

4 PROVIDER PARTICIPATION

4.1 PROVIDER CREDENTIALING POLICY

The Plan requires that all providers complete the credentialing process in order to participate in the Plan.

The Plan delegates some credentialing functions to its participating (contracted) hospitals (i.e., delegated credentialing entities). All delegated entities that are hospitals or stand alone health centers must be Joint Commission accredited. Entities must provide the Plan with a written attestation that it complies with Plan credentialing procedures and demonstrate this through a pre-screen review, and that they hold evidence of appropriate documentation and conducts primary source verification. They submit to the Plan, data for all credentialed providers in a Plan-prescribed electronic format. Providers working with delegated credentialing entities may participate in the Plan as fully credentialed providers after Plan verification of credentialing status. The Plan will not exclude any appropriately licensed type of physician as a class.

All new non-delegated provider applications received by the Plan will be date stamped upon receipt and will be entered into the Credentials Tracking Database. It is the Plan's Policy to complete initial credentialing activities within ninety (90) days of receipt of the application. Any incomplete application will be returned to the applicant for re-submission.

Once the application has been reviewed and approved by the Plan's Credentialing Committee the provider will be notified in writing within thirty (30) days. Upon approval the provider will receive their Provider Identification Number and commence the new provider orientation process.

New York State Insurance Law now states that MCO's will allow newly-licensed practitioners or practitioners relocating from another state that are joining an in-network group practice to apply for provisional credentialing if the MCO has not credentialed the practitioner within ninety (90) days after receipt of a **complete application**. Practitioners with provisional credentialing are treated as in-network providers for the provision of covered services, but may not be designated as primary care providers (PCPs).

Provisional credentialing may be granted on or before the ninety-first day of receipt of the complete application and shall last until the final credentialing determination is made. The law also indicates that should it be determined that the provider does not meet the MCO's credentialing standards that the group practice must have agreed at the time provisional credentialing was requested to refund all monies paid by the Plan for services rendered to Plan members by the provisionally credentialed provider and the member is to be held harmless.

PLEASE NOTE: The Plan does not permit any medical provider who has been sanctioned by Medicare or Medicaid and who has been prohibited from serving Medicaid clients or receiving Medical Assistance Program payments from participating in the network. If a provider is now, or at any time during their participation in the Plan, sanctioned by a regulatory agency, they must notify the Plan immediately.

4.1.1 Credentialing Documentation

To join the Health Plan, providers must successfully complete the credentialing process. The process begins with the submission of an executed provider agreement (contract) and the return submission of all required credentialing information. Applicants have two options for providing their credentialing information; they can either utilize the Council of Affordable Quality Healthcare (CAQH). Universal Provider Data source (UPD) or, if they are not CAQH account holders, they can complete the Health Plan's own application which may be downloaded from the Plan websites. (CAQH UPD is a free service that allows providers to store, access, manage and update their credentialing information so that it can then be accessed by authorized UPD-participating organizations. Providers must authorize each health plan that will be permitted to obtain the stored data through CAQH. This can be done by logging into the CAQH website (www.caqh.org/cred/.)

Please note that some credentialing information may be requested by the Plan in addition to the CAQH application (i.e., HIV/AIDS Specialist Attestation questionnaire (page 10 of the Plan Provider Application).

Please note that any cross-outs and/or whiteouts **MUST** be accompanied by the initials of the person responsible for completing the application. The application **MUST be completely filled out**. Example: if there are any section(s)/question(s) that do not apply please put N/A.

As referenced in Section 4.1 incomplete applications will be returned to the provider. Any information entered into this application which subsequently is found to be false could result in termination from the Plan.

Please remember to sign and date the attestation and the consent for release of information form.

The following documentation must be included within your application:

- Signed agreement/contract.
- Copy/copies of your current SIGNED NY State Registration.
- Copy of your current DEA certificate (if applicable).
- Copy of your current malpractice insurance (face sheet) MUST list policy period and limits of liability.
- Documentation of Board Eligibility/Board Certification (if applicable).

- Copy of your current resume/Curriculum Vitae, including months/years.
- Signed and dated consent for release of information and attestation forms.
- Documented Collaborative Relationship (for Nurse Practitioners and Licensed Nurse Midwives).
- Confidential Information Form (with written explanation to any question answered yes).
- Identification of all hospital(s) that provider has hospital privileges. This MUST include appointment period dates.
- Details of any pending professional misconduct proceedings or malpractice actions and the substance of the allegations.
- Information from other HMOs or hospitals with which you have been associated regarding professional misconduct or medical malpractice, and associated judgments/settlements and any reports of professional misconduct by a hospital pursuant to NY State Public Health Law Section 2803-E. (you must obtain and submit this information).
- W-9 tax information form.

Pursuant to 42.CFR 455.104, the Plan must require any subcontractor to disclose the ownership, control and relationship with whom it had a business transaction that totaled more than \$25,000 during the twelve (12) month period ending on the date of the request. This disclosure must be provided within thirty-five (35) days of the date of request by SDOH, OMIG or DHHS.

4.1.2 SITE ENVIRONMENT REVIEW

In accordance with regulatory standards, the Plan conducts an office/center environment review as part of the initial credentialing process for primary care and prenatal providers, for new and additional sites and in response to complaints or any reports on quality of care issues. The Provider Relations Representative may also perform a scheduled or unscheduled environmental site visit of any provider office or medical center as part of the Plan's general monitoring schedule. This is done to ensure that the site accessibility, appearance, safety and adequacy of equipment as well as record keeping and confidentiality practices of a provider meet the standards of the Plan and all regulatory agencies. Provider Relations Representatives should be trained on ADA standards for site review. It is our expectation that providers seeking participation will schedule the site visit and medical record screening within 10 business days of the request to conduct this review.

The following guidelines are considered by the Provider Relations Representative during a site review:

Accessibility - The office signage/direction to the office should be easily seen from the street. Office hours/days of operation and telephone numbers to reach during off hours are prominently posted in the waiting area. Handicap accessibility (compliance with ADA) should also be noted.

Appearance - The external and internal office/center should appear clean, well-lit and safe. Floors and carpet should be clean and clear of any obstructions. Examination room table tops should be hygienic and free of clutter and the room should be well lighted.

Infection Control - Office/center should have a syringe disposal method and hazardous waste management procedure.

Pharmaceuticals - Medications should be dated and none appear to be expired.

Radiology - Area should be clean and a valid radiation inspection notice is posted.

Medical equipment - Equipment appears well maintained and in good working condition.

Laboratory Services - CLIA Certificate and procedure manual should be maintained.

Appointment Log – should indicate that members are able to request for appointments within the standards set by the Plan and the New York State Department of Health.

Waiting Time - The estimated wait time a patient is in the provider waiting area is noted. It should not exceed one (1) hour passed the scheduled appointment time.

Safety – There should be functioning smoke alarms and recently inspected fire extinguisher(s). The office/center should have visible exit signs and an evacuation plan.

Emergency Procedures - Indicate whether office/center provider and staff are certified in Cardiac Pulmonary Resuscitation (CPR), Basic Life Support (BCLS) or Advanced Life Support (ACLS).

Appointment Standards - Record the number of days to obtain the various appointments.

Confidentiality - Records should indicate that office/ center had obtained authorization for the release of confidential information.

Medical Files - Filing cabinets should be accessible to the provider and staff but secure and located in a private section of the office/center.

Any incident of noncompliance of Plan requirements is documented by the Provider Relations Representative.

Office/Center Reviews performed by Provider Relations Representatives are documented in the Site Review forms and are submitted to the Credentialing Unit within one week of site review and are incorporated in the provider file as reviewed by the Chief Medical Officer and the Credentialing Committee and maintained by the Credentialing Unit. A copy of the NHP PR Site Visit Record is given to the provider office/center reviewed.

In cases where the Site Review yields a result that is less than satisfactory or sub-standard, the Site Review is forwarded to the Assistant Director for Provider Network Management as well as the Chief Medical Officer for action. The Provider is immediately informed in writing of a failed site review; this notice includes prescribed corrective action(s), and another Site Review is scheduled within the next 6 months until standards are met.

4.1.3 Medical Records Screening

Basic screening of medical record keeping practices for primary care and prenatal care providers are conducted during the site review. The Plan will allow new office-based providers or health centers not designated as an Article 28 facility up to sixty (60) days to accumulate five (5) records from Plan members. If sixty (60) days passes and the provider has not accumulated five (5) Plan patient records, the Provider Relations Representative will review existing records of current patients. The reviewer will keep all record information confidential. The provider or health center may block out the patient's name and medical record number prior to the record screening. Records will be reviewed for the following:

- Each patient has an individual, consistently organized and properly marked/identified medical record.
- Medical records are legible.
- Medical records contain documentation of personal and biographical data (demographic) of the individual patients.
- Medical record contains dated author identification for each entry.

4.2 Provider Re-credentialing Policy

4.2.1 Delegated Re-Credentialing

Delegated credentialing entities such as participating (contracted) hospitals are responsible for re-credentialing their providers. These entities provide the Plan with a written attestation stating that it has Re-Credentialing Policies and Procedures that minimally satisfy the Plan, that they hold evidence of appropriate documentation and that they conduct Primary Source Verification. This is demonstrated to the Plan through a pre-delegation audit review, as well as annual audits of a sampling of each delegated entities files to ensure continued compliance with Policies and Procedures.

4.2.2 Non-Delegated Re-Credentialing

Re-credentialing of non-delegated providers is conducted every three (3) years by the Plan. Re-credentialing criteria includes a re-validation of the licensure, privileges and coverage requirements, as well as information gathered from quality improvement activities including emergency room utilization, member satisfaction survey, medical record audit results, member complaints and corrective actions. The Plan will make every effort to notify participating providers that they are due to be re-credentialed at least ninety (90) days prior to the expiration of the provider's initial thirty-six (36) month credentialing period. If the provider does not provide their re-credentialing application and supporting materials within the allotted time frame, the Plan will follow up with the provider thirty (30) days prior to the expiration of the provider's current credentialing period. This will serve as the final notice to the provider that failure to submit the re-credentialing application and supporting documents requested will result in termination upon the expiration of the initial approved credentialing date. In addition, they will be informed that providers can reapply to the Plan by submitting a new application for participation. The initial credentialing process will be followed in this instance. If a provider wishes to appeal this action they have the right to request a hearing or review by NHP. In order to do this the provider must submit a written request to the Chief Medical Officer within thirty (30) days of the date of the notification letter. NHP will convene a hearing within thirty (30) days of receipt of this request.

Once a re-credentialing application with all required supporting documents is received, the application will be date stamped and entered in the Credential Tracking Database. The Plan will complete all re-credentialing activities, to the best of their ability, within ninety (90) days of receipt of the application. If the Plan is not going to be able to complete this process within the ninety (90) day timeframe they will notify the provider in writing of the delay and the reason for such delay.

Participating providers must promptly report a "Letter of Notification" to the Plan's Chief Medical Officer in the instance of any of the following:

- Any disciplinary action proposed or taken against the provider by the State Medical Board;
- Any disciplinary action proposed or taken against the provider by a health care organization at which the practitioner has privileges;
- The filing of any lawsuit alleging malpractice; any indictment, guilty plea or medical finding of guilt involving a felony misdemeanor committed in the course of the practice of medicine or misdemeanor involving moral turpitude;
- Or, any "quality letter" from a Peer Review Organization (PRO) or equivalent review organization.

Failure to comply with the above reporting requirements may result in corrective action.

4.3 Delegation Oversight

NHP delegates credentialing/recredentialing functions to participating hospitals, health centers, independent practice associations, and large medical groups which have a credentialing/re-credentialing process in place that meets Plan standards. Prior to delegating credentialing/recredentialing to an entity, the Plan reviews all of the entity's Credentialing Policies and Procedures and/or By-Laws to confirm that Plan standards are met. This review is followed by an audit of a sample of provider files to confirm that the entity's policies and procedures are being followed. Thereafter, the Plan audits delegated functions via onsite inspection of functions performed by the delegated organization annually.

4.3.1 Provider Performance Evaluation

The Plan informs its participating providers of information maintained to evaluate providers' performance or practice. This Provider Manual contains standards of care, clinical guidelines, and other pertinent information regarding what information the Plan uses to evaluate performance and how performance is measured. The Plan publishes a Provider Newsletter at least twice per year that contains current updates and information about policies and criteria. The Plan mails standards of care, clinical guidelines, and other pertinent information to appropriate participating providers.

The Plan consults with health care professionals in developing methodologies to collect and analyze health care professional profiling data and maintains a toll free phone line for providers to access the Plan with ideas and suggestions. The Plan provides such information and profiling data and analysis to network providers.

Such information, data, or analysis is provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided.

We use medical record standards, office environment standards, adult and pediatric preventive health guidelines and several disease specific guidelines including guidelines for the care of members with asthma, HIV/AIDS, TB, diabetes and high cholesterol. Providers are monitored for over and under-utilization of services including member emergency room usage. In addition, providers are reviewed for compliance with current New York State Quality Assurance Reporting Requirements (QARR) on an annual basis.

Any profiling data used to evaluate the performance or practice of a health care professional is measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each health care professional is given the opportunity to discuss the unique nature of the health care professional's patient population which may have a bearing on the health care professional's profile and to work cooperatively with the Plan to improve performance.

4.3.2 Written Notification

The Plan will notify providers in writing of the Credentialing Committee's decision to approve, limit, suspend, deny or terminate the privileges of a provider to participate in the Provider Network within thirty (30) days of the Credentialing Committee decision. However, under no circumstances will this written notification exceed ninety (90) days from the receipt of the original application received date unless the provider was previously notified of the delay.

We will immediately deny participation or terminate participation of any provider who has been sanctioned by Medicare or Medicaid and has been prohibited from serving Medicaid clients or receiving Medical Assistance Program payments as a result of a final disciplinary action.

If the Credentialing Committee determines that a new provider applying for participation does not meet our credentialing standards, participation in the Plan will be denied. The decision will be based on the information provided in the application for participation and the information collected as a result of primary source verification. The provider will be notified of the reason(s) for such denial within thirty (30) days of the Credentialing Committee's decision. The provider will not have the right to appeal this denial. However, under no circumstances will this written notification of denial exceed ninety (90) days from the receipt of the original application received date unless the provider was previously notified of the delay.

The Plan will not limit, suspend or terminate **ANY** provider because the provider:

- advocated on behalf of a member,
- filed a complaint against the Plan,
- appealed a decision of the Plan,
- provided information or filed a report that the Plan was in violation of any Public Health regulations pursuant to PHL 4406-c, or
- Requested a hearing or review pursuant to PHL 4406-d.

Decisions which result in sending an educational letter or continuing peer observation are sent to the provider and, if applicable, health center/hospital management within sixty (60) days of the Committee meeting.

If the decision is to limit, suspend, or terminate participation, the provider and/or, if applicable, health center/hospital management will have the right to appeal this decision within thirty (30) days of the receipt of the letter by the provider. The notification letter includes:

- the action to be taken and the effective date of the action, which will be no less than sixty (60) days from the receipt of the written notification by the provider;
- the reason(s) for the proposed action;
- the manner in which the provider may appeal the decision - including notice that the provider has the right to request a hearing or review, at the provider's discretion, before a hearing panel appointed by the Plan;
- the time limit of thirty (30) days to request a hearing; and
- the time limit for a hearing date which must be held within thirty (30) days after the receipt of the provider's request for a hearing

In cases where denial or termination are the result of imminent harm to patients, fraud or final disciplinary action by a governmental agency, a written explanation and notice of hearing rights will not be sent.

If a provider chooses not to appeal the Plan Credentialing Committee's decision to terminate your participation in the Provider Network, their participation will be terminated not less than sixty (60) days from the date the provider received the written notification of the original determination.

4.3.3 Provider Participation Appeal Process

A provider who wishes to appeal a Plan decision to limit, suspend, deny or terminate network participation privileges may do so by notifying the Plan Chief Medical Officer in writing of his/her intention to appeal. **The provider must send a written request to appeal the decision to the address identified in the decision letter. The request should include any documentation or evidence to support the provider's position. The request must be sent certified mail and postmarked no later than thirty (30) days following the receipt of the decision letter.**

As previously indicated, **the Plan does not allow in its network any provider who has been sanctioned by Medicare or Medicaid and has been prohibited from serving Medicaid clients or receiving Medical Assistance Program payments as a result of a final disciplinary action.** Since these final disciplinary actions are rendered by the Office of Professional Medical Conduct (OPMC), the Office of the Inspector General and the Office of the Medicaid Inspector General, participating providers who are identified by one of these entities as no longer allowed on either a temporary or permanent basis to provide medical care within New York State will be ***immediately*** terminated from the network for all Medicaid, Child Health Plus and Family Health Plus products. The Plan is not obligated to notify the provider of their termination from the Plan when the termination is the direct result of a sanction by a Federal or State agency.

Providers terminated from the network based on a case involving imminent harm to patient care, a determination of fraud or a Medicaid or Medicare final disciplinary action are *not eligible for a fair hearing or review of the termination from provider network.*

4.3.3.1 How to Appeal the Plan's Decision to Limit, Suspend, or Terminate Network Participation

4.3.3.1.1 Request to Review the Decision

Upon receipt of the written notification from the Plan of the Credentialing Committee's decision to limit, suspend or terminate network participation, the provider will have thirty (30) days from the date of receipt of the notification to appeal the decision. **Please Note: Written explanation and notice of hearing rights may not be sent when the termination is due to cases of imminent harm to patients, fraud or final disciplinary action by a governmental agency as indicated previously.** This appeal may be either a review of the decision based on additional information that the provider wants to have presented or the provider may request a hearing.

In the case where the provider requests a review of the Credentialing Committee's decision based on additional information the provider may want to supply the Plan's Chief Medical Officer who will notify the provider of the date that the Credentialing Committee will meet to review the appeal. This meeting will occur not less than thirty (30) days from the request for review in order to give the provider an opportunity to participate in the meeting.

Requests for additional time or to reschedule the meeting must be made in writing and received before the scheduled Credentialing Committee meeting date. The provider may choose to not attend the meeting though participation by the provider is encouraged.

Any documentation to be submitted to the Credentialing Committee by the provider must be mailed to the address identified in the decision letter and received before the meeting date. Documentation submitted after this date may be accepted for consideration at the Plan's discretion. The Credentialing Committee decisions are documented in Committee minutes.

The provider is advised in writing of the Committee decision within three (3) business days of the Committee meeting. Appeal documentation is maintained in the provider's file.

4.3.3.1.2 Request for a Hearing

If the provider requests a hearing to review the Credentialing Committee's decision, the Plan will hold the hearing within thirty (30) days after receipt of a request for a hearing. The Chief Medical Officer will notify the provider of the date that the hearing will take place. **Providers terminated from the network based on a case involving imminent harm to patient care, a determination of fraud or a Medicaid or Medicare final disciplinary action are not eligible for a hearing of the termination from NHP's network.**

The "Hearing Panel" will be comprised of three (3) persons appointed by the Plan. At least one (1) person will be a clinical peer in the same discipline and/or the same specialty as the practitioner under review. The panel may consist of more than three (3) persons provided that the number of clinical peers on the panel is one third or more of the total panel membership. No person involved in the original decision will be allowed to be part of the Hearing Panel.

Any documentation to be submitted to the Hearing Panel by the provider must be mailed to the address identified in the decision letter and received before the meeting date. Documentation submitted after this date may be accepted for consideration at the Plan's discretion.

At the Hearing Panel meeting, the provider or designee presents his/her explanation as to why the decision should be reversed. The Chief Medical Officer or a Credentialing Committee physician member presents the Plan's position. Appeal documentation is maintained in the provider's file.

The Hearing Panel will render a decision in a timely manner. The hearing panel will notify the provider in writing within three (3) business days following the hearing panel meeting. The decision may include:

- reinstatement of the provider,
- provisional reinstatement subject to conditions set forth by the Plan, or
- Termination of the provider.

A decision by the panel to terminate a practitioner will be effective thirty (30) days after the practitioner's receipt of the hearing panel's decision, but in no event not less than sixty (60) days from the receipt by the provider of the original notification of termination.

Notwithstanding the termination of a provider for cause or pursuant to a hearing, the Plan will permit a member to continue an ongoing course of treatment for a transition period of ninety (90) days or for a transitional period to include postpartum care related to the delivery if a member has entered their second trimester of pregnancy, subject to provider agreement, pursuant to 4406(6) (e).

4.3.4 Duty to Report

The Plan is required to report to the State Department of Health (SDOH) and the Office of the Medicaid Inspector General (OMIG) any adverse actions taken for program integrity reasons against a Provider.

The Plan must notify SDOH of any Provider denied credentialing or termination of the Provider's contract for program integrity related reasons such as being on the Excluded Provider list and/or having existing fraud, licensing or Office of Professional Medical Conduct (OPMC) issues.

The Plan is legally obligated pursuant to PHL4405-b to report to the appropriate professional disciplinary agency within thirty (30) days of the occurrence of any of the following:

- the termination of a health care provider contract pursuant to section 4406-d of the Managed Care Reform Act for reasons related to alleged mental or physical impairment, misconduct, or impairment of patient safety or welfare;
- the voluntary or involuntary termination of a contract or employment or other affiliation with such organization to avoid the imposition of disciplinary measures; or
- The termination of a health care provider contract in the case of a determination of fraud or in a case of imminent harm to patient health.

The Plan is also legally obligated to report to the appropriate professional disciplinary agency within sixty (60) days of obtaining knowledge of any information that reasonably appears to show that a health care professional is guilty of professional misconduct as defined in Article 130 or Article 131-A of the education law.

Reports of professional misconduct will be made in writing to the appropriate professional disciplinary agency and shall include the following information:

1. the name, address, profession and license number of the individual; and
2. a description of the action taken by the organization including the reason for the action and the date thereof, or the nature of the action or conduct that led to the resignation, termination of contract or withdrawal, and the date thereof stated with sufficient specificity to allow a reasonable person to understand which of the reasons enumerated led to the action of the organization or the resignation or withdrawal of the individual, and, if the reason was an act or omission of the individual, and the particular act or omission.