language for New Hampshire Granite State Health Plan Unique Requirements to include primary source verification of hospital privileges.	12/10/2014
Revised language for Louisiana Healthcare Connections Unique Requirements to clarify that Provisional credentialing process is used for expedited and temporary credentials.	2/27/2015
Revised language for South Carolina Absolute Total Care Unique Requirements to include detail on site visit documentation.	3/23/2015
Kansas Sunflower State Health Plan Unique Requirement language was updated to include acceptance of the Kansas state minimum malpractice coverage amount.	3/30/2015
WA Coordinated Care Health Plan Unique Requirement language was updated to include reporting for screening of excluded individuals.	7/15/2015
Revised language to clarify that reference to Board Certification is most applicable to physician level practitioners.	10/7/2015

Revised language in Section V.B that practitioner must reply regarding discrepancies in accordance with the due date stated on the request. Revised language in Section VII.B from thirty (30) days to twenty one (21) days. Kansas Sunflower State Health Plan Unique Requirement language was updated to include information specific to HCBS/Autism waiver providers.	
• Revised Attachment M Absolute Total Care Health Plan Unique Requirement to meet SCDHHS MCO Policy and Procedure Guide, revised November 2015.	11/9/2015
• Revised title of Procedure IV on page 22 to provide clarity	1/6/2016
• Revised Attachment F Coordinated Care Unique Requirements for Credentialing to include language allowing 120 days after return to civilian status to complete the recredentialing process for active duty military service providers.	3/9/2016
• Added 'current' to the section regarding Disclosure of Ownership form in section I.B.v (page 7) • Slight revision of language in Procedure IV (page 22) to provide clarification that the disclosure of ownership form is collected at both initial and recredentialing, however, the team member responsible for the collection is different for the separate process type. • Updated reference to NCQA Standards year; and updated reference to SC MCP policy and procedure year.	3/28/2016
• Added Attachment L - Pennsylvania Health and Wellness Unique Requirements for Credentialing	5/4/2016
• Revised Attachment L title – from Pennsylvania Health and Wellness Unique Requirement for Credentialing to Trillium Unique Rerquirements for Credentialing. • Added Attachment M – Arizona Medicaid Health Plan Unique Requirements for Credentialing • Added Attachment N - Pennsylvania Health and Wellness Unique Requirements for Credentialing (pasted previous information and included additional language) • Added Attachment O – Nebraska Total Care Unique Requirements	6/2/2016
• Added additional Pennsylvania Department of Health's requirements • Added language to ATC – SC Unique requirements that SCDHHS Form 1514 is the required format for DOO. Also added to page 7, as footnote 16. • Clarified Celticare 24 month recredentialing requirement in Unique Requirement section and in footnote 6.	7/7/2016
• Removed the requirement for Site visit at initial credentialing for PCP and OB/GYN from ATC – SC Unique Requirement section and footnote section. • Updated sources in References section to 2016 as applicable. • Removed the following items from the "Replaces Documents: section of the header, and added notation to review the comment on this date: CC.CRED.01 Credentialing Program Description; CC.CRED.03 Primary Source Verification; CC.CRED.04 Initial Credentialing Process; CC.CRED.04.01 Practitioner Rights to Review and Correct; CC.CRED.04.02 Provisional Credentialing; CC.CRED.05 Initial Sanction Information; CC.CRED.07 Recredentialing Policy	8/6/2016
• Added language which requires provider participation in NH Medicaid to the Unique Requirement list for New Hampshire Healthy Families.	10/12/2016
• Added "LEIE" after OIG to help specify source on page 17 item E (OIG). • Revised the titles for items listed in the Reference section to notate 'current' standards. Louisiana Healthcare Connections Unique requirements (and footnotes) revisions: • processing of complete applications from 30 days to 60 days. • Revised name of query database from LA Exclusion List (LED) to LA DHHS Adverse Action List.	11/16/16

ATC – SC Unique requirements (and footnotes) revisions/additions: • to report any excluded individuals and entities discovered to SC DHHS. • to specify acceptable application form. • To clarify acceptance that 'atypical' provider types may not have NPI. • Clarified SC DHHS Form 1514 is specific to ATC • Added requirement for validating enrollment in SC Medicaid • Added reference to SC.CRED.13 in footnote for Board Certification. • Added requirement for hospital privileges or admitting arrangements are at an in network hospital. • Added requirement to verify NPs acting as PCP have formal collaborative relationship with in network licensed physician with admitting privileges at a contracted inpatient hospital facility. • Added requirement to completely process credentialing applications within 60 days of receipt of complete application. • Tweaked language for notification to SC regulatory agencies of providers denied credentialing or recredentialing.	
• Minor changes made to page 9, section E and added section XV to clarify PDM and Credentialing responsibilities.	2/2/2017
• Added Maryland Physicians Care (MPC) Unique Requirements Attachment	2/22/2017
• Added Nevada SilverSummit Unique Requirements Attachment	3/9/2017
• Added clarifying language to IX.C.ii – to note that clean file approvals received via email are from a secure system.	3/22/2017
• Added Arkansas Health and Wellness Unique Requirements Attachment	5/16/2017
• Revised Trillium unique requirements to specify DMAP review, recredentialing application type, and verification of nonlicensed behavioral health practitioners through CCO Document Bank. • Revised Maryland Physicians Care unique requirements with 10 year lookback period for malpractice settlements.	8/18/2017
• Add Western Sky Community Care, Inc (New Mexico) Attachment.	10/18/2017
• Added clarifying language to Magnolia Unique Requirement Attachment – all active network providers are enrolled (in Medicaid) using the same NPI numbers; and Nurse Practitioners acting as PCPs are held to the same requirements and standards as physicians acting as PCPs. • Added language to Nebraska Total Care Unique Requirements Attachment – acceptance of a lower coverage amounts in accordance with the State Excess Liability Fund.	11/10/2017
• Added language to California Health & Wellness Unique Requirement Attachment: Effective 1/1/2018, all California Health & Wellness network providers must enroll in the Medi-Cal Program. California Health & Wellness relies on the enrollment and screening results conducted by DHCS and will access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers.	12/8/2017
• Added language to PA Health & Wellness Unique Requirement Attachment – added review of MAID number; review of mid-level supervisory agreement; and specific language requirements in letters of denial.	12/20/2017
• Added language to KS Sunflower Unique Requirement Attachment to clarify that the State Uniform Credentialing application is used. And, clarification on CLIA collection: Per state, when a copy of CLIA is unavailable, a screen shot of CLIA certification via CMS website is acceptable	12/23/2017

• Added Carolina Complete Health, Inc. Unique Requirement Attachment.	12/2017
• Revised Carolina Complete Health, Inc Unique Requirement Attachment to clarify that only the NC DOI Uniform Credentialing application is accepted and no other information is required. • Updated first sentence (bolded) of section IV in an effort to provide better clarity regarding recred process.	1/22/2018
• Updated Magnolia Health Plan Unique Requirements language to specify that the Health Plan follows credentialing and recredentialing standards of NCQA and EQRO recommendations; Credentialing must be completed before final execution of the contract with the Provider; notification to practitioner within five (5) business days of any missing or invalid information that would impede completion of credentialing and/or contracting; added footnote and unique requirement to state that Magnolia Health Plan will load provider information into it's claims processing system within thirty (30) calendar days of provider contract approval. • Updated core policy section XV to include reference to 'the claims system'. • Updated references to Board Certification policy (formerly state specific and number 13) to the current/active policy CC.CRED.10.	2/5/2018
• Added Next Level Health (IL Medicaid) Unique Requirement Attachment. • Clarified 'make par' timeline for Arizona Medicaid Health Plan.	2/5/2018
• Added ATC South Carolina requirement to query the SC DHHS Termination for Cause List query during cred/recred.	4/2018
• Added clarifying language to Trillium Unique Requirement Policy in accordance with OHA/CCO contract.	5/2018
• Added language to Procedure I.Biv - to the extent such provider is not an atypical provider as defined by CMS. • Added 'Behavioral Health Service Providers' in the Policy 'Types of Providers' section.	6/2018
• Updated Sunflower Health Plan requirements to include validation of KMAP ID prior to enrollment. • Updated Nebraska Total Care Unique Requirement to note that the Health Plan recognizes the licensure for Provisional Licensed Mental Health Practitioners (PLMHP) and Provisional Licensed Alcohol and Drug Abuse Counselors (PLADC) as active and unrestricted.	8/18
• Added Iowa Total Care Unique Requirement Attachment.	9/18
• Updated Magnolia Health Plan Unique Requirement to include query of Medicaid MS Sanctions Provider List.	11/18
• Added following item to the Minimum Administrative Requirements section: does not contain information that the practitioner is excluded from participation in the federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.; Added item 6 regarding Autism providers to the California H&W Unique Requirement attachment; Added items 7 & 8 regarding Addictions Counselor Act and non-clinical BH types to submit supervising clinician statement.; Added item 6 regarding SUD providers and item 7 regarding LADC supervision to the New Hampshire Healthy Families Unique Requirement Attachment,; Added item 5 regarding ABA providers to the Coordinated Care Unique Requirement Attachment. • Added Ambetter of Tennessee Unique Requirement Attachment • Added Ambetter of Virginia Unique Requirement Attachment	12/18
• Added language to Unique Requirements for Iowa regarding PCP eligibility. • Added language to Unique Requirements for Kansas to clarify requirements for Autism service providers.	1/19

• Updated Procedures I.D (which details how the enrollment team enters demographic and other information into the system based upon the application) to include reference to Panel Size. • Added language in Unique Requirements for Home State Health Plan regarding Medicaid Enrollment requirements. • Revised Unique Attachment M from Arizona Medicaid Health Plan to Arizona Complete Health • Updated Unique Requirement for Iowa Total Care item #2 for timeliness, removed duplicate item.	2/19
• Updated ATC Unique Requirement Attachment language to include: SC List of Suspended Providers, Behavioral Health Actions and any other databases as the Department or Secretary of Health and Human Services may prescribe. • Removed the following previous revision dates from header: 9/14; 09/14; 10/14; 12/14; 12/14; 3/15; 7/15; 10/15; 1/16; 3/16; 3/16; 5/16; 6/16; 7/16; 8/16; 10/16; 11/16; 2/17; 2/17; 3/17; 3/17; 5/17; 8/17; 10/17; 11/17; 12/17; 12/17; 1/18; 2/18; 4/18; 5/18; 8/18; 9/18; 11/18; 12/18; 1/19; 2/19 • Updated Coordinated Care Unique Requirements with 10 calendar day notification requirement. • Removed Requirement for Supervising Clinician document or statement for LADC. • Updated Louisiana Healthcare Connections Unique Requirements attachment with additional detail on the restriction on contracting with excluded providers – particularly as related to HCBS; no payment for services to providers located outside fo the United States; additional language to accreditation requirements for BH organizations; acknowledgement that state may contract with a single CVO and we will agree to utilize with at least 90 days notice before implementation. • Added Attachment Y: MHS Health Wisconsin Unique Credentialing Requirements • Added query of CMS Preclusion list to core policy	4/2019
• Updated New Hampshire Healthy Families Unique Requirement Grid to clarify time frame and liquidated damages requirements.	6/2019
• Updated Trillium Unique Requirement grid with regulatory citation for exclusion monitoring, and CLIA. • Removed requirement for supervising/collaborative agreement for LADC (it is not applicable).	7/2019
• Revised language in Core section of Policy IX. A. vii – review of work history. The language added doesn't change our current process, but helps to clarify and align with guidance in other sections of the policy. • In section III.B.ii – (DEA Coverage Plan) replaced the word 'physician' with 'practitioner'. This is not a change in policy, instead we updated the word for clarification as it is understood that DEA is not limited to physician only, and neither is the coverage plan.	11/2019
• Updated Trillium/HealthNet Oregon Unique Requirements to comply with Contract requirements. Notably, requirement to verify licensure expiration and non-renewal; and specific language regarding not applying licensure for Indian Health Services. • Updated Ambetter TN Unique Requirements with numbers 1-4	12/2019
• **Updated Louisiana Healthcare Connections Unique Requirements with the following:** report to LDH within 3 days those participating providers terminated due to exclusions; added footnote denoting that behavioral health providers are LMHPs for Healthy Louisiana Contract; updated the reference entity of the LA State Exclusion list site from DHHS to LDH; removed the requirement that providers must be enrolled in LA Medicaid to participate; practitioners who do not meet timeliness for recredentialing requirementss are sent notice of termination effective 15 days from date of the notice, claims for services provided prior to the termination date will be paid; If participating provider is presented to Credentialing	2/2020

Committee for recredentialing and is denied – letter is sent effective 15 days from the date of the notice; removed older/duplicative item related to compliance with Act 358, the item removed referenced completion of cred within 90 days, the correct item remains with a completion within 60 days; added requirement to send a minimum of 3 written notices with the firs issued no later than 6 months prior the expiration of current credentialing. • **Updated Core policy** Process III.B (page 20) to clarify DEA covering plan to align with NCQA language which requires Name of the covering provider, but, does not require the DEA number of the covering provider; updated Process II.A (page 12) with clarifying language for the requirements for license review. Verification of active/valid license in all states where practitioner sees our members, and review for sanctions, license disciplinary actions, and scope of practice restrictions for all active state licenses even in those states which the practitioner may not see members. Clarified sources for each. • Updated reference section for OR slightly. Changed the former OAR 410-141-3420 to OAR 410-141-3120	
• Updated Core policy language for query of NPPES to clarify that the NPI must be unique for every provider type • Update New Hampshire Healthy Families Unique Requirements attachment to clarify that providers submitting new or missing information will be acted upon within 10 business days. • Updated New Hampshire Healthy Families Unique Requirement attachment to clarify that Medicaid ID is required.	3/2020
• Updated Western Sky Community Care, Inc (New Mexico) Unique Requirement attachment to clarify requirement for Medicaid participation is for the Medicaid product; added language to note that contract shall not include a clause relieving either party (contractor or health carrier) of liability for actions or inactions; added clarification that the credentialing verification program will be provided to the regulator/superintendent upon request. • Updated Absolute Total Care Uniqe Requirement attachment – Requirement to collect Disclosure of Ownership is no longer required for any product. • Added Unique Requirement Attachment for Ascension Joint Venture network. • Added Unique Requirement Attachment for ICNF network.	6/2020
• **Updated Coordinated Care Unique Requirement attachment with updated language regarding timeliness for credentialing and specification of reimbursement to occur upon receipt of complete credentialing application.** • **Clarified 'References' sections to include reference to State and Federal Regulations for credentialing and recredentialing.** • **Clarified Unique Requirement for Western Sky Community Care, Inc. are inclusive of Ambetter from Western Sky Community Care.**	8/2020

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Corporate Credentialing: __Approval on file_____

Attachment A

CeltiCare Health Plan

Unique Requirements for Credentialing

1. Celticare Health Plan requires recredentialing of practitioners every twenty-four (months).

2. CeltiCare Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application.

3. CeltiCare Health Plan requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.

4. CeltiCare Health Plan requires verification of the MA CSR, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement. The document does not contain an expiration date. The certificate is valid for three (3) years from date of issuance for physicians and one (1) year for non-physician mid-level practitioners.

5. CeltiCare Health Plan requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10.

6. For CeltiCare Health Plan non-physician mid-level practitioners a copy of the physician collaborative agreement is obtained for the credentialing file.

7. CeltiCare Health Plan applicants must be notified of the credentialing committee decision on an initial application within four (4) business days. The notice shall include the committee decision and the decision date.

8. CeltiCare Health Plan is required to accept and utilize the Integrated Massachusetts Application for Initial Credentialing and the Integrated Massachusetts Application for Recredentialing

9. Physician Assistants shall not be approved for credentialing as a primary care physician for CeltiCare Health Plan.

Attachment B

Magnolia Health Plan

Unique Requirements for Credentialing

1. Magnolia Health Plan requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application, if applicable.
2. Magnolia Health Plan is required to accept and utilize the Mississippi Participating Physician Form for the credentialing application.

3. Magnolia Health Plan verification sources for Malpractice Insurance coverage include current copy of insurance certificate, Federal Tort letter or primary source verification document with the Carrier.

4. Magnolia is required to ensure that all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include a current copy of certificate or waiver, or information obtained directly from CLIA. If the Laboratory Services section of the application is blank, Magnolia Health Plan will consult the Provider Data Form submitted with the contract to confirm whether CLIA verification is appropriate.

5. Magnolia shall ensure that all providers are enrolled as a Medicaid Provider and that all active network providers are enrolled using the same National Provider Identifier (NPI) numbers. Acceptable source for confirmation Medicaid enrollment shall be a review of a file of participating Medicaid providers supplied by the Department of Medicaid.

6. Magnolia Health Plan will verify that Nurse Practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility. Nurse Practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting as PCPs.

7. Magnolia Health Plan shall credential all completed application packets within ninety (90) calendar days of receipt. In cases of network inadequacy, Magnolia Health Plan shall credential all completed application packets within forty-five (45) calendar days of receipt. Magnolia Health Plan shall notify the Division of any Provider applications requiring longer than ninety (90) calendar days via monthly report. Credentialing must be completed before final execution of the contract with the Provider.

8. Magnolia Health Plan shall notify the Division within ten (10) calendar days of the denial of a Provider credentialing application either for program integrity-related reasons or due to limitations placed on the Provider's ability to participate for program integrity-related reasons.

9. The Magnolia Health Plan shall conduct site visits for all providers in accordance with the process outlined in Policy and Procedure MS.CONT.03 Site Assessments for New Provider Contracts.

10. Magnolia Health Plan requires the use of credentialing and recredentialing standards set forth by the National Committee for Quality Assurance (NCQA) and EQRO recommendations

11. Magnolia Health Plan shall notify a practitioner within five (5) business days of any missing or invalid information that would impede completion of credentialing and/or contracting.

12. Magnolia Health Plan will load provider information into it’s claims processing system within thirty (30) calendar days of provider contract approval.

13. The Medicaid MS Sanctioned Provider List shall be queried at initial and recredentialing and proof of query will be included in the files.

14. Magnolia Health Plan LPC’s are not eligible to enroll into Medicaid; therefore, a Medicaid number is not required for this particular state.

Attachment C

Louisiana Healthcare Connections (LHC)

Unique Requirements for Credentialing

1. Louisiana Healthcare Connections will accept and utilize the Louisiana Standardized Credentialing Application or the CAQH Application for the credentialing application.

2. Louisiana Healthcare Connections requires verification of the LA controlled dangerous substance certificate, if applicable. A current copy of the certificate is considered a valid source for meeting the requirement or primary source verification.

3. All changes to this Policy & Procedure shall be submitted to the DHH when a change is made and annually thereafter.

4. Louisiana Healthcare Connections requires board certification or alternate educational and clinical pathways as outlined in CC.CRED.10

5. Louisiana Healthcare Connections shall notify LDH of denial of a Provider credentialing application for program integrity-related reasons or otherwise limits the ability of Providers to participate for program integrity-related reasons.

6. Per Louisiana – Act 358. Interim credentialing requirements: Under certain circumstances and contingent upon the provisions of this Subsection being met, a managed care organization contracting with a group of physicians that bills a managed care organization utilizing a group identification number, such as the group federal tax identification number or the group National Provider Identifier as set forth in 45 CFR 162.402 et seq., shall pay the contracted reimbursement rate of the physician group for covered health care services rendered by a new physician to the group, without health

care provider credentialing as described in this Subpart. This provision shall apply in each of the following circumstances:

a. When the new physician has already been credentialed by the managed care organization and the physician's credentialing is still active with the managed care organization.

b. When the managed care organization has received the required credentialing application and information, including proof of active hospital privileges, from the new physician and the managed care organization has not notified the physician group that credentialing of the new physician has been denied.

c. A managed care organization shall comply with the provisions of Subsection A of this Section no later than thirty days after receipt of a written request from the physician group.

7. Louisiana Healthcare Connections shall completely process credentialing applications from all types of providers within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documents and attachments, and a signed provider agreement. "Completely process" shall mean that LHC shall:

   a. Review, approve, and load approved applicants to its provider files in its claims processing system;

   b. Submit on the weekly electronic Provider Directory to the LDH or LDH's designee, or

   c. Deny the application and assure the provider is not used by the MCO.

8. Louisiana Healthcare Connections utilizes Provisional credentialing to meet the requirement to process expedited and temporary credentials.

9. Louisiana LDH Adverse Action List shall be queried.

10. LHC shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c- 5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings:

    a. Revocation of the provider's home and community-based services license or behavioral health service license;

    b. Exclusion from the Medicaid program;

    c. Termination from the Medicaid program;

    d. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41);

e. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or

f. The Louisiana Attorney General's Office has seized the assets of the service provider.

11. LHC shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.
12. Louisiana Healthcare Connections understands that the State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, LHC and our subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. LCH will be given at least 90 days' notice before implementation of any CVO contract.
13. Louisiana Healthcare Connections will report to LDH those participating providers who have been terminated due to exclusion within three (3) business days.
14. Behavioral Health Services Providers - Licensed Mental Health Practitioners for Louisiana Healthcare Connections for the Healthy Louisiana contract.
15. Louisiana Healthcare Connections will provide a minimum of three (3) written notices to a contracted provider with information regarding the recredentialing process, including requirements and deadline for compliance. The first notice shall be issued no later than six (6) months prior to the expiration of the provider's current credentialing. The notice shall include the effective date of termination if the provider fails to meet the requirements and deadlines of the recredentialing process.
16. For those practitioners who fail to meet timely recredentialing requirements, Louisiana Healthcare Connections will send termination notice via certified mail, effective fifteen (15) days from the date of the notice. Claims will be paid for services delivered prior to the termination date.

17. For those practitioners reviewed by Committee for recredentialing and denied continued participation, Louisiana Healthcare Connections will send a termination notice effective fifteen (15) days from the date of the notice via certified to the last mailing and email address submitted by the provider.

Attachment D

IlliniCare Health Plan

Unique Requirements for Credentialing

1. IlliniCare Health Plan will accept and utilize the Illinois Health Care Professional Credentialing and Business Data Gathering Form or the CAQH Application for the credentialing application.

2. IlliniCare Health Plan shall ensure that all providers are enrolled as a Medicaid Provider. Acceptable source for confirmation of Medicaid enrollment shall be a review of a file of participating Medicaid providers supplied by the Department of Medicaid.

3. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

4. IlliniCare Health Plan requires recredentialing of practitioners at least every 3 years based on the last digit of their social security number. A recredentialing cycle cannot occur more than once in this 3 year cycle.

Attachment E

Home State Health Plan

Unique Requirements for Credentialing

1. Home State Health Plan will accept and utilize the CAQH Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180 (as amended), as the credentialing application for all practitioner credentialing in compliance with section 2.18.8c of the contract.
2. Home State Health Plan will require each that ordering and referring professional providing services to Home State Health Plan members have a national provider identifier (NPI) in accordance with 45 CSR 162.410 in accordance with Sections 2.2.6 and 3.9.6w of the contract. Home State Health Plan will query the National Plan & Provider Enumeration System https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do at the time of initial and recredentialing to confirm that the practitioner has a current, valid NPI.
3. Home State Health Plan requires verification of Bureau of Narcotics and Dangerous Drugs issued by the Missouri Department of Health & Human Services, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement. Alternately, this may be verified on line: https://webapp01.dhss.mo.gov/mohworx/RegistrantSearch.aspx
4. As per Missouri 376.1578: A health carrier shall assess a health care practitioner's credentialing information and make a decision as to whether to approve or deny the practitioner's credentialing application within sixty business days of the date of receipt of the completed application. A completed application is a practitioner's application to a health carrier that seeks the health carrier's authorization for the practitioner to provide patient care services as a member of the health carrier's network and does not omit any information which is clearly required by the application form and the accompanying instructions. The sixty-day deadline established in this section shall not apply if the application or subsequent verification of information indicates that the practitioner has:
    a. A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;
    b. Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;
    c. Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or
    d. A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit.
5. Home State Health Plan will notify the state agency of any denial of provider credentialing or re-credentialing in a timely manner and will report provider terminations as part of its quarterly fraud and abuse report following the State provided forms.

6. Home State Health Plan will initially submit Credentialing Policies & procedures to MO HealthNet for approval in compliance with section 2.18.8c, 2.18.8c5, 3.9, 3.9.6 of the contract and thereafter as changes are made.
7. Home State Health Plan may execute network provider agreements pending the outcome of Medicaid enrollment of up to 120 days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b).

Attachment F

Coordinated Care

Unique Requirements for Credentialing

1. Coordinated Care will utilize the Washington Practitioner Application to process credentialing for all practitioners that require credentialing. The database selected pursuant to RCW 48.165.035 must be used to manage credentialing applications from health care providers. Coordinated Care will not require a health care provider to submit credentialing information in any format other than through the database selected pursuant to RCW 48.165.035

2. Coordinated Care shall ensure that all providers are enrolled in Washington as a Medicaid Provider. Acceptable source for confirmation of Medicaid enrollment shall be a review of the Provider One website.

3. Any excluded individuals and entities discovered as a result of screening for Fraud, Waste and Abuse during the provider application, credentialing and recredentialing processes, must be reported to HCA within five (5) business days of discovery. Credentialing staff will report identified excluded individual/entities to the Compliance Department, who will report to HCA using HCA PIR006- WA Excluded Individual Template.

4. Coordinated Care Health Plan allows active duty military service providers a period of at least one hundred twenty days to complete the recredentialing process after return to civilian status. The one hundred twenty days will begin no earlier than the date the provider's period of active duty ends.

5. Coordinated Care recognizes and credentials Centers of Excellence (COE) and Applied Behavior Analysis (ABA) therapy providers that provide ABA therapy services under the Applied Behavior Analysis Program and in accordance with WAC 182-531A-0900

6. Coordinated Care will will a determination approving or denying a credentialing application no later than ninety (90) days after receiving a complete application from a health care provider. All determination made in approving or denying credentialing applications must average no more than sixty (60) days. This criteria does not apply to health care entities that utilize credentialing delegation arrangements. Credentialing means the collection, verification, and assessment of whether a health care provider meets relevant licensing, education, and training requirements.

7. Coordinated Care will provide notification of Committee Decision within 10 calendar days.

8. When credentialing a new health care provider through a new provider contract, Coordinated Care reimburses the health care provider for covered services provided to

members retroactively to the date of contract effectiveness if the credentialing process extends beyond the effective date of the new contract. When credentialing a provider to be added to an approved and in use provider contract where a relationship already existed between Coordinated Care and the healthcare provider or entity for whom the health care provider is employed or engaged at the time health care provider submitted the completed credentialing application, Coordinated Care will reimburse the health care provider for covered services provided to members during the credentialing process beginning when the health care provider submitted a completed credentialing application. Coordinated Care will reimburse the health care provider at the contracted rate for the applicable health benefit plan that the health care provider would have been paid at the time the services were provided if the health care provider were fully credentialed.

Attachment G

Kansas Sunflower State Health Plan
Unique Requirements for Credentialing

1. In accordance with the State Uniform Credentialing and Recredentialing MMIS Policy, Kansas Sunflower State Health Plan will accept and utilize the State of Kansas Standard Credentialing Application/CAQH to process credentialing for all providers/practitioners that require credentialing.

2. Kansas Sunflower State Health Plan shall obtain copies of the valid CLIA certificates from the laboratories and/or all entities providing laboratory services funded by Title XIX and Title XXI of the Social Security Act at credentialing and recredentialing. Per state, when a copy of CLIA is unavailable, a screen shot of CLIA certification via CMS website is acceptable. Kansas Sunflower State Health Plan shall provide a listing to the State of all laboratories and/or entities providing laboratory services and shall certify to the State that the laboratories and/or entities providing laboratory services are CLIA certified. Kansas Sunflower State Health Plan shall update the listing and certification as laboratories and/or entities providing laboratory services are added to or dropped from the list.

3. Kansas Sunflower State Health Plan shall ensure that credentialing of all service providers applying for network provider status shall be completed as follows: 90% within 30 days; 100% within 45 days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Credentialing Committee's decision.

4. Kansas Sunflower State Health Plan accepts the State minimum insurance of $200,000/$600,000 per Kansas State Statute.

5. Sunflower Health Plan accepts HCBS Autism and/or State Plan Autism Serviceproviders who are Medicaid enrolled, meet the criteria as an Autism Specialist (CCTS) or IIS. The CCTS Provider will be either a 1) Board Certified Behavior Analyst (BCBA) licensed through the Kansas Behavioral Sciences Regulatory Board (KS BSRB) or 2) an individual with a Master's degree, preferably in Human Services or Education, with 2,000 hours of supervised experience working with a child with an Autism Spectrum Disorder and completion of state approved training curriculum (prior to or within six (6) months of receiving notification of being an approved Medicaid provider).

6. The IIS worker will be at least eighteen years of age with a high school diploma or equivalent; documentation of 1000 hours of experience working with a child with an Autism Spectrum Disorder and the completion of the state approved training

curriculum. This provider will work under the direction of the BCBA or other qualified CCTS practitioner.

7. If a provider is KMAP approved, Sunflower Health Plan will not require documentation in excess of the requirements in the state contract.

8. In accordance with the Addictions Counselor Licensure Act, the Company must provide assurance that addiction counselors are licensed by the Behavioral Sciences Regulatory Board (BSRB). The Company must ensure that any provider of Substance Use Disorder (SUD) treatment services in a facility setting be licensed by the Kansas Social & Rehabilitation Services (SRS) to provide SUD treatment services. Any provider determining the medical necessity of such services according to the Kansas definition must be a BSRB-licensed practitioner practicing within their scope as defined by the BSRB. Omnibus Health Bill – HB 2182, 2011: Expands independent practice, as applied to addiction counseling and licensed clinical addiction counselors, to include not only the diagnosis and treatment of substance abuse disorders but to allow for both independent practice and diagnosis and treatment of substance abuse disorders; and allows a licensed addiction counselor, on and after July 1, 2011, to practice in treatment facilities exempted under KSA 59-29b46.

Attachment H

New Hampshire Healthy Families Health Plan
Unique Requirements for Credentialing

1. New Hampshire Healthy Families will credential all service providers applying for network provider status in the following timelines: primary care providers within 30 calendar days of receipt of clean and complete credentialing applications; Specialists within 45 days of receipt of clean and complete credentialing applications. The start time begins when New Hampshire Healthy Families has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status. In the event the Provider's credentialing application is not processed within the these time frames, the Provider will be paid retroactive to thirty (30) calendar days or forty five (45) calendar days after receipt of the Provider's clean and complete application. For each day an application is delayed beyond the prescribed timeframe, the Health Plan will be fined in accordance with Exhibit N (Liquidated Damages Matrix) in the New Hampshire Medicaid Care Management Services Model Contract.

2. New Hampshire Healthy Families' Contracting team will conduct outreach to prospective Participating Providers within ten (10) business days after receiving notice of the Provider's desire to enroll, and will concurrently work through the Health Plan's and the DHHS contracting and credentialing processes with Providers in an effort to expedite the Provider's network status.

3. New Hampshire Healthy Families is required to ensure that all laboratory testing sites providing services have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number. Acceptable formats for review include application attestation, current copy of certificate or waiver, or information obtained directly from CLIA.

4. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

5. New Hampshire Healthy Families requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application.

6. New Hampshire Healthy Families shall ensure that all providers are enrolled as New Hampshire Medicaid providers, they must have a NH Medicaid identification number.

7. New Hampshire Healthy Families requires all practitioners to be licensed or certified in accordance with the laws of New Hampshire.

8. New Hampshire Healthy Families shall offer contracts to Medicaid enrolled SUD providers who meet the Health Plan's credentialing standards.

9. For any provider submitting new or missing information for it's credentialing application, New Hampshire Healthy Families will act upon the new or updated information within ten (10) business days.

Attachment I

California Health and Wellness Plan
Unique Requirements for Credentialing

1. All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and are appropriately licensed, certified or registered. All providers of Medi-Cal managed care services must have good standing in the Medicare and Medicaid/Medi-Cal programs. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in California Health and Wellness Plan's provider network for Medi-Cal managed care.

2. All providers of Medi-Cal managed care services must have a valid National Provider Identifier (NPI) number.

3. California Health and Wellness Plan shall ensure that all contracted laboratory testing sites for use in Medi-Cal managed care have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

4. The California Health and Wellness Plan shall conduct Facility Site, Medical Record, and Facility Site Physical Accessibility reviews on all Primary Care and high volume provider sites by reviewers who are appropriately trained, monitored, and evaluated. These site visits shall consist of initial surveys and subsequent periodic site inspections conducted at least every three (3) years. The California Health and Wellness Plan shall use Med-Cal Managed Care Division survey criteria and scoring methodology for site and medical record audits. The initial full scope site review survey can be waived by a plan for a pre-contracted provider site if the provider has documented proof that a current full scope survey with a passing score was completed by another plan within the past three years.

5. Effective 1/1/2018, all California Health & Wellness network providers must enroll in the Medi-Cal Program. California Health & Wellness relies on the enrollment and screening results conducted by DHCS and will access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers.

6. The California Health and Wellness Plan recognizes and credentials Qualified Autism Service (QAS) providers, professionals, and paraprofessionals that provide Behavioral Health Therapy (BHT) services in accordance with Section 1374.73 of the California Health and Safety Code.

Attachment J

Absolute Total Care Plan
Unique Requirements for Credentialing

1. Absolute Total Care will report to SC DHHS any excluded individuals and entities discovered as a result of screening for fraud, waste and abuse during the provider application, credentialing or recredentialing process. Credentialing staff will report to the Compliance Department, who will submit the report to the SC DHHS and other regulatory agencies as necessary.

2. For the state of South Carolina's (SC) report of exclusions based on fraud, convictions, loss of license, patient abuse and other reasons, the SC Excluded Providers Listing and the Termination for Cause List on the SC DHHS website, SC List of Suspended Providers, Behavioral Health Actions and any other databases as the Department or Secretary of Health and Human Services may prescribe shall be queried during the credentialing/recredentialing process.

3. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

4. Absolute Total Care shall ensure that all offices with laboratory services have Clinical Laboratory Improvement Act (CLIA) certificates or waivers. Certificates or waivers may be primary source verified or a copy of the certificate or waiver is acceptable.

5. Credentialing or recredentialing policies and procedures must be submitted to SCDHHS for approval prior to implementing the changes. The changes must be submitted to SCDHHS prior to implementation and follow the same submission process as changes outlined in the contract submission process.

6. Any type of provider who is denied credentialing or recredentialing by Absolute Total Care, regardless of the reason, will be reported to the SC Division of Program Integrity/SUR and SC DHHS. Credentialing staff will notify the Compliance Department, who will provide the notification.

7. Medical professionals to include, but not limited to physicians, physician's assistants, certified nurse midwives/ licensed midwives, certified registered nurse anesthetists (CRNAs)/ anesthesiologist assistants (AAs), nurse practitioners/ clinical nurse specialists, podiatrists, chiropractors, private therapists and audiologists must all be licensed and certified to practice by the appropriate Board/ Licensing body (i.e., Board of Medical Examiners, Board of Nursing, Council on Certification of Nurse Anesthetists, Board of Podiatry Examiners, Board of Chiropractic Examiners, Board of Occupational

Therapy, Board of Physical Therapy, Board of Examiners in Speech Language Pathology and Audiology).

8. For all other state agencies and organizations, including the Department of Alcohol and Other Drug Abuse, The South Carolina Department of Mental Health, The Department of Social Services, The Department of Health and Environmental Control, local education agencies, Rehabilitative Behavioral Health providers (public and private) and The Department of Disabilities and Special Needs, the MCO will credential the state agency/organization rather than the individual providers in the agency/organization. The state agency/organization is responsible for screening and exclusions for any employees utilized for service provision.
9. Absolute Total Care recognizes that some 'atypical' Provider types may not have NPI.
10. Disclosure of Ownership form is not required for submission for any ATC product.
11. Absolute Total Care shall ensure all providers are enrolled in South Carolina Medicaid.
12. Absolute Total Care requires hospital privileges or alternate admitting arrangements at an in network hospital.
13. Absolute Total Care will ensure that Nurse Practitioners are able to perform those services allowed within the parameters of the SC Nurse Practice Act (State Statute Section 40–33) by verifying NP license status, review of formal, written protocols as evidence of a collaborative/consultative relationship with a licensed physician participating in the network;
14. Contract section 2.8.2.4.2, Absolute Total Care (ATC) will completely process credentialing applications within sixty (60) calendar days of receipt of a completed credentialing application. Complete application is defined as all necessary documentation and attachments, and a verify that there is a process in place to accommodate medically necessary hospital admissions.
15. In accordance with South Carolina model MCO contract, completely process means the ATC shall review, approve, and load approved applicants to it's Provider files in it's claims processing system or deny the application and assure that the Provider is not used by ATC.

Attachment K

Michigan Complete Care

Unique Requirements for Credentialing

1. Michigan Complete Care requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application, if applicable.

2. Michigan Complete Care shall ensure that all offices with laboratory services have Clinical Laboratory Improvement Act (CLIA) certificates or waivers. Certificates or waivers may be primary source verified or a copy of the certificate or waiver is acceptable.

3. To ensure practitioner has not opted-out of receiving Medicare funds the regional Medicare administrator must be queried for the applicable state in which the practitioner is providing services to Plan members.

4. Michigan Complete Care must have a formal process by which a health professional may submit supplemental or corrected information to the Plan's Credentialing Committee and request a reconsideration of the health professional's credentialing verification application if the health professional feels that the Plan's Credentialing Committee received information that is incorrect or misleading.

Attachment L

Trillium/HealthNet Oregon
Unique Requirements for Credentialing

1. Trillium Community Health Plan will apply for DMAP when necessary. Practitioners who have submitted a credentialing application for Medicaid participation, but have not yet been approved by Medicaid, will be allowed to go through the credentialing process. Network participation may be pended up to 120 days until the Medicaid approval has been received and confirmed. If after 120 days the provider cannot be enrolled with OHA, Contract team will terminate the contract immediately.
2. Trillium shall ensure that individuals or programs have a letter of approval or license from OHA for the Substance Use Disorders services they provide and meet all other applicable requirements of the Medicaid contract, except that Providers under The Drug Addiction Treatment Act of 2000, Title 42 Section 3502 Waiver may treat and prescribe Buprenorphine for opioid addiction in any appropriate practice setting in which they are otherwise credentialed to practice and in which such treatment would be Medically Appropriate.
3. Trillium will not refer Members to or use Providers who have been terminated from OHA or excluded as Medicare, CHIP or Medicaid Providers by CMS or who are subject to exclusion for any lawful conviction by a court for which the Provider could be excluded under 42 CFR 1001.101 and 42 CFR 455.3(b). Trillium will not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act and in accordance with 42 CFR 438.214(d). Trillium will not accept billings for services to Members provided after the date of the Provider's exclusion, conviction, or termination. If Trillium knows or has reason to know that a Provider has been convicted of a felony or misdemeanor related to a crime, or violation of federal or state laws under Medicare, Medicaid, or Title XIX (including a plea of "nolo contendere"), Trillium will immediately notify OHA's Provider Services Unit.
4. If Participating Providers (whether employees or Subcontractors) are not required to be licensed or certified by a State of Oregon board or licensing agency, Trillium will document, certify and report on Exhibit G the date that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.
   (1) If Participating Providers are not required to be licensed or certified by a State of Oregon board or licensing agency, then, in accordance with:
   Coordinated Care Organization – Amended and Restated Effective: January 1, 2018
   Contract # (XXXXXX) Exhibit B – Part 8 Page 114 of 224
   (a) Participating Providers must meet the definitions for QMHA (qualified mental health associate) or QMHP (qualified mental health professional) as described in Exhibit A, Definitions and provide services under the supervision of a LMP (licensed medical practitioner) as defined in Exhibit A, Definitions; or
   (b) For Participating Providers not meeting either the QMHP or QMHA definition,

Trillium shall document and certify that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.

*The State of Oregon monitors the agencies and provides oversight for non-licensed behavioral health practitioners. Access to verification information is with the State of Oregon CCO Document Bank.

5. Trillium will ensure that its employees, Subcontractors and facilities are prepared to meet the special needs of Members who require accommodations because of a disability or limited English proficiency. Trillium will include in its Grievance and Appeal procedures, described in Exhibit I, a process for Grievances and Appeals concerning communication or access to Covered Services or facilities.
6. Trillium will only use psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0340
7. In addition to access and Continuity of Care standards specified in the rules cited in Subsection a, of the OHA contract section, Trillium will establish standards for access to Covered Services and Continuity of Care which are consistent with the Accessibility requirements in OAR 410-141-3220.
8. Practitioners are allowed to submit the CAQH or the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application.
9. Trillium will screen providers for compliance with 42 CFR 455 Subpart E (42 CFR 455.410 through 42 CFR 455.470) and retain all resulting documentation for audit purposes
10. Trillium shall ensure that data received from providers, either directly or through a third party, is accurate, truthful, and complete in accordance with OAR 410-120-1280 and OAR 410-141-3420 by:
    a. Verifying the accuracy and timeliness of data reported
    b. Screening the data for completeness, logic, and consistency
    c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with OHA Electronic Data Transmission (EDT) procedures in OAR Chapter 943 Division 120.
11. Ownership and Disclosure information to be submitted on OR Form 3974
12. Trillium/HealthNet Oregon shall and shall ensure that any Laboratories used by Contractor shall comply with the Clinical Laboratory Improvement Amendments (CLIA 1988), 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories, which require that all laboratory testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those Laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.
13. Trillium/HealthNet Oregon shall provide accurate and timely information to the Authority about License or Certification expiration and renewal dates; whether a

provider's license or certification is expired or not renewed or is subject to licensing termination, suspension or certification sanction.

14. Trillium/HealthNet Oregon shall not apply any requirement that an entity operated by the HIS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. This requirement is pursuant to 25 USC 1621t and 1647a. Trillium/HealthNet Oregon shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another state. Contracts will be offered to all Medicaid eligibile IHCPs and to provide timely access to specialty and primary care within their networks to enrolled IHS beneficiaries seen and referred by IHCPs, regardless of the IHCPs status as contracted provider within the network.

15. Each atypical provider is required to be enrolled with the Authority and shall obtain and use registered National Provider Identifiers (NPIs) and taxonomy codes reported to the Authority in the Provider Capacity Report for purposes of encounter data submission prior to submitting encounter data in connection with services by the provider. Each qualified provider is required to have and use an NPI as enumerated by the National Plan and Provider Enumeration System (NPPES).

16. The provider enrollment request (for encounter purposes) and credentialing documents require the disclosure of taxpayer identification numbers. The Authority shall use taxpayer identification numbers for the administration of this program including provider enrollment, internal verification, and administrative purposes for the medical assistance program for administration of tax laws. The Authority may use taxpayer identification numbers to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), and Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of all tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification numbers may result in denial of enrollment as a provider and denial of a provider number for encounter purposes or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters

Attachment M

Arizona Complete Health
Unique Requirements for Credentialing

1. AZ Complete Health Medicaid Acute and ALTCS Plans follow all standards and elements outlined in AMPM 950.

2. Arizona Complete Health utilizes the option of Provisional credentialing when necessary to increase the available network of providers in medically underserved areas, whether rural or urban. This also includes providers in a Federally Qualified Health Center (FQHC), FQHC Look-Alike Center and hospital employed physicians (when appropriate). A decision regarding provisional credentialing is rendered within 14 calendar days from receipt of complete application.

3. Arizona Complete Health will include the name of the Supervising Physician for Physician Assistants in the Committee review materials.

4. Arizona Complete Health will report adverse credentialing actions to the AHCCCS Clinical Quality Management Unit within one business day.

5. Arizona Complete Health requires a review of malpractice history for a ten (10) year look back period from the date of presentation to committee for approval.

6. Arizona Complete Health will ensure the practitioner is listed as participating within thirty (30) calendar days of Credentialing Committee approval.

Attachment N

Pennsylvania Health and Wellness
Unique Requirements for Credentialing

1. Pennsylvannia Health and Wellness will initially submit Credentialing Policies & procedures to Pennsylvannia Department of Health for approval and changes shall be submitted for approval before implementation.
2. Pennsylvannia Health and Wellness will submit a report at least two (2) years regarding its credentialing process to include:
    a. The number of applications made to the plan
    b. The number of applications approved by the Plan
    c. The number of applications rejected by the Plan
    d. The number of providers terminated for reasons of quality

3. PA Health & Wellness reviews applications for the MAID number issued by DHS, however will not delay processing of Provider applications which do not contain the MAID number. Network participation will be pended until the Medicaid approval has been received and confirmed.

4. PA Health & Wellness will ensure that mid-level practitioners functioning as part of the PCP team are doing so within the scope of his or her license via collection and review of the collaborative agreement, protocols or other written authorization.

5. When an adverse credentialing decision is rendered, PA Health & Wellness will provide written notice which will include a clear and complete explanation of the rationale and factual basis for the determination. The notice shall include any utilization profiles used as a basis for the decision and explain the methodology for adjusting profiles for non-clinical management factors.

6. Pennsylvania Health and Wellness Clean File eligibility criteria is expanded to include a defined threshold for applicants with previous history of limitation o of licensure, malpractice claims, or privilege actions based upon an expanded level of review and determination by the Medical Director.
   Standard:

   No past or present suspensions or limitations of state licensure within a five (5) year look back period.

   Expanded:

   Past restrictions which have been lifted and were not related to alleged moral turpitude violations

   Voluntary surrender of license or privileges not due to avoidance of an investigation

   Medical Board reprimand(s) involving resolved fines and penalties due to CMEs (Continuing

   Medical Education) can be resolved at the Medical Director's level regardless of the time frame. The Medical Director can forward case(s) to the Credentialing Committee if the Medical Director desires.

   Medical Board reprimand(s) involving resolved fines and penalties due to documentation and/or records can be resolved at the Medical Director's level, if events took place over 5 years ago.

   The Medical Director can forward case(s) to the Credentialing Committee if the Medical Director desires.

   Standard:

   No malpractice claims that resulted in a settlement or a verdict in favor of the plaintiff (claims ruled in favor of the defendant are acceptable for a clean file) in a five (5) year look back period[125] from date of settlement.

   Expanded:

   Less than or equal to four (4) unrelated cases for initial applications; less than or equal to two (2) unrelated cases for recredentialing applications.

   Death or complication with indirect provider involvement.

Less than $2 Million per case or $5 Million total payment or settlement

Complication common to procedure or treatment not directly due to malpractice

Standard:

No current hospital membership or privilege restrictions and no history of hospital membership or privilege restrictions within a five (5) year look back period;

Expanded:

Resolved investigations at a facility that occurred over five years. Clinical privileges must have been restored. Medical Director can forward to the Credentialing Committee if deemed necessary

No additional actions or involvement occurring within the past 5 years for initial applicants and 3 years for recredentialing applicants.

Standard:

No history of or current use of illegal drugs or alcoholism

Expanded:

When the substance abuse treatment is beyond 5 years for initial applications and 3 years for

recredentialing applications

Standard:

No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

Expanded:

Health issues not limiting full scope of practice or access to services for Health Plan or a customer/client.

Standard:

No criminal/felony convictions, including a plea of no contest

Expanded:

Civil or Criminal Convictions (Misdemeanor) not related to violations of moral turpitude.

Attachment O

Nebraska Total Care
Unique Requirements for Credentialing

1. Nebraska Total Care Health Plan shall ensure that credentialing of all service providers applying for network provider status shall be completed within 30 days; from the-time when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Credentialing Committee's decision.

2. Nebraska Total Care will review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC's designee, or deny the application and ensure that the provider is not included in the Nebraska Total Care network. A provider whose application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.

3. Nebraska Total Care will accept provider credentialing information submitted via the Council for Affordable Quality Healthcare system. Nebraska Total Care will also accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.

4. A provider whose credentialing/re-credentialing application is denied will receive written notification of the decision, with a description of his/her/its appeal rights.

5. Nebraska Total Care shall ensure that all clinical laboratories provide verification of CLIA licensure (including the CLIA identification number) or Certificate of Waiver and is a minimum administrative requirement for participation in the network.

6. Nebraska Total Care will confirm the provider has a valid Medicaid Identification number. Acceptable source for confirmation shall follow MLTC requirements. Providers who have submitted an application as a Medicaid provider but have not yet been approved will be allowed to go through the credentialing process and, if necessary, network participation may be pended until the Medicaid provider application is approved or denied. Once approved, confirmation that a valid Identification number has been issued is performed and the network status may change from pending to participating.

7. Nebraska Total Care accepts the State minimum insurance limits of $500,000 per occurrence and $1,000,000 aggregate per policy period. For hospitals the required limits are $500,000 per incident and $3,000,000 aggregate per policy period. The

Nebraska Excess Liability Fund then provides coverage for any damages exceeding those amounts but falling below the applicable damage cap.

8. Nebraska Total Care recognizes the licensure for Provisional Licensed Mental Health Practitioners (PLMHP) and Provisional Licensed Alcohol and Drug Abuse Counselors (PLADC) as active and unrestricted.

Attachment P

Maryland Physicians Care (MPC)
Unique Requirements for Credentialing

1. For Maryland Physicians Care, Centene Health Plan refers to management services provided by Envolve, Inc

2. Practitioner credentialing and recredentialing files are maintained by the Envolve/Centene Credentialing Department and are made available upon request to the Maryland Physicians Care Quality Management Oversight Committee, accreditation agencies, state regulators, CMS and/or an External Quality Review Organization (EQRO) and to the extent required by law as determined by the appropriate regional general counsel. The Envolve/Centene Credentialing Department is responsible for monitoring the activities performed by the MPC Credentialing Committee and preparing summary reports of credentialing and recredentialing decisions for the MPC Quality Management Oversight Committee and MPC Board of Directors.

3. Maryland Physicians Care does not include Physician Assistants in their credentialing program. This mid-level practitioner type must be under the direct supervision of a physician and is not eligible for independent practice.

4. Maryland Physicians Care does not utilize the provisional credentialing option.

5. Practitioners who are denied initial participation for Maryland Physicians Care may reapply for admission into the network at any time following the initial denial.

6. Maryland Physicians Care requires a copy of the DEA certificate, and does not accept a DEA Coverage Plan in lieu of this requirement.

7. Maryland Physicians Care accepts the Maryland Uniform Credentialing form or CAQH. MPC accepts the Maryland Uniform Credentialing form or CAQH. Plan Contracting will return incomplete applications to provider at the address listed on the application within ten (10) days after the date application was received, and will indicate to provider what information is needed to make application complete. Within thirty (30) days of receipt of completed application, MPC shall send to the provider at the address listed in the application written notice of MPC's intent to continue to process the Provider's application to obtain necessary credentialing information or rejection of the provider for participation in the MPC provider panel. If MPC provides notice to the provider of its intent to continue to process the provider's application, MPC, within 120 days after the date notice is provided, shall: accept or reject the provider for participation; or send written notice of the acceptance or rejection to the provider at the address on the application. MPC will track the date of the application so that dates of credentialing can be calculated.

8. Maryland Physicians Care conducts an initial site visit of primary care practitioners, and primary care obstetricians to ensure that the practitioners' offices and medical record keeping practices meet MPC standards and compliance with the ADA. Site audits are performed for practitioners with a new location and/or not part of an existing group.

9. Maryland Physicians Care conducts a re-assessment of Provider Site for ADA compliance when the provider has relocated to a site that has not been previously evaluated and approved as being ADA compliant, or there is evidence of ADA non-compliance issues with a particular site of care delivery. Documentation of performance indicators provided by the Quality team to the Credentialing team for recredentialing review includes a notation regarding the results of the review for ADA compliance.

10. Maryland Physicians Care requires verification of the MD CDS, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement.

11. Maryland Physicians Care will include a review of EPSDT certification as part of the credentialing and recredentialing process for those PCPs who deliver preventive health care services to enrollees less than 21 years of age.

12. For Maryland Physicians Care if missing or expired information can not be secured within 21 calendar days of the first outreach attempt for initial credentialing but the Letter of Intent has gone out the application will proceed through the credentialing process as an Unclean File.

13. MPC Credentialing Committee determinations for Unclean Files are presented to the MPC Board of Directors who hold the authority for making final determinations

14. Maryland Physicians Care Clean File eligibility criteria is expanded to include malpractice claims with settlement amount under $49,999.99.

15. Files with History of Malpractice claims settled for over $50,000.00, within ten (10) year lookback period, which have been and all Open, Pending and Discovery Claims are designated as unclean and require review by Maryland Physicians Care Credentialing Committee and Board of Directors.
16. Maryland Physicians Care letter of denial includes reason and right to view and/or correct for currently participating providers only.

17. Request for reconsideration of non-administrative denials by new (non-participating) practitioners is not applicable to Maryland Physicians Care.

18. If a practitioner's credentials are terminated Maryland Physicians Care notifies appropriate regulatory boards or agencies. If appropriate, law enforcement is also notified.

Attachment Q

Nevada Silver Summit
Unique Requirements for Credentialing

1. Nevada SilverSummit shall ensure all providers are enrolled in Nevada Medicaid (this does not preclude the option to enter into a single case agreement with non-Medicaid providers if needed).

2. If Nevada Silver Summit decredentials, terminates or disenrolls a provider, Nevada Silver Summit will inform DHCFP Provider Enrollment Unit within five (5) business days.

3. Nevada SilverSummit shall ensure that all laboratory testing sites providing services under this contract have a valid Clinical Laboratory Improvement Amendments (CLIA) certificate or a waiver of certificate of registration, a CLIA identification number, and comply with CLIA regulations as specified by 42 CFR Part 493. Nevada SilverSummit shall provide to the DHCFP, on request, copies of certificates of any laboratories with which it conducts business.

4. Nevada SilverSummit recognizes the following additional provider licensure types as QMHPs:
   a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).
   b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.
   c. Psychological Assistants who hold a doctorate degree in psychology, is registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and is an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.
   Reimbursement for Interns/Psychological Assistants is based upon the rate of a QMHP, which includes the clinical and direct supervision of services by a licensed supervisor.

5. Nevada SilverSummit will have written policies and procedures that include a uniform documented process for credentialing, which include the vendor's

initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners. Nevada SilverSummit will comply with NAC 679B.0405 which requires the use of Form NDOI-901 for use in credentialing providers.The DHCFP reserves the right to request and inspect the credentialing process and supporting documentation. Nevada SilverSummit agrees to allow the DHCFP and/or its contracted EQRO to inspect its credentialing process and supporting documentation.

6. Nevada SilverSummit may not employ or contract with providers excluded from participation in the federal health care programs under Section 1128 of the Social Security Act.

7. Nevada SilverSummit retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners. Nevada SilverSummit has policies and procedures for the suspension, reduction or termination of practitioner privileges

8. Changes to the credentialing process will need to be provided in writing to the DHCFP's Provider Enrollment unit thirty (30) calendar days prior to the change. If the change is unanticipated, the vendor will notify the DHCFP's Provider Enrollment unit within five (5) calendar days of the change.

9. All credentialing policies will be reviewed and approved by the Governing Body or their delegate.

Attachment R

Arkansas Health and Wellness (AHW)
Unique Requirements for Credentialing

1. Primary Source Verification

Arkansas state law requires that credentialing information for MD/DOs must be requested from the Arkansas State Medical Board Centralized Credentials Verification Service (CCVS). This information must be requested within three business days of receiving a completed application. The CCVS Authorization and Release Form and the attestation form is faxed to the CCVS which will initiate primary source verifications. CCVS has 15 days to provide an initial profile, the Arkansas credentialing team has 60 days to complete credentialing.

When CCVS completes verification on a practitioner, an email is generated by CCVS to advise the Credentialing Specialist that the report is available on the Arkansas State Medical Board website. The credentialing/recredentialing report from the Arkansas State Medical Board Centralized Credentials Verification Service is printed and will be maintained in the credentialing file for MDs and DOs. Initial credentialing reports should verify the following information:

a. Current Arkansas state medical license
b. Current DEA certificate
c. Current malpractice insurance with minimum limits of $1 million/$3 million
d. Current clinical privileges in a participating network facility or documentation that such is not needed for practice.
e. Verification of education (medical school, residency, fellowship)
f. Work history from completion of the highest level of medical education with no unexplainable gaps of thirty (30) days or more. A written explanation of any work gap over thirty (30) days is provided by the Arkansas State Medical Board.
g. Medicare and Medicaid verification if applicable.
h. Verification of board certification if applicable
i. Criminal conviction information
j. Attestation signed and dated by applicant with questions regarding any physical or mental condition, illegal drug use, history of loss of license or DEA certificate, misdemeanor or felony charges or convictions, and privileges at hospitals or healthcare organizations

2. Processing of Credentialing Applications/Documents

Arkansas Health & Wellness utilizes the credentialing team to secure applications and associated documents, as well as verifying all requested documentation. The PDM team updates Portico with information after credentialing is completed.

3. Disclosure of Ownership/Interest Forms

Disclosure of Ownership/Interest forms are currently only required for practitioners providing services for products associated with the Arkansas Health & Wellness Health Plan HMO (Medicare/Medicaid).

4. Primary Source Verification for Recredentialing

Recredentialing files are pended until receipt of the CCVS report. The CCVS recredentialing report verifies all the elements of the initial credentialing report with the exception of education. Recredentialing reports will be printed and maintained in the provider file. CCVS has a thirty (30) day window in which recredentialing information may be requested.

5. Delegation to Cenpatico

Arkansas Health and Wellness accesses the NovaSys Health provider network. NovaSys Health does not delegate credentialing or re-credentialing of behavioral health practitioners and providers to *Cenpatico*. NovaSys Health is responsible for this process for all behavioral health practitioners and providers.

6. Provider Notification Requirements

The following notices must be sent to Practitioners within designated timeframes:

- Acknowledgement of application within 10 days of receipt
- Notice of incomplete application within 15 days of receipt
- Notice within 90 days to submit recredentialing application
- Notification of termination within 45 days which includes reason for termination

7. Allied Credentialing

Initial Allied credentialing applications must be completed within 180 days of receipt. All other steps follow regular procedure. Allied practitioners includes, but is not limited to the following:

- Doctor of Chiropractic
- Doctor of Podiatry Medicine
- Doctor of Dental Surgery specializing in Maxillofacial
- Licensed Certified Social Worker
- Licensed Professional Counselor
- Doctor of Philosophy (Ph.D.)
- Doctor of Education (Ed.D.)
- Doctor of Optometry
- Nurse Practitioner

8. Cases of Information Variance

In cases where information obtained from CCVS varies from information provided by the practitioner, Credentialing contacts the applicant by phone, e-mail and/or letter to alert the applicant to the variance. It should be clearly communicated to the applicant that all updated information must be submitted to CCVS and not the AHW Credentialing team. After the requested information is submitted to CCVS, a new profile will be available to the AHW Credentialing team.

9. Arkansas Prescription Monitoring Program

In order to encourage legitimate use; help curtail misuse and abuse; and assist in combating illegal trade in and diversion of controlled substances, an enrolled AHW practitioner that holds an active DEA certificate and licensure issued to provide healthcare services in Arkansas must attest that they are enrolled in the Arkansas Prescription

Monitoring Program ("AR PMP"). The enrolled consents to the Arkansas Department of Health confirming enrollment in AR PMP to AHW.

Attachment S

Western Sky Community Care, Inc (New Mexico); and Ambetter from Western Sky Community Care Unique Requirements for Credentialing

1. Because practitioners may participate in multiple products (Medicare, Medicaid, Exchange/Marketplace, Commercial), the unique requirements for Western Sky Community Care, Inc (New Mexico) and Ambetter from Western Sky Community Care are the same except where noted as product specific requirements.

2. Western Sky Community Care, Inc. will participate and collaborate with any statewide initiatives to standardize the credentialing/re-credentialing process, including the usage of one entity for primary source verification and collection and storage of provider credentialing/re-credentialing application information.

3. Western Sky Community Care, Inc (New Mexico) requires Contract providers within the Medicaid product to be enrolled with New Mexico Medicaid as a managed care provider.

4. The credentialing verification plan shall include a process to assess and verify the qualifications of providers applying to become participating providers within 45 calendar days of receipt of a provider's request for credentialing or a provider's completed uniform credentialing form, whichever is earlier. The plan shall allow for the following to take place within this 45 calendar days:

   (a) time required to obtain the completed uniform credentialing form in electronic format, if necessary; (b) time to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials; (c) a final decision by a credentialing committee if the health carrier's plan requires such review; and (d) time to notify the provider of the health carrier's decision.

5. Western Sky Community Care, Inc shall not use any provider credentialing application form other than uniform credentialing forms, as that term is defined in 13.10.28.7 NMAC. Exceptions are made if the provider is licensed and practices in a state other than New Mexico. Western Sky Community Care, Inc shall not require an applicant to submit information not required by the uniform credentialing or re-credentialing forms other than information or documentation that is reasonably related to information on the application.

6. Upon receiving a provider's request for credentialing or a provider's completed credentialing form, Western Sky Community Care, Inc and/or our agent shall review the application to verify that the application includes all necessary information and documentation that is reasonably related to the information in the application. We may initially attempt to obtain additional or missing information by informal means including but not limited to fax, telephone, or e-mail.

7. Western Sky Community Care, Inc and/or our agent shall notify the applicant by US certified mail within 10 days of receipt that the request for credentialing has been received, but that if the application is incomplete that the 45-day time period set forth in Subsection C of 13.10.28.11 NMAC shall not commence until the applicant provides all requested information or documentation. Except as may otherwise be required by a health carrier's accreditation organization a health carrier may not require a participating provider to be re-credentialed based on: a change in the provider's federal tax identification number; a change in the federal tax identification number of a provider's employer; or a change in the provider's employer, if the new employer: is a participating provider; or also employs other participating providers.

8. Reporting requirements. Each health carrier shall submit a report to the superintendent regarding its credentialing process for the prior two-year period beginning December 31, 2018, and on December 31 for all even numbered years thereafter, or as otherwise directed by the superintendent. The report shall include the following:
   - the number of applications made to the plan for each type of provider;
   - the number of applications approved by the plan for each type of provider;
   - the number of applications rejected by the plan for each type of provider;
   - the number of providers terminated for reasons of quality; and
   - the amount of time taken to review and reach a determination on an application.

9. A copy of the Western Sky Community Care, Inc Credentialing verification plan (policies) will be provided to the Regulator - NM Office of Superintendent of Insurance upon request.

10. No contract between Western Sky Community Care, Inc and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

11. Western Sky Community Care, Inc shall reimburse a provider, subject to co-payments, co-insurance, deductibles, or other cost-sharing provisions, for any clean claims for covered services, provided that:

- the date of service is more than 45 calendar days after the date the provider requested credentialing from the health carrier and either the provider supplied a completed uniform credentialing application or made the completed uniform credentialing application available for electronic access, including submission of any supporting documentation requested in writing during the initial 10-day review period;
- has approved, or has failed to approve or deny the applicant's completed uniform credentialing application within the timeframe established pursuant to Subsection C of 13.10.28.11 NMAC;

- the provider has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and
- the provider has professional liability insurance or is covered under the Medical Malpractice Act.

Sole practitioner. A provider who, at the time services were rendered has been approved for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was not in a practice or group that has contracted to provide services at specified rates of reimbursement, shall be paid in accordance with the standard reimbursement rate or at an agreed upon rate.

Provider group reimbursement. A provider who, at the time services were rendered, has been approved for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 NMAC and was in a provider group that has contracted to provide services at specified rates of reimbursement, shall be paid in accordance with the terms of the provider group contract.

Reimbursement period. Western Sky Community Care, Inc shall reimburse a provider pursuant to Subsections A, B, and C of 13.10.28.12 NMAC until the earlier of the following occurs: denial of the provider's credentialing application; approval of the provider's credentialing application and the provider enters a contract to replace a previously agreed upon rate, or the passage of three years from the date of receipt of the provider's completed uniform credentialing application.

12. **Credentialing and Payment Dispute Resolution Internal review process.** Western Sky Community, Inc will establish an internal process for resolving disputes regarding payment of claims for providers arising when a credentialing decision is delayed beyond the timeline found in Subsection C of 13.10.28.11 NMAC, the prompt payment deadline described in Paragraph (2) of Subsection A of 13.10.28.9 NMAC has passed, and payment has not been made. The internal process shall include required notification regarding pending claims and calculation and payment of interest on overdue claims, as described in Subsections C and D of 13.10.28.9 NMAC. The internal process shall provide for resolution of disputes regarding reimbursement rates as described in 13.10.28.12 NMAC. At a minimum, the internal review process shall provide for the following:

To initiate a payment dispute, the provider shall contact Western Sky Community Care, Inc in writing to determine the status of a claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim is considered to be a clean claim.

Western Sky Community Care, Inc shall respond in writing to a provider's inquiry regarding the status of an unpaid claim within 15 days of receiving the inquiry. The response shall explain its failure or refusal to pay, and the expected date of payment if payment is pending.

The internal review process may provide specific procedures for resolving payment disputes, including by not limited to, the use of mediation.

Attachment T

Carolina Complete Health, Inc.
Unique Requirements for Credentialing

1. Carolina Complete Health, Inc. accepts only the North Carolina DOI's 'Uniform Application to Participate as a Health Care Practitioner' and does not require an applicant to submit information not required by the application. This is in accordance with North Carolina General Statute 58-3-230.

2. Application processing timelines.

    a. **Complete App at time of Receipt:** (b) Within 60 days after receipt of a completed application and all supporting documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision. If, by the 60th day after receipt of the application, the carrier has not received all of the information or verifications it requires from third parties, or date sensitive information has expired, the carrier shall issue a written notification to the applicant either closing the application and detailing the carrier's attempts to obtain the information or verification, or pending the application and detailing the carrier's attempts to obtain the information or verifications. If the application is held, the carrier shall inform the applicant of the length of time the application will be pending. The notification shall include the name, address and phone number of a credentialing staff person who will serve as a contact person for the applicant.

    b. **Incomplete App at time of Receipt:** (c) Within 15 days after receipt of an incomplete application, the carrier shall notify the applicant in writing of all missing or incomplete information or supporting documents, in accordance with the following procedures: (1) The notice to the applicant shall include a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person for the applicant. (2) Within 60 days after receipt of all of the missing or incomplete information or documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision, in accordance with paragraph (b) of this rule. (3) If the missing information or documents have not been received within 60 days after initial receipt of the application or if date-sensitive information has expired, the carrier shall close the application or delay final review, pending receipt of the necessary information. The carrier shall provide written notification to the applicant of the closed or pending status of the application and where applicable, the length of time the application will be pending. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person to the applicant.

3. Nurse Practitioners and Physician Assistants must provide a copy of their physician collaborative agreement.

Attachment U

Next Level Health (IL Medicaid)
Unique Requirements for Credentialing

1. In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in the Next Level Health provider network, Next Level Health will verify that provider is enrolled in IMPACT. As stated in Contract item 5.9.4, Next Level Health is prohibited from requiring providers to undergo additional credentialing processes that are not part of the contract.

2. Contractor shall ensure that only those Providers that are approved and authorized by the Department are providing Covered Services under HCBS Waivers, and that those Providers are providing to Enrollees only Covered Services for which they are approved and authorized. The Department will provide Contractor with a weekly Department extract file containing the list of such approved and authorized Providers.

3. In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, Next Level Health does not have a Credentialing Committee.

Attachment V

Iowa Total Care

Unique Requirements for Credentialing

1. Iowa Total Care (ITC) shall submit provider network information via electronic file to the Department of Human Services (DHS) in the timeframe and manner defined by DHS. ITC shall keep provider enrollment and disenrollment information up-to-date.

2. The Provider Credentialing Report details the timeliness and effectiveness of the provider credentialing processes, including but not limited to credentialing committee and onsite provider reviews. Credentialing of all providers applying for network provider status shall be completed as follows: (i) eighty-five percent (85%) within thirty (30) calendar days; and (ii) one hundred percent (100%) within forty-five (45) calendar days. The start time begins when Iowa Total Care has received all necessary credentialing materials from the provider. If a request for additional materials, not already submitted by the provider, as a result of committee review, the time shall not be measured while waiting for the requested materials.Completion time ends when written communication is mailed or faxed to the provider notifying them of the credentialing decision.

3. Credentialing and re-credentialing process for all contracted providers shall meet the guidelines and standards of the accrediting entity through which ITC attains accreditation and in compliance with 441 Iowa Administrative Code Chapter 88 as well as all State and Federal rules and regulations.

4. When individuals providing covered services under the Contract are not required to be licensed or certified, ITC shall ensure, based on applicable state licensure rules and/or program standards, that they are appropriately educated, trained, qualified and competent to perform their job responsibilities.

5. ITC shall not permit the provider into the provider network if the Agency or Contractor determines that any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or CHIP, or if DHS or ITC determine that the provider did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1).

6. Physicians and Nurse Practitioners are eligible to provide PCP services, Physician Assistants are not eligible to provide PCP services.

7. For monitoring of Disclosure of Ownership forms, ITC follows process outlined in CC.COMP.27

Attachment W

Ambetter of Tennessee

Unique Requirements for Credentialing

1. Ambetter of Tennessee shall accept, in addition to its own credentialing and recredentialing applications, the credentialing and recredentialing applications from the Council on Affordable Quality Healthcare (CAQH). Ambetter is a participating organization of CAQH, and shall accept the application from either CAQH by electronic means or from the provider by electronic means or by a paper copy. The provider shall complete and submit the attestation clause of Ambetter of Tennessee before an application is considered complete.
2. Ambetter of Tennessee shall notify the health care provider of the results of the provider's clean CAQH credentialing application and shall notify the health care provider as to whether or not the health insurance entity is willing to contract with that provider within ninety (90) calendar days after receipt of the completed application (this notification is provided by the Contracting Department.
3. A clean CAQH application means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing.
4. Ambetter of Tennessee shall provide to any medical group practice with which there is an existing contract a list of all information and supporting documentation required for a credentialing application of a new provider applicant to be considered complete pursuant to subsection (f) of the Tenn Code Ann. 56-7-1001. **(A)** Ambetter Contracting Department will notify a new provider applicant in writing of the status of a credentialing application no later than five (5) business days of receipt of the application. The notice shall indicate if the application is complete or incomplete, and, if the application is incomplete, the notice shall indicate the information or documentation that is needed to complete the application. **(B)** If the application is incomplete and the new provider applicant submits additional information or documentation to complete the application, Ambetter shall comply with the requirements of subdivision (f)(2)(A) upon receipt of the additional information or documentation.**(C)** Ambetter shall notify a new provider applicant of the results of the new provider applicant's credentialing application within ninety (90) calendar days after notification from the Ambetter Contracting Department that the application is complete.**(D)** If a new provider applicant fails to submit a complete credentialing application to Ambetter within thirty (30) calendar days of notice of an incomplete application, then the application is deemed incomplete and credentialing is discontinued. If a new provider applicant fails to submit a complete network participation enrollment form, including signature evidencing intent to participate with the group and any other required documentation, to Ambetter within thirty (30) calendar days of notice of an incomplete application, then the new provider applicant is ineligible to receive the payment set out in (f)(3)(A).

Attachment X

Ambetter of Virginia

Unique Requirements for Credentialing

1. None

Attachment Y

MHS Health Wisconsin

Unique Requirements for Credentialing

1. MHS Health Wisconsin requires credentialing for locum tenens

2. MHS Health Wisconsin does not utilize the provisional credentialing option

3. MHS Health Wisconsin will accept and utilize CAQH or the Wisconsin Universal Application to process credentialing for all practitioners that require credentialing

4. MHS Health Wisconsin Ownership and Disclosure information is not required when providers are Wisconsin Medicaid enrolled as outlined in WI policy WI.CRED.19

5. MHS Health Wisconsin adds queries only for surrounding states, IA, IL, MI and MN

6. MHS Health Wisconsin does not perform provisional credentialing

7. MHS Health Wisconsin requires a copy of the DEA certificate, and does not accept a DEA Coverage Plan in lieu of this requirement

8. MHS Health Wisconsin requires primary source verification of hospital privileges at the practitioner's primary admitting hospital as indicated on the application

9. MHS Health Wisconsin requires clarification in writing for gaps exceeding six (6) months

10. MHS Health Wisconsin Ownership and Disclosure information is not required when providers are Wisconsin Medicaid enrolled as outlined in WI policy WI.CRED.19

11. MHS Health Wisconsin primary source verification criteria is expanded to include malpractice claims with settlement amounts under $250,000 and any claim resulting in a death

12. MHS Health Wisconsin applicants must be notified of the Credentialing Committee decision on an initial and re-credentialing application within thirty (30) calendar days. The notice shall include the committee decision and the decision date

Attachment Z

Ascension Joint Venture

Unique Requirements for Credentialing

1. None

Attachment AA

ICNF (Integrated Care Network of Florida)

Unique Requirements for Credentialing

1. None

Exhibit B-9

DEPARTMENT: Credentialing	**DOCUMENT NAME:** Practitioner Appeal Hearing Process
PAGE: 136 of 214	**REPLACES DOCUMENT:**
APPROVED DATE: 01/21/03	**RETIRED:**

EFFECTIVE DATE: 01/21/03	**REVIEWED/REVISED:** 4/2019; 2/2020; 6/2020; 8/2020; 3/2021
PRODUCT TYPE: All	**REFERENCE NUMBER:** CC.CRED.08

SCOPE:

Centene Corporate and Plan Credentialing ("Credentialing") on behalf of Centene Health Plans (the "Plan"). Medical Management and Provider Relations Departments. Plan-specific requirements are included in the Appendices.

PURPOSE:

To give practitioners the opportunity for appeal when the Credentialing Committee[126] recommends termination, revocation, or suspension of the practitioner's network participation for reasons relating to the competence or professional conduct of the practitioner.

POLICY:

A practitioner is entitled to an opportunity for a hearing in the event the Credentialing Committee recommends termination, revocation, or suspension of the practitioner's network participation for reasons relating to the competence or professional conduct of the practitioner, or in the event the practitioner is entitled by law to an opportunity for a hearing.

Opportunity for a Credentialing appeals hearing is afforded as follows:

A. The practitioner is entitled to an opportunity for a hearing in the event the Credentialing Committee recommends termination, revocation or suspension of the practitioner's network participation for *reasons relating to the competence or professional conduct of the practitioner, or in the event the practitioner is entitled by law to an opportunity for a hearing* [127].

B. In the event the Credentialing Committee recommends termination, revocation, or suspension of the practitioner's network participation for reasons relating to utilization review standards, measures, policies, rules or regulations of Plan, or pursuant to the terms of the practitioner's Participation Agreement, the Credentialing Committee may, at its discretion, afford the practitioner the opportunity for a hearing.

C. Notwithstanding any term or provision contained in this Policy and Procedure, no practitioner is entitled as a matter of right to more than a single hearing or review on any matter giving rise to an opportunity for a hearing under these provisions. Nothing in this Policy and Procedure limits or should be construed to limit any contractually granted right on the part of Plan to terminate a practitioner's Participation Agreement or participation in the network.

[126] In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, Next Level Health does not have a Credentialing Committee, replace all Credentialing Committee references in this policy to Quality Improvement Committee.

[127] Maryland Physicians Care allows appeal of ALL recredentialing applications. Initial applicants must reapply.

PROCEDURE:

A. Upon the Credentialing Committee's decision to terminate, revoke or suspend the practitioner's network participation, Plan provides a written notice stating:

1. The Plan's Credentialing Committee, a peer review committee, has terminated, revoked or suspended the practitioner's network participation;
2. The general reason(s) or condition(s) for the Committee's decision;
3. A statement as to the practitioner's right of appeal;
4. A summary description of the appeal process; and
5. Guidance that a request for appeal hearing must be submitted in writing within thirty (30) days from the date of the notice.

B. Upon receipt of a practitioner's timely written request for a hearing, Credentialing staff notifies the practitioner that a hearing will be scheduled, and that Plan will provide further information when a hearing date is set.

1. If a hearing cannot be scheduled within six (6) months due to the unavailability of the practitioner or the practitioner's representative, the request for the hearing is considered withdrawn.
2. If the purpose of the hearing is to review a recommendation to restrict, suspend, or terminate a practitioner's network participation, the hearing is scheduled prior to the date the recommended action becomes effective, except in the case of an immediate suspension, restriction or termination as detailed in the associated policy, CC.CRED.07 Practitioner Disciplinary Action and Reporting.
3. If the practitioner submits an untimely written request for a hearing, the Credentialing Committee's proposed decision becomes final. The practitioner is sent written notice of such within thirty (30) days of Plan's receipt of an untimely request.

C. In the event a practitioner requests a hearing pursuant to this Policy and Procedure, the Plan appoints an Appeals Committee on an ad hoc basis[128]. The Appeals Committee conducts hearings regarding proposed decisions from the Credentialing Committee to suspend, restrict or terminate the network participation of practitioners. The Appeals Committee is comprised of a minimum of three (3) network practitioners, at least one who is in the same specialty as the practitioner under review. The Plan must *not* select Appeals Committee members who:

1. Are in direct economic competition with the practitioner,
2. Are in business with the practitioner, or
3. Have previously made a recommendation or decision regarding the practitioner's network participation

[128] MPC Appeals Committee is identified as the Maryland Physicians Care Appeal Hearing Panel. Appeal Hearings will be a direct participation meeting, however, panel members may participate telephonically if attending in person is not possible.

D. When the Appeals Committee is appointed and hearing is scheduled, Plan provides a written hearing notice stating:

4. The time, location and date of the hearing, which will not be less than thirty (30) days after the date of the notice;

5. A list of witnesses and consultants, if any, expected to be called by Plan at the hearing;

6. The composition of the Appeals Committee; and

7. A statement that the practitioner has fourteen (14) days from receipt of the notice of hearing to notify the Credentialing Committee in writing if the practitioner believes that any member of the Appeals Committee does not meet the criteria set forth in Section C above.

E. The Appeals Committee and the practitioner under review may be afforded the opportunity to examine Plan's exhibits before the hearing. However, failure on the part of Plan to distribute an exhibit before the hearing does not render such exhibit inadmissible at the hearing.

F. Plan provides the Appeals Committee with a copy of the letter sent to the practitioner notifying him or her of the recommended action and a copy of the practitioner's written response, if any.

G. The hearing holds to the following evidentiary standards [129]:

8. The evidence must reasonably relate to the specific issues or matters involved in the recommended action.

9. The Appeals Committee has the right to refuse to consider evidence that it deems irrelevant or otherwise unnecessary to consider.

10. The rules of evidence applicable in a court of law are not applicable at any hearing.

11. A party who objects to the presentation of any evidence must state the grounds for the objection and the Appeals Committee will determine whether the evidence will be admitted.

12. The Appeals Committee determines the relative weight to be given to various items of evidence submitted.

H. The hearing abides by the following format:

1. Representation: The practitioner and Plan may be represented by counsel or other person of their choice. The practitioner must inform Plan at least ten (10) days prior to the hearing of counsel or witnesses appearing on his/her behalf at the hearing.

2. Record: Plan creates a record of the hearing. Plan may take summary minutes, arrange for a court reporter to provide a record of the hearing, or make an audio recording of the hearing, in its sole discretion. If a court reporter is present, she/he names the parties present and, as necessary,

[129] Maryland Physicians Care Appeal Committee does not allow additional information to be submitted after the Committee Hearing.

identifies their representatives. The reporter swears in all witnesses, records all oral testimony, and marks and maintains the documents submitted as exhibits. Following the hearing, the reporter provides a copy of the written transcript to each of the parties and the Appeals Committee. Plan pays the court reporter's fees, except that the practitioner is responsible for the cost of his or her copy of the transcript. If an audio recording is made of the hearing, copies of this record are made available to the practitioner upon payment of a reasonable charge.

3. Quorum: The presence of at least one-half of the voting members of the Appeals Committee, plus one additional voting member, constitutes a quorum for purposes of the conduct of the hearing. Any action taken by the Appeals Committee as a result of the hearing will be by majority of the members present at a meeting at which a quorum is present.
4. Chairperson's Statement of the Procedure: Before evidence or testimony is presented in an in-person or telephonic hearing, the Chairperson of the Appeals Committee announces the purpose of the hearing and the procedure to be followed for the presentation of evidence as determined by the Appeals Committee.
5. Presentation of Evidence by Plan: Plan may present any oral testimony or written evidence collected by Plan staff relevant to the proposed action. The practitioner will have the opportunity to cross-examine any witness testifying on behalf of Plan.
6. Presentation of Evidence by practitioner: After Plan submits its evidence, the practitioner may present evidence to rebut or explain the situation or events described by Plan. Plan will have the opportunity to cross-examine any witness testifying on behalf of the practitioner.
7. Plan Rebuttal: Plan may present additional witnesses or written evidence to rebut the practitioner's evidence. The practitioner will have the opportunity to cross-examine any additional witnesses testifying on Plan's behalf.
8. Summary Statements: After the parties have submitted their evidence, first the Plan and then the practitioner may have the opportunity to make a brief closing statement. In addition, the parties may have the opportunity to submit written statements to the Appeals Committee. The Appeals Committee establishes a reasonable time frame, but not less than thirty (30) days, for the submission of such statements. Each party submitting a written statement must provide a copy of the statement to the other party.
9. Examination by Appeals Committee: Throughout the hearing, the Appeals Committee may question any witness who testifies.

I. The Appeals Committee decision is rendered utilizing the following decision-making guidelines:

1. Standard of Review: Plan has the initial obligation to present evidence in support of its recommendation. The practitioner requesting the hearing has the burden of persuading the Appeals Committee that the Plan's

recommendation lacks substantial factual basis or is unreasonable, arbitrary, or capricious.

2. Review of Evidence and Vote: After the hearing and receipt of summary written statements, the Appeals Committee convenes and privately discusses the Credentialing Committee's recommendation. The Appeals Committee may uphold, reject, or modify the recommendation. The Appeals Committee's decision is based upon the evidence admitted at the hearing and by the affirmative vote of the majority of the members of the Appeals Committee.

J. Notification of the action of the Appeals Committee, and any change in the practitioner's participation status, is communicated as follows:

3. Written notice of the decision is given to the practitioner in an expeditious and appropriate manner and no more than sixty (60) days following the determination, and includes a statement, containing specific reasons, of the basis of the decision.

4. If the practitioner is a Primary Care Physician or Primary OB/GYN whose network participation is terminated, Plan notifies the members who regularly obtain health services from, or who are assigned to such practitioner, that such practitioner is no longer participating in the Plan network.

5. The Credentialing Committee Chair or his or her designee provides written notice of a final adverse determination or action materially affecting a practitioner to such managed care organizations, health plans, and similar entities as required by contract or state or federal law. It is the responsibility of the Plan to fulfill any obligation to report the adverse determination or action to the State licensure board and the NPDB as may be required under the provisions of the HCQIA, as amended from time to time.

6. The action of the Appeals Committee regarding any restriction, suspension, or termination matter is final.

REFERENCES:
CC.CRED.07 Practitioner Disciplinary Action and Reporting
NCQA Health Plan Standards and Guidelines

EXHIBITS:

A. Notice of Administrative Suspension

ATTACHMENTS:

A. CeltiCare Health Plan Unique Requirements
B. Magnolia Health Plan Unique Requirements
C. Louisiana Healthcare Connections Unique Requirements
D. IlliniCare Health Plan Unique Requirements
E. Home State Health Plan Unique Requirements
F. Coordinated Care Unique Requirements
G. Kansas Sunflower State Health Plan Unique Requirements
H. New Hampshire Healthy Families Unique Requirements
I. California Health and Wellness Plan Unique Requirements
J. Absolute Total Care Plan Unique Requirements
K. Fidelis Secure Care Unique Requirements
L. Trillium – Oregon Health PlanUnique Requirements
M. Arizona Complete Health Unique Requirements
N. Pennsylvania Health and Wellness Unique Requirements
O. Nebraska Total Care Unique Requirements
P. Maryland Physicians Care (MPC) Unique Requirements
Q. Nevada SilverSummit Unique Requirements
R. Western Sky Community Care, Inc (NM); Ambetter from Western Sky Community Care Unique Requirements
S. Carolina Complete Health, Inc. Unique Requirements
T. Next Level Health (IL Medicaid) Unique Requirements
U. Iowa Total Care Unique Requirements
V. Ambetter of Tennessee Unique Requirements
W. Ambetter of Virginia Unique Requirements
X. Ascension Joint Venture Unique Requirements
Y. HealthSmart Unique Requirements
Z. Oklahoma Complete Health, Inc. Unique Requirements

REVISION LOG:	DATE
• Added Iowa Total Care Unique Credentialing Requirements Attachment	9/2018
• Added Ambetter of Tennessee Unique Requirements Attachment • Added Ambetter of Virginia Unique Requirement Attachment	12/2018
• Added Exhibit A – Notification of Receipt of Request for Appeal Hearing • Updated Attachment M from Arizona Medicaid Health Plans to Arizona Complete Care • Removed the following previous revision dates from header: 3/5/09; 3/31/10; 11/4/10; 12/10; 4/22/11; 8/10/11: 05/03/12; 9/19/13; 9/15/14; 11/5/15; 6/2/16; 2/22/2017; 3/9/2017; 3/20/2017; 10/18/2017; 12/2017; 2/5/2018; 9/2018; 12/2018	4/2019
• Updated Louisiana Healthcare Connections Unique Requirement Attachment to include reference to Act 489.	2/2020
• Added Ascension Joint Venture Unique Requirement Attachment • Added ICNF (Integrated Care Network of Florida) Unique Requirement Attachment	6/2020
Clarified Unique Requirement for Western Sky Community Care, Inc. are inclusive of Ambetter from Western Sky Community Care.	8/2020
• Removed Unique Requirement Attachment for Integrated Health Network (FL) • Added Unique Requirement Attachment for HealthSmart • Added Unique Requirement Attachment for Oklahoma Complete Health, Inc. • Removed reference to Compliance 360 and added Archer	3/2021

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer, Centene P&P management software, is considered equivalent to a physical signature

Corporate Credentialing: _____Electronic Signature_____

Exhibit A

Notification of receipt of request for Appeal Hearing

Date

VIA CERTIFED MAIL

[Provider Name]
Address
City, State Zip

Dear Dr. _____:

We have received your request for an appeal hearing.

Plan will appoint a Hearing Committee to review the appeal, and will provide further information when a hearing date has been set. You have the right to be represented by an attorney or another person of your choice. If a hearing cannot be scheduled within six (6) months due to the unavailability of you or your representative, the request for the hearing will be considered withdrawn.

Where Network participation is suspended or terminated for reasons relating to the practitioner competence or professional conduct, Plan shall notify the appropriate authorities, including state agencies and NPDB, of the action.

Sincerely,

Medical Director

CC: Provider File

Attachment A

CeltiCare Health Plan
Unique Requirements for Appeal Rights and Hearing Process

1. None

Attachment B

Magnolia Health Plan
Unique Requirements for Appeal Rights and Hearing Process

1. None

Attachment C

Louisiana Healthcare Connections
Unique Requirements for Appeal Rights and Hearing Process

1. Policies/Procedure changes to provider dispute and appeal process for sanctions, suspensions, and terminations imposed against network provider/contractor(s) will be submitted to LDH for review and approval.

2. All notifications will be made in compliance with Louisiana Act 489. If a provider is terminated for reasons other than failure to properly recredential, termination notice effective fifteen (15) days from the date of the notice via certified to the last mailing and email address submitted by the provider. The termination shall be immediate if pursuant to R.s. 46:460.73(B) or loss of required license.

3. If provider fails to meet timely recredentialing requirements, termination notice shall be sent via certified mail effective fifteen (15) days from the date of the notice. Any claims for services delivered prior to the termination date will be paid by Louisiana Healthcare Connections.

Attachment D

IlliniCare Health Plan
Unique Requirements for Appeal Rights and Hearing Process

1. None

Attachment E

Home State Health Plan
Unique Requirements for Appeal Rights and Hearing Process

1. Home State Health Plan will initially submit Credentialing Policies & procedures to MO HealthNet for approval in compliance with section 2.18.8c, 2.18.8c5, 3.9, 3.9.6 of the contract and thereafter as changes are made.

Attachment F

Coordinated Care
Unique Requirements for Appeal Rights and Hearing Process

1. None

Attachment G

Kansas Sunflower State Health Plan
Unique Requirements for Appeal Rights and Hearing Process

1. None

Attachment H

New Hampshire Healthy Families
Unique Requirements for Appeal Rights and Hearing Process

1. None

Attachment I

California Health and Wellness Plan
Unique Requirements for Appeal Rights and Hearing Process

1. None

Attachment J

Absolute Total Care Plan
Unique Requirements for Appeal Rights and Hearing Process

1. Credentialing or recredentialing policies and procedures must be submitted to SCDHHS for approval prior to implementing the changes. The changes must be submitted to SCDHHS prior to implementation and follow the same submission process as changes outlined in the contract submission process.

Attachment K

Fidelis Secure Care
Unique Requirements for Appeal Rights and Hearing Process

1. None

Attachment L

Trillium – Oregon Health Plan
Unique Requirements for Practitioner Appeal Hearing Process

1. None

Attachment M

Arizona Complete Health
Unique Requirements for Practitioner Appeal Hearing Process

1. None

Attachment N

Pennsylvania Health and Wellness
Unique Requirements for Practitioner Appeal Hearing Process

1. None

Attachment O

Nebraska Total Care
Unique Requirements for Practitioner Appeal Hearing Process

1. None

Attachment P

Maryland Physicians Care (MPC)
Unique Requirements for Practitioner Appeal Hearing Process

1. For Maryland Physicians Care, Centene Health Plan refers to management services provided by Envolve, Inc

2. Maryland Physicians Care Appeals Committee is identified as the Maryland Physicians Care Appeal Hearing Panel. Appeal Hearings will be a direct participation meeting, however, panel members may participate telephonically if attending in person is not possible.

3. Maryland Physicians Care allows appeal of ALL recredentialing applications. Initial applicants must reapply.

4. Maryland Physicians Care Appeal Committee does not allow additional information to be submitted after the Committee Hearing.

5. Maryland Physicians Care reviews and investigates potential quality of care concerns (PQoC) as outlined in MPC's QM63 - Review of Potential Quality of Care Concerns Policy. MPC quality of care issues are reviewed by the MPC CMO who makes a determination regarding appropriate actions and who may forward the issue to the MPC Credentialing Committee and and/or the MPC Quality Management/Utilization Management Committee for peer review with final determination from the Board of Directors.

Attachment Q

Nevada SilverSummit
Unique Requirements for Practitioner Appeal Hearing Process

1. All credentialing policies will be reviewed and approved by the Governing Body or their delegate.

Attachment R

Western Sky Community Care, Inc); and
Ambetter from Western Sky Community Care
Unique Requirements for Practitioner Appeal Hearing Process

1. Because practitioners may participate in multiple products (Medicare, Medicaid, Exchange/Marketplace, Commercial), the unique requirements for Western Sky Community Care, Inc (New Mexico) and Ambetter from Western Sky Community Care are the same except where noted as product specific requirements.

2. None

Attachment S

Carolina Complete Health, Inc.
Unique Requirements for Appeal Rights and Hearing Process

1. None

Attachment T

Next Level Health (IL Medicaid)
Unique Requirements for Appeal Rights and Hearing Process

1. In accordance with IL MCO Model Contract Article 5.9 Uniform Provider Credentialing and Recredentialing, Next Level Health does not have a Credentialing Committee, replace all Credentialing Committee references in this policy to Quality Improvement Committee.

Attachment U

Iowa Total Care
Unique Requirements for Credentialing

1. None

Attachment V

Ambetter of Tennessee
Unique Requirements for Credentialing

1. None

Attachment W

Ambetter of Virginia
Unique Requirements for Credentialing

1. None

Attachment X

Ascension Joint Venture
Unique Requirements for Credentialing

1. None

Attachment Y

ICNF (Integrated Care Network of Florida)
Unique Requirements for Credentialing

1. None