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Subcontractors, if one credentialing process meets NCQA requirements.

28; Provider Services

28.3; Implementation of a Credentialing Verification Organization (CVO)

- The Contractor shall comply with and take all necessary actions to implement the requirements of 2018 Ky. Acts Ch. 69 and all other applicable Federal and State laws. The Contractor shall work with any identified CVO designated by the Department.

28; Provider Services

28.4; Provider Credentialing and Recredentialing

- The Contractor shall conduct Credentialing and Recredentialing in compliance with NCQA, KRS 205.560(12), 907 KAR 1:672 and other applicable state regulations and federal law. The Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Enrollees. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in Appendix J. "Credentialing Process."
- The Contractor shall complete the Credentialing or Recredentialing of a Provider within forty-five (45) calendar days of receipt of all relative information from the Provider. The status of pending requests for credentialing or recredentialing shall be submitted as required in Appendix J. "Credentialing Process."
- The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.
- The Contractor shall provide a credentialing process whereby the Provider is only required to go through one credentialing process that applies to the Contractor and any or all of its Subcontractors, if one credentialing process meets NCQA requirements.

Appendix J. Credentialing Process

Credentialing and Recredentialing Requirements

This documentation shall include, but not be limited to, defining the scope of providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements. The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers. Those providers accountable to a formal governing body for review of credentials shall include physicians, dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant and other licensed or certified practitioners. Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department. The Contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:

- A. The Contractor shall verify that its enrolled network Providers to whom Members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations and have in effect such current policies of malpractice insurance as may be required by the Contractor.



B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.

C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.

D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 205.560(12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.

The process for verification of Provider credentials and insurance shall include the following:

A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;

B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;

C. A review of the credentialing policies and procedures by the formal body;

D. A credentialing committee which makes recommendations regarding credentialing;

E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;

F. Written procedures for the termination or suspension of Providers; and

G. Written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.

The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of Provider's credentials shall include the following:

A. A current valid license or certificate to practice in the Commonwealth of Kentucky;

B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;

C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program as applicable; if provider is not board certified.

D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;

E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;



- F. Previous five (5) years' work history;
- G. Professional liability claims history;
- H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;
- I. Current, adequate malpractice insurance, as verified through attestation;
- J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;
- K. Documentation of curtailment or suspension of medical staff privileges;
- L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;
- M. Documentation of censure by the State or County professional association; and
- N. Most recent information available from the National Practitioner Data Bank.
- O. Health and Human Services Office of Inspector General (HHS OIG)
- P. System for Award Management (SAM)

The provider shall complete a credentialing application that includes a statement by the applicant regarding:

- A. The ability to perform the essential functions of the positions, with or without accommodation;
- B. Lack of present illegal drug use;
- C. History of loss of license and felony convictions;
- D. History of loss or limitation of privileges or disciplinary activity;
- E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and
- F. Applicants attest to the correctness and completeness of the application.

Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:

- A. National practitioner data bank, if applicable;
- B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and
- C. Other recognized monitoring organizations appropriate to the practitioner's discipline.

At the time of credentialing, the Contractor shall perform an initial visit to providers as it deems necessary and as required by law. (See 42 CFR Part 455 Subpart E.). The Contractor shall



document a structured review to evaluate the site against the Contractors organizational standards and those specified by this contract. The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.

The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:

- A. A current license to practice;
- B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;
- C. A valid DEA number, if applicable;
- D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialled;
- E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and
- F. A current signed attestation statement by the applicant regarding:
 - (1) The ability to perform the essential functions of the position, with or without accommodation;
 - (2) The lack of current illegal drug use;
 - (3) A history of loss, limitation of privileges or any disciplinary action; and
 - (4) Current malpractice insurance.
 - (5) Health and Human Services Office of Inspector General (HHS OIG)
 - (6) System for Award Management (SAM)

There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:

- A. The national practitioner data bank;
- B. Medicare and Medicaid;
- C. State boards of practice, as applicable; and
- D. Other recognized monitoring organizations appropriate to the practitioner's specialty.

The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers,



residential treatment centers, and clinics. At least every three (3) years, the Contractor shall confirm that the provider is in good standing with state and federal regulatory bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.

The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services. The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.

If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.

The contractor shall use the provider type summaries listed at <http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm>

Purpose:

This policy outlines credentialing and recredentialing requirements for providers who are contracted for Humana's Kentucky Medicaid Provider network. The policy defined below is in addition to the established credentialing and recredentialing requirements defined in Humana's Corporate Credentialing and Recredentialing Policy 2019; 17th Edition, Humana's Kentucky Medicaid Provider Enrollment Policy, and Humana's Kentucky Medicaid Sanctions Policy.

Policy and procedures:

- Humana's Credentialing Operations shall follow the credentialing and recredentialing standards defined in Humana's Credentialing and Recredentialing Policy 2019, 17th Edition.
- Humana's Credentialing Operations shall follow the provider enrollment process defined in Humana's Kentucky Medicaid Provider Enrollment Policy.
- Humana's Credentialing Operations shall follow the ongoing sanctions monitoring process defined in Humana's Kentucky Medicaid Sanctions Policy.
- Humana will contract with and utilize a Credentialing Verification Organization (CVO) chosen by the Kentucky Department for Medicaid Services for credentialing and recredentialing activities.
- Practitioners defined in Humana's Credentialing and Recredentialing Policy are included in the scope of credentialing for Humana's Kentucky Medicaid provider network. Those include, but are not be limited to, the following: physicians, dentists, advanced registered nurse practitioners, audiologists, certified registered nurse anesthetists, optometrists, podiatrists, chiropractors, physician assistants and other licensed or certified practitioners. However, if any of these providers are hospital-based, credentialing will be performed by the Department.
- Organizational providers defined in Humana's Corporate Credentialing and Recredentialing Policy 2019, 17th Edition are included in the scope of credentialing for Humana's Kentucky Medicaid provider network. Additionally, free standing birth centers are subject to credentialing.
- Before making a credentialing or recredentialing decision, Credentialing Operations will verify professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner for the previous 5 years are within acceptable standards.
- When a provider practices in the state of Kentucky, Credentialing Operations will verify the provider has a current valid license or certificate to practice in the Commonwealth of Kentucky before making



a credentialing or recredentialing decision. Credentialing Operations will verify out of state providers have a current valid license issued by the state in which they practice.

- Credentialing Operations will verify a provider's professional board certification, eligibility for certification, or graduation from a training program to service children with special health care needs under twenty-one (21) years of age before making a credentialing or recredentialing decision.
- Credentialing Operations will collect Kentucky Medicaid numbers for all Medicaid contracted providers during credentialing and recredentialing. The Medicaid numbers will be loaded into the credentialing system. Refer to Attachments A and B.
 - If there is no evidence of a Medicaid number, the steps outlined in the Kentucky Medicaid Provider Enrollment Policy will be followed.
- Credentialing will verify eligibility for participation by querying the Kentucky Department for Medicaid Services exclusions list at <https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/terminated.aspx>.
- Network Operations and Credentialing Operations will collect information regarding accessibilities to provider office locations via the provider's credentialing application.
- Credentialing activities may be delegated to an entity approved for Humana's Kentucky Medicaid Provider network.
- Credentialing Operations will provide a credentialing process whereby the Provider is only required to go through one credentialing process that applies to all Humana networks and any or all of its Subcontractors, if one credentialing meets NCQA requirements.

Additional Resources

Policies:

Humana's Credentialing and Recredentialing Policy 2019
Kentucky Medicaid Provider Enrollment Policy
CR Sanctions KY Medicaid Policy

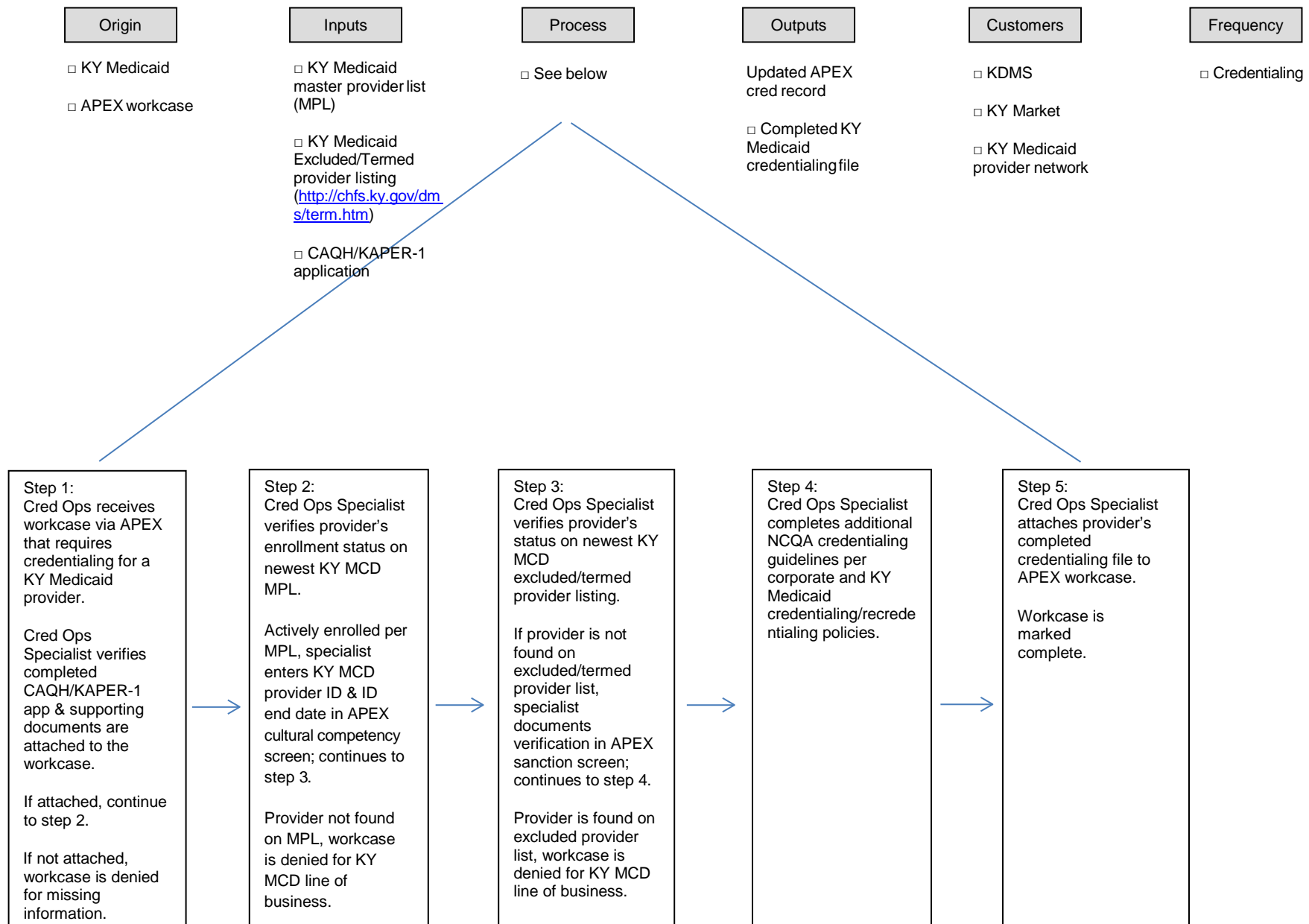
Attachments:

Attachment A – Kentucky Medicaid Provider Enrollment & Sanction Verification – Credentialing
Attachment B – Kentucky Medicaid Provider Enrollment & Sanction Verification – Recredentialing

Attachment A

12/2014, Revised 03/2017

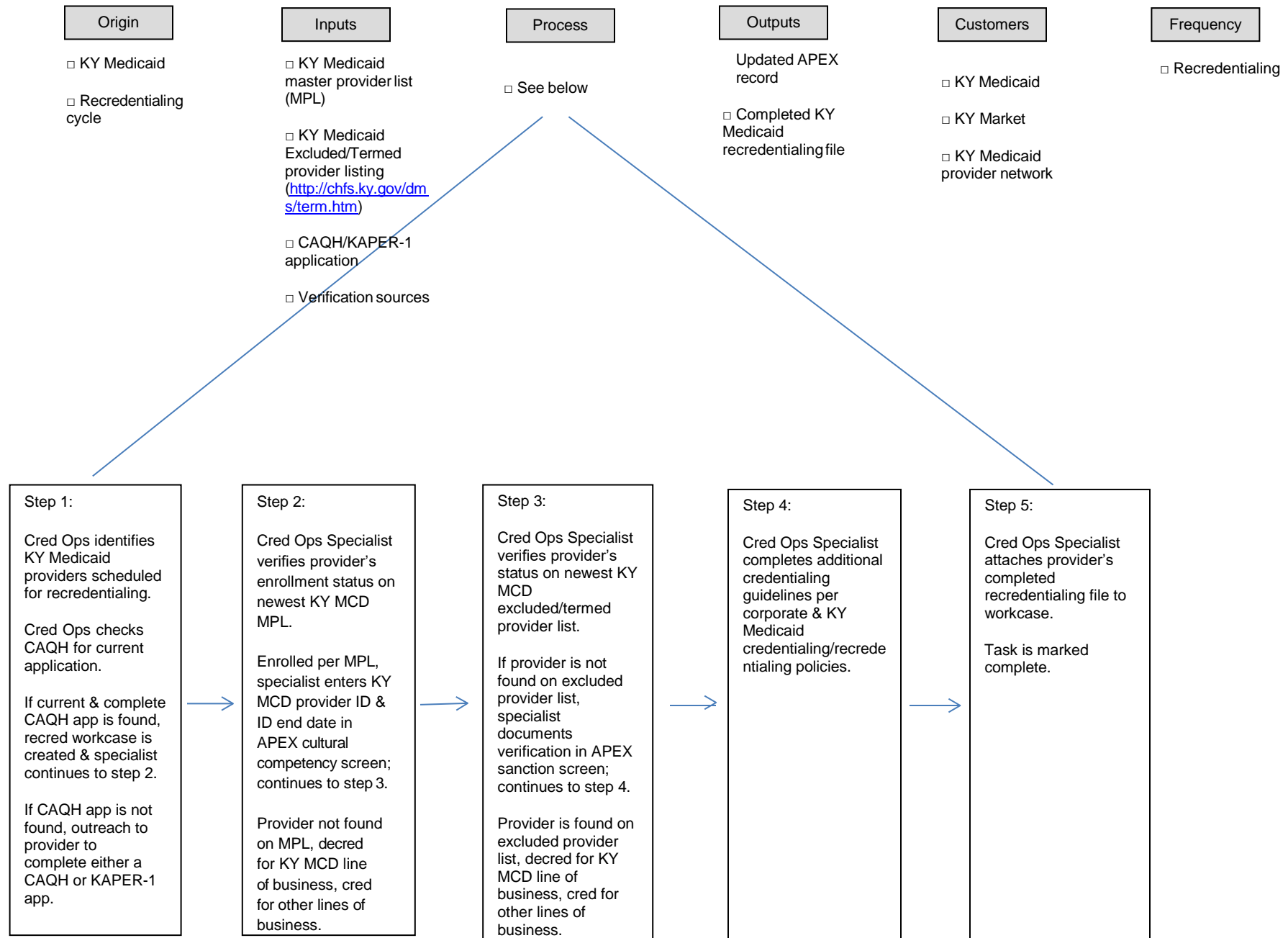
Kentucky Medicaid Provider Enrollment & Sanction Verification – Credentialing



Attachment B

12/2014, Revised 03/2017

Kentucky Medicaid Provider Enrollment & Sanction Verification – Recredentialing



Humana Policy and Procedure(s)



Credentialing and Recredentialing (19th ed.)

Original Date:	January 1998	Last Reviewed Date:	December 18, 2019
Last Revised Date:	December 18, 2019	Accountable Dept.:	48130 Credentialing Operations

Overview:

This policy defines the credentialing and recredentialing process for selecting and evaluating licensed and independent practitioners and the assessment process for organizational providers who provide care to Humana members. Consistent with Humana's mission to assist members in achieving life-long well-being, the goal of this policy is to enable selection of qualified practitioners and providers.

In some circumstances, Humana is subject to certain credentialing requirements, such as state and federal regulations, that exceed or differ from those outlined in this policy. Additional compliance with individual state Medicaid credentialing and recredentialing requirements are governed by Humana's separate individual state policies.

Scope:

Credentialing requirements apply to practitioners meeting all of the following:

- Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision); and
- Practitioners who have an independent relationship with Humana (an independent relationship exists when Humana directs its members to see a specific practitioner or group of practitioners, including all practitioners whom a member can select as primary care practitioners); and
- Practitioners who provide care to members under Humana's medical, dental and vision benefits.

Credentialing Criteria apply to practitioners in the following settings:

- Individual or group practices
- Organizational providers
- Rental networks
- Telehealth

Unless otherwise required by applicable law, practitioners who do not require credentialing include:

- Practitioners, including hospitalists and extenders (who are not individually contracted and who do not print in the directory) who practice exclusively in the inpatient setting and who provide care for members only as a result of members being directed to the hospital or another inpatient setting. This includes hospital-based anesthesiology, emergency medicine, hospitalist, neonatology, pathology and radiology providers.
- Practitioners who practice exclusively in freestanding facilities and who provide care for members only as a result of their being directed to the facility
- Pharmacists who work for a pharmacy benefits management (PBM) organization
- Covering practitioners (e.g., locums tenens) who do not have an independent relationship with Humana
- Practitioners who do not provide care for members in a treatment setting (e.g., board-certified consultants)
- Rental network practitioners who are specifically for out-of-area care
- Non-licensed applied behavior analysis (ABA) providers
- Physician extenders who do not act as a primary care physician (PCP) and who do not print in the directory. This includes licensed practical nurses, nurse anesthetists, physician assistants (non-PCP), registered nurses and registered nurse first assistants, as well as surgical assistants and surgical first assistants.

Definitions:

“Humana” means Humana Inc. and its affiliates and subsidiaries that underwrite or administer health, dental or vision plans, long-term services and support (LTSS), CarePlus Health Plans Inc. and Health Value Management Inc., d/b/a ChoiceCare Network and d/b/a Humana Behavioral Health Network.

“Humana members” means participants in health, dental and vision plans, LTSS and programs provided by Humana.

An “independent relationship” exists when Humana directs its members to see a specific provider, including all practitioners whom a member can select as a primary care provider, to provide care under Humana’s medical benefit.

“Organizational providers” means providers described as hospitals or other healthcare facilities.

“Telehealth Services” includes “OM Telehealth Covered Services,” “Additional Telehealth Covered Services,” and “Supplemental Telehealth Covered Services,” provided to Medicare plans as outlined in the Claims Payment Policy CP2008102 or its successor policy, and any telehealth services that are covered by any Humana commercial and Medicaid plans.

Other terms are defined throughout this policy.

Requirements:**Standard: Types of Practitioners to Credential and Recredential**

Practitioners who require credentialing include all participating practitioners who fall within the scope of credentialing, not limited to:

Medical practitioners:

- Medical doctors
- Oral surgeons
- Chiropractors
- Osteopaths
- Podiatrists
- Nurse practitioners who are licensed, certified or registered by the state to practice independently or as required by state regulations
- Dentists
- Optometrists

Behavioral health practitioners:

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master’s level psychologists who are state certified or licensed
- Master’s level clinical social workers who are state certified or licensed
- Master’s level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
- Other behavioral health specialists who are licensed, certified or registered by the state to practice independently

All practitioners requiring credentialing should complete the credentialing process prior to the provider’s contract effective date, except where required by state regulations. Additionally, a provider will print in the provider directory only when credentialing is complete.

Standard: Verification Sources for Credentialing and Recredentialing

Verification of credentialing information should come from one of the following sources:

- The primary source (or its website), the entity that originally conferred or issued the credential
- A contracted agent of the primary source (or its website)
- Another National Committee for Quality Assurance (NCQA)-accepted source (or the source’s website) listed for the credential

Appropriate documentation of verifications includes:

- Credentialing documents signed (or initialed) and dated by verifier
- A checklist,* including the name of the source used, the date of verification, the signature or initials of the person who verified the information and the report date, if applicable. If the checklist does not include these requirements, appropriate credentialing information should be included.
- Copies of credentialing information and checklist. If the checklist does not include checklist requirements, appropriate credentialing information should be included.

*This checklist must have a single signature and a date for all verifications that has a statement confirming the signatory verified all of the credentials on that date. The statement should include the source and report date of each verification, if applicable.

Humana assigns each member of its credentialing staff a unique electronic identifier. The identifier, along with the date of verification, verification source and report date, if applicable, are recorded as part of the credentialing and recredentialing process in the automated credentialing system.

The verification time limit is 180 calendar days prior to the Credentials Committee's decision, with the exception of education and training, which has no time limit.

The following sources may be used to verify credentialing information:

Licensure (current and valid in all states where the practitioner provides care to Humana members, unless practitioner meets exception for Indian Health Care Improvement Act)

Verification should come directly from the state licensing or certification agency.

NOTE: Physicians and other practitioners providing Telehealth Services must hold appropriate licensure, certifications, and registrations (including Drug Enforcement Agency [DEA] registration if applicable) and comply with applicable professional practice standards and telehealth requirements in the state(s) in which they practice and also in the state(s) in which any Humana member receiving Telehealth Services is located at the time of such encounter. See the Telehealth Credentialing and Recredentialing Standards for more detail on applicable requirements for physicians and other practitioners providing Additional Telehealth Covered Services (as described in Claims Payment Policy CP2008102).

DEA or a controlled dangerous substance (CDS) certificate (current and valid in all states where the practitioner provides care to Humana members)

- Confirmation with the state pharmaceutical licensing agency, where applicable
- DEA or CDS certificate
- Documented visual inspection of the original certificate
- Confirmation with the DEA or CDS agency
- Confirmation with the National Technical Information Service (NTIS) database
- Confirmation with the American Medical Association (AMA) Physician Master File
- American Osteopathic Association (AOA Physician Profile Report or Physician Master File (DEA only)

Education and Training

Verification of the highest of the three levels of education and training obtained by the practitioner:

- Graduation from medical or professional school
- Residency, if appropriate
- Board certification, if appropriate

Physician (M.D. or D.O.)

Graduation from medical school

- Medical school
- AMA Physician Master File
- American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986
- Association of schools of the health professions, if the association performs primary-source verification of graduation from medical school. At least annually, Humana should obtain written confirmation from the association that it performs primary-source verification of graduation from medical school.
- State licensing agency, if the state agency performs primary-source verification. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification.

Completion of residency training:

Residency training program

- AMA Physician Master File
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File
- Association of schools of the health professions, if the association performs primary-source verification of residency training. At least annually, Humana should obtain written confirmation from the association that it performs primary-source verification of residency training.
- State licensing agency, if the state agency performs primary-source verification of residency training. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of residency training.
- The Federation Credentials Verification Service (FCVS) for closed residency programs

Chiropractor:

Graduation from chiropractic college

- Chiropractic college whose graduates are recognized as candidates for licensure by the regulatory authority issuing the license
- State licensing agency, if the state agency performs primary-source verification of graduation from chiropractic college. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of graduation from chiropractic college.

Oral surgeon:

Completion of residency

- Training programs in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA)
- Appropriate specialty board if the board performs primary-source verification of graduation from a CODA-accredited training program. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of graduation from a CODA-accredited training program.
- State licensing agency, if the state agency performs primary-source verification of graduation from a CODA accredited training program. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of graduation from a CODA-accredited training program.

Podiatrist:

Graduation from podiatry school

- Podiatry school
- Appropriate specialty board, if the specialty board performs primary-source verification of podiatry school graduation. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of graduation from podiatry school.
- Confirmation from the state licensing agency, if Humana provides documentation that the state agency performs primary-source verification of graduation from podiatry school. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of graduation from podiatry school.

Completion of residency

- Residency training program
- Appropriate specialty board, if the specialty board performs primary-source verification of completion of residency. At least annually, Humana should obtain written confirmation from the 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 completion of residency. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of completion of residency.

Dentist:

Graduation from dental school

- Dental school
- Appropriate specialty board, if the specialty board performs primary-source verification of dental school graduation. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of graduation from dental school.
- Confirmation from the state licensing agency, if Humana provides documentation that the state agency performs primary-source verification of graduation from dental school. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of graduation from dental school.

Completion of postdoctoral education, if applicable

- Postdoctoral education program
- Appropriate specialty board, if the specialty board performs primary-source verification of completion of postdoctoral education. At least annually, Humana should obtain written confirmation from the specialty board that it performs primary-source verification of completion of postdoctoral education.
- Confirmation from the state licensing agency, if the state agency performs primary-source verification of completion of postdoctoral education. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary source verification of completion of postdoctoral education.

Optometrist:**Graduation from optometry school**

- Optometry school
- Specialty board or registry, if the board or registry performs primary-source verification of professional school training. At least annually, Humana should obtain written confirmation from the specialty board or registry that it conducts primary-source verification of graduation from optometry school.
- State licensing agency, if the state agency performs primary-source verification of professional school training. At least annually, Humana should receive written confirmation from the state licensing agency that it performs primary-source verification of professional school training.

Other healthcare professional:

- Professional school
- Specialty board or registry, if the board or registry performs primary-source verification of professional school training. At least annually, Humana should obtain written confirmation from the specialty board or registry that it conducts primary-source verification of professional school training.
- State licensing agency, if the state agency performs primary-source verification of professional school training. At least annually, Humana should receive written confirmation from the state licensing agency that it performs primary-source verification of professional school training.

Board Certification**Physician (M.D. or D.O.):**

- American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS display agent, where a dated certificate of primary-source authenticity has been provided. **NOTE:** The ABMS' "Is Your Physician Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.
- AMA Physician Master File
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File
- Boards in the United States that are not members of the ABMS or AOA. For non-ABMS or non-AOA boards, Humana will decide which specialty boards to accept and should include the information in its policies and procedures. At least annually, Humana should obtain written confirmation from the non-ABMS or non-AOA board that it performs primary-source verification of education and training.
- State licensing agency, if the state agency performs primary-source verification of board status. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of board status.

Oral surgeon:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if Humana provides documentation that the state agency performs primary-source verification of board status. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of board status.

Podiatrist:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.

- State licensing agency, if Humana provides documentation that the state agency performs primary-source verification of board status. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of board status.

Dentist:

- American Dental Association-recognized dental specialty certifying boards when a dated certificate of primary-source authenticity has been provided
- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if Humana provides documentation that the state agency performs primary-source verification of board status. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary source verification of board status.

Optometrist:

NOTE: Board certification is not applicable to optometrists

Other healthcare professional:

- Appropriate specialty board, if Humana provides documentation that the specialty board performs primary-source verification of education and training. At least annually, Humana should obtain written confirmation from the board that it performs primary-source verification of education and training.
- State licensing agency, if Humana provides documentation that the state agency performs primary-source verification of board status. At least annually, Humana should obtain written confirmation from the state licensing agency that it performs primary-source verification of board status.
- Registry, if Humana provides documentation that the registry performs primary-source verification of board status. At least annually, Humana should obtain written confirmation from the registry agency that it performs primary-source verification of board status.

NOTE: Verification of board certification does not apply to nurse practitioners unless Humana communicates to its members that the nurse practitioner is board-certified.

The Credentialing Department reviews the information contained in verification systems to verify that practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification and specialty. If inconsistencies with credentialing data are found, the credentialing department notifies the appropriate department for correction.

Work history

Most recent five years of relevant work history included on the application or curriculum vitae.

NOTE: An explanation of any gaps in employment that exceed one year should be supplied in writing. An explanation of any gaps in employment greater than six months but less than one year can be supplied verbally or in writing.

Malpractice history

Confirmation of the past five years of malpractice settlements from the malpractice carrier or query to the National Practitioner Data Bank (NPDB)

State sanctions and restrictions on licensure

- Appropriate state agencies
- NPDB

Medicare and Medicaid sanctions and exclusions

- NPDB
- List of excluded individuals and entities maintained by Office of the Inspector General (OIG): <https://exclusions.oig.hhs.gov/>
- General Services Administrations (GSA): <https://www.sam.gov/SAM/>
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)
- State Medicaid agency or intermediary and Medicare intermediary

NOTE: In certain circumstances, Humana is subject to certain credentialing requirements, such as individual state Medicaid credentialing requirements that exceed or differ from those outlined in this policy.

Standard: Practitioner Educational and Training Requirements

Credentialed practitioners should have completed education and training programs in their contracted and/or published specialty. Residents and fellows are generally not credentialed until their training has been completed. Specific education/training guidelines for particular specialties are as follows:

General practitioner

- Medical school and
- Verifiable one-year U.S. (including Puerto Rico) or Canadian residency program in a primary care specialty; and
- Independent and unrestricted license

Pain management

- Training in anesthesiology, physical medicine and rehabilitation, or psychiatry and neurology (Accreditation Council for Graduate Medical Education [ACGME] approved); and
- Completion of a 12-consecutive-month training program in pain medicine

Midwife

Graduate and/or nursing school completion that includes an accredited education program for this specialty

In instances where a credentialed practitioner elects to change contracted and published specialties, the Credentialing Operations Department should confirm that the practitioner meets the criteria for the new specialty. This process should include re-verification of additional education and training related to the new specialty and re-verification of the board certification related to the new specialty.

Standard: Telehealth Credentialing and Recredentialing**Licensure**

Physicians and other practitioners providing Telehealth Services must hold all applicable licensure, certifications, and registrations (including DEA registration if applicable) and comply with applicable professional practice standards in the state(s) in which they practice and also in the state(s) in which any Humana member receiving Telehealth Services is located at the time of such encounter.

Recredentialing

Humana shall conduct recredentialing in accordance with its existing policies (see Recredentialing and Sanction Information), but may elect to recredential physicians and practitioners providing Telehealth Services more frequently than every 36 months.

Standard: Decision-making Criteria for Credentialing and Recredentialing

The decision to credential or recredential practitioners is based on the criteria listed below, including, but not limited to, the information gathered through the credentialing and recredentialing process.

Education and Training. Practitioner has completed appropriate education and training for applied specialty.

State License. Practitioner holds a current state professional license, certificate or registration in the state(s) in which practitioner will treat Humana members. Pursuant to the Indian Health Care Improvement Act (IHCIA), practitioners employed by a tribal health program are not required to have a license from the state in which they are currently practicing but must have a license in at least one state. Practitioners must provide documentation to demonstrate qualification under IHCIA.

License certificate or registration should not be suspended or revoked and should be free of any other "Material Limitations." Material Limitations are sanctions, probations or other conditions that pertain to (a) any requirement to obtain a second opinion for diagnosis or treatment; (b) any condition or limitation on the ability to prescribe medicine or treatment; (c) any requirement for the presence of a second person during any examination, diagnosis or procedure; or (d) any other serious limitations. The Credentials Committee may waive a Material Limitation if the practitioner satisfies the committee that no such Material Limitation indicates a continuing quality-of-care concern.

DEA and/or CDS Certificate. Practitioner holds a current federal DEA certificate and/or a CDS certificate, if applicable to profession.

Eligible for Medicaid. Practitioner demonstrates current eligibility for participation in Medicaid, as applicable.

Eligible for Medicare. Practitioner demonstrates current eligibility for participation in Medicare, as applicable.

Professional Liability Insurance. Practitioner holds current professional liability insurance (PLI) in contracted amounts, has completed the PLI exception procedure or has documentation of coverage under the Federal Tort Claims Act for professional liability coverage.

Claims History. Practitioner has acceptable liability claims history. Any history of repeated catastrophic claims which, after examination by the Credentials Committee and/or the medical/dental director, indicates a propensity for, or trend in, malpractice claims, and/or are unusual for a practitioner in that particular specialty is grounds for denial, unless the practitioner satisfies the Credentials Committee that such actions do not indicate a continuing quality of care concern.

Work History. Practitioner demonstrates appropriate history of employment and clinical practice. Practitioner should explain any gaps in work history greater than six months and should satisfy the Credentials Committee that such gaps do not indicate a continuing quality-of-care concern.

Facility Privileges. Practitioner holds current clinical privileges in good standing at a participating facility or provides an explanation of admitting arrangements applicable to the care the practitioner provides. Clinical privileges should not contain any Material Limitations.

Federal State, and Local Sanction-free Status. Practitioner holds current sanction-free status from federal, state and local authorities to provide healthcare services, unless practitioner satisfies the Credentials Committee that such sanction does not present a continuing quality-of-care concern. Medicare preclusion list is not considered a sanction.

Prior Actions or Relinquishments. Practitioner should not have a history of any action in effect within the last five years taken by a federal, state or local government, including, but not limited to the applicable state licensing body; by a hospital, health plan or other healthcare entity; or by a professional society to discipline, exclude, suspend, revoke or deny; or any suspensions or other restrictions that include Material Limitations. Additionally, practitioner, within the last five years, should not have voluntarily relinquished any membership, license, privileges or participation status or other ability to render healthcare services, including but not limited to a state license or clinical privileges, while under investigation by the entity providing such membership, privileges, participation status or other ability to render healthcare services, or in return for such entity not conducting an investigation. Such prior actions or relinquishments may not be grounds for denial if the practitioner satisfies the Credentials Committee that such action or relinquishment does not indicate a continuing quality-of-care concern.

Convictions. Practitioner has not been convicted of or pleaded guilty or no contest to any felony or to any misdemeanor involving moral turpitude or related to the practice of a healthcare profession, the Federal Health Program fraud and abuse, third-party reimbursement or controlled substances, unless the practitioner satisfies the Credentials Committee that the conviction or plea does not present a continuing quality-of-care concern.

Absence of Physical or Mental Impairment. Practitioner should not be physically or mentally impaired, including impairments due to chemical dependency that may affect the practitioner's ability to practice or may pose a risk of harm to patients.

Quality. For recredentialing purposes only, practitioner should demonstrate an acceptable performance record related to Humana members with no evidence of quality issues. This record includes activities/findings collected through Humana's quality improvement programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys and other plan activities. "Quality" refers to the measure of competence, professional conduct, care and safety that a practitioner affords a patient. Denials based on this criterion that constitute an adverse action require further action under the Humana provider quality review process. Please see the "Decision-making Process for Credentialing and Recredentialing" standard for more information.

Standard: Decision-making Process for Credentialing and Recredentialing

The decision to credential or recredential is based upon the criteria described in the "Decision-making Criteria for Credentialing and Recredentialing" standard ("Credentialing Criteria"). Humana acts only upon complete credentialing and recredentialing applications. A complete application is defined as a submitted application form that is fully filled in with responsive and accurate information, dated and signed as required and accompanied by all required and requested documents. The burden of submitting a complete application rests solely on the applicant. Humana may return unprocessed any incomplete application.

Upon receipt of a complete credentialing application, the credentialing process should be completed within 30 days or as required by state or federal regulations. The credentialing staff should designate files that meet all the Credentialing Criteria as Category I files. Credentialing staff should designate as Category II each file that does not meet all Credentialing Criteria.

The medical/dental director may approve any Category I file that meets all Credentialing Criteria. The medical/dental director review and approval should be recorded in each such file with the approval date being after appropriate review.

The medical/dental director should present all Category II files to the Credentials Committee for review and decision. The Credentials Committee may postpone a decision to receive additional information. Humana should process the credentialing or recredentialing decision of the Credentials Committee as follows:

Approvals: Practitioners with Category II files approved by the Credentials Committee should be notified of the decision. Humana should notify the applicant in writing of the Credentials Committee's approval within 60 days.

Denials: The Credentials Committee must notify a practitioner of a denial based on Credentialing Criteria. The notice must inform the practitioner of the reasons for the denial and should provide notice of an opportunity to request reconsideration of the decision in writing within 30 days of the notice. Upon reconsideration, the Credentials Committee may affirm, modify or reverse its initial decision. Humana should notify the applicant in writing of the Credentials Committee's reconsideration decision within 60 days. Reconsideration decisions are final, unless the denial is based on quality criteria and the practitioner has the right to request a fair hearing. Practitioners who have been denied are eligible to reapply for network participation once they meet the minimum health plan Credentialing Criteria.

Adverse Actions: Adverse actions are actions or recommendations that limit, reduce, restrict, suspend, revoke, terminate, deny or fail to renew a practitioner's participation in a Humana health plan for reasons relating to quality and that adversely affect, or could adversely affect, a patient's health or welfare. Adverse actions lasting longer than 30 days entitle the applicant to prompt notice of his or her right to request a hearing under the Humana provider quality-review process. Denials based on quality may constitute an adverse action and require the Credentials Committee to comply with the Humana provider quality review process. Thus, the committee should consult the Legal Department on each denial based on quality.

Standard: Delegation of Credentialing and Recredentialing

Humana may delegate credentialing and recredentialing activities to organizations or entities that are able to demonstrate compliance with federal, state and accreditation requirements such as NCQA's. Humana retains the right to approve, suspend and terminate individual practitioners, providers and sites where it has delegated decision-making.

The following items may be delegated for credentialing and/or recredentialing and should be included in the delegation agreement:

- Accepts applications, reapplications and attestations
- Collects licensure information from NCQA-approved sources
- Collects DEA and CDS information from NCQA-approved sources
- Collects education and training information from NCQA-approved sources
- Collects work history information from NCQA-approved sources
- Collects history of liability claims information from NCQA-approved sources
- Collects licensure sanction information from NCQA-approved sources
- Collects Medicare and Medicaid sanction information from NCQA-approved sources
- Conducts site visits
- Collects and evaluates ongoing monitoring information
- Makes credentialing and/or recredentialing decisions

When Humana elects to delegate credentialing and/or recredentialing, an approved written agreement outlining those delegated activities and any other responsibilities of the delegate should be signed before the delegate performs any delegated activities. The written agreement should be mutually agreed upon and contain the following information:

- Humana's and the delegated entity's responsibilities
- Description of the delegated activities and Humana's and the delegated entity's responsibilities
- Required minimum of semi-annual reporting to Humana
- Process by which Humana evaluates the delegate's performance
- Remedies, including revocation of the delegation agreement, available to Humana if the delegated entity does not fulfill its obligations
- A statement that Humana retains the right to approve, suspend and terminate individual practitioner, providers and sites where it has delegated decision-making.

Prior to implementing delegation, the delegate's performance capacity is evaluated through the pre-delegation audit process to ensure the entity demonstrates compliance with the applicable federal, state and accreditation requirements. Once the delegation agreement is executed, the delegate's performance is evaluated on an annual basis to ensure the delegated entity remains

compliant with applicable federal, state and accreditation requirements. Opportunities for improvement should be identified and followed up on at least once every two years.

If a delegate sub-delegates credentialing to another entity, documentation verifying that the delegate performs oversight and conducts annual audits is required, unless Humana chooses to conduct these activities itself. Complete listings of all practitioners credentialed and/or recredentialed are due from the delegate on a semi-annual basis and reviewed by Humana.

Standard: Nondiscrimination in Credentialing and Recredentialing

Humana does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age or sexual orientation or on type of procedure or patient (e.g., Medicaid) in which a practitioner or organizational provider specializes. Humana does not discriminate against a provider on the basis of the practitioner's license or certification or because the provider services high-risk populations and/or specializes in the treatment of costly conditions.

Monitoring for and the prevention of potential discriminatory credentialing and recredentialing decisions should be evaluated at least annually. To identify potential discrimination, the Credentialing Operations Department reviews the reason for denying practitioner or organizational provider. Instances of potential discrimination discovered during this process are referred to the corporate quality improvement committee for review and decision.

Standard: Confidentiality of Credentialing Information and System Controls

Credentialing information is confidential and should be held in strict confidence. Humana should keep credentialing files and committee meeting minutes locked in a secured area. Access to electronic credentialing information (i.e., the credentialing system) should be password protected using strong passwords that are regularly changed and limited to staff that requires access for business purposes. The records should be retained for at least 10 years or as applicable to Humana's record- retention policy.

Primary source verifications are received directly from the issuing entity, such as the state licensing board, educational institution, or an authorized source of such organizations, as described within this policy. The staff conducting such verifications will ensure the document is saved in portable document format (PDF), digitally uploaded to the credentialing system and saved within the specific record of the review. The credentialing system electronically adds the verification date as dictated by the user, and an automated process adds the unique electronic identifier of that specific user, the verification source and the date of the report, as applicable.

Modifications are only permitted by an authorized user prior to final committee review and are tracked in the historical data within the automated credentialing system. Authorized users are staff and management within the Credentialing Operations Department who perform practitioner and provider credentialing verification functions as part of their role assignment. Unauthorized modifications are prohibited and monitored by credentialing management. Modifications are authorized when:

- More current information is required as identified during the credentialing review.
- Credentialing committee members request additional documentation or provider clarification.
- Updated or clarification documents are received from practitioners or providers.

Credentialing management oversees staff audits of files completed for each authorized user who performs practitioner and provider credentialing verifications. Weekly random audits are conducted by Humana's Provider Quality Audit (PQA) team to ensure the adherence to policies, procedures and data- entry accuracy. Additionally, Humana's Internal Audit and Regulatory Compliance team administers audits at least annually to ensure the compliance of policies, procedures, accreditation standards as well as state specific requirements.

Quality management files that contain peer-review information are highly confidential and should be kept separate from credentialing files. Credentialing files should not be produced for outside parties without prior approval from the Corporate Law Department and/or the Corporate Insurance Risk-management Department. The records should be retained for at least 10 years or as applicable to Humana's record retention policy.

Standard: Medical/Dental Director Responsibility

The medical/dental director is responsible for overall compliance with the credentialing process. The medical/dental director, or designee, is the chairperson of the Credentials Committee. The chairperson oversees committee voting procedures and verifies approval of each report and file. The medical/dental director, or designee, does not have voting privileges except in the event of a tie vote by the committee. In that event, the chairperson may vote to break the tie.

Standard: Practitioner Rights

Notification of practitioner rights is contained in the Provider Manual for Physicians, Hospitals and Other Healthcare Providers. Practitioners have the right to review information obtained to evaluate their credentialing application, attestation or CV and the right to correct erroneous information. Humana notifies practitioners when credentialing information obtained from other sources varies substantially from information provided by the practitioner. The practitioner should be notified within seven days of the discrepancy. The notification indicates which part of the application is discrepant, the format for submitting corrections and the person to whom corrections should be submitted. If the application, attestation and/or CV must be updated, only the practitioner may attest to the update, a staff member may not. The practitioner has 14 business days to respond in order to resolve the discrepancy. The receipt of any corrections should be documented in the credentialing file.

A practitioner has the right, upon request, to be informed of the status of his/her application. Humana should respond to these requests in a timely manner. Once a practitioner application for initial credentialing has been approved or denied, the practitioner should be notified within 60 days. Credentialing denials will be communicated to the practitioner by the medical/dental director in writing, will include the reason(s) for the denial and should be provided within 60 days of denial.

Humana will make available all application and verification policies and procedures upon written request from the applying healthcare professional.

NOTE: Provider Manual for Physicians, Hospitals and Other Healthcare Providers is available at Humana.com/providermanual, with references to sections X and XII.

Standard: Credentials Committee

Humana designates a Credentials Committee that uses a peer review process to make recommendations regarding credentialing decisions. The Credentials Committee uses participating practitioners to provide advice and expertise for credentialing decisions. The Credentials Committee reviews credentials for practitioners who do not meet Humana's established criteria and gives thoughtful consideration to the credentialing information. The Credentials Committee also ensures that files it does not see meet established criteria and are reviewed and approved by a medical/dental director. The Credentials Committee has final approval or disapproval decision-making authority for credentialing and recredentialing applications.

The Credentials Committee comprises representation from a range of participating practitioners in both primary care and specialty disciplines, i.e., the types of practitioners the committee is reviewing. Participating practitioners are those that participate in Humana's practitioner network. Clinical peer input from non-committee members may be accessed when discussing Credentialing Criteria for specific specialties. Members of the Credentials Committee are asked to sign a confidentiality and conflict of interest agreement. The Credentials Committee meets monthly, for the purpose of conducting credentialing and recredentialing activities and reviewing, offering input and approving credentialing and recredentialing policies and procedures.

Evidence of the Credentials Committee's discussions and decisions are documented in meeting minutes. The chairperson, or designee, should sign and date the committee minutes.

Humana's corporate credentialing and recredentialing policy is reviewed at least annually by the Credentials Committee.

NOTE: Credentials Committee meetings and decision-making may take place in the form of real-time virtual meetings (e.g., through video-conferencing or web conferences with audio). Meetings may not be conducted only through email.

Standard: Initial Credentialing and Sanction Information

The following items are verified through primary or NCQA-approved sources prior to initial credentialing, unless otherwise noted:

- Current and valid license to practice
- Current and valid DEA or CDS certificate, as applicable
- Education and training and board certification, as applicable
- Work history
- History of professional liability claims that resulted in a settlement or judgment paid on behalf of the practitioner (NPDB)
- One peer reference, as applicable for Accreditation Association for Ambulatory Health Care (AAAHC) only

The following sanction or exclusion information is documented prior to initial credentialing, unless otherwise noted:

- State sanctions, restrictions on licensure and limitations on scope of practice
- Medicare and Medicaid sanctions and exclusions
- CMS Medicare preclusion list (Medicare only)

- Current Medicare opt-out list (Medicare only)

Standard: Application and Attestation

Practitioners are required to complete an application for initial credentialing and recredentialing that includes a current, signed attestation regarding their health status and any history of loss or limitation of licensure or privileges. Applications should be signed within 180 days of the credentialing decision and should include any necessary explanations, as applicable. Applicant signatures may be faxed, digital, electronic, scanned or photocopied, but signature stamps are not acceptable. The submission of false information or deliberate omission of requested information on the application may constitute grounds for the denial of credentialing or recredentialing.

The signed and dated application should include detailed information concerning:

- Current state professional license number(s)
- Current federal DEA certificate number(s) or state CDS certificate number(s) (if applicable)
- Current Medicare/Medicaid provider number (if applicable)
- Professional education, residency and board certification (if applicable)
- Work history of at least five years
- Current professional liability insurance coverage and claims history
- Clinical privileges at a primary participating hospital (if applicable)
- Signed and dated consent and release form

The signed and dated application also includes an attestation that addresses the following:

- Reasons for any inability to perform the essential functions of the position
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice coverage
- Current and signed attestation confirming the correctness and completeness of the application

NOTE: Humana requires participation in the Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing DataSource initiative, an online service that helps physicians and other healthcare providers with the credentialing process, including state-specific credentialing applications required by state regulations. Each market's vice president must approve use of any application other than CAQH, if use of other applications are permitted by state law.

Standard: Recredentialing and Sanction Information

Humana formally recredentials its practitioners at least every 36 months. The following items are re-verified through primary or NCQA-approved sources prior to recredentialing, unless otherwise noted:

- Current and valid license to practice
- Current and valid DEA or CDS certificate, as applicable
- Board certification, as applicable
- History of professional liability claims that resulted in a settlement or judgment paid on behalf of the practitioner (NPDB)
- Performance indicators

The following sanction or exclusion information is documented prior to recredentialing, unless otherwise noted:

- State sanctions, restrictions on licensure and limitations on scope of practice
- Medicare and Medicaid sanctions and exclusions
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)

Practitioners on active military duty, maternity leave or sabbatical may be recredentialed upon return. The reason for delaying recredentialing should be documented in the practitioner's file. In these cases, a practitioner should be recredentialed within 60 calendar days of his or her return to practice.

Practitioners in areas affected by natural disasters (regardless of cause, fire, flood or explosion), as established by disaster declarations issued by the Federal Emergency Management Administration (FEMA) or the governor of a state with the corresponding guidance provided by Humana's Crisis Management Team, will be reviewed for possible extension or grace period to respond to requests for recredentialing materials. Such extension will begin on the effective date of the disaster order and continue through the expiration date of the disaster order.

Practitioners who have been administratively decertified may be re-activated within a 30-calendar-day time period. Any practitioner who has been decertified for longer than 30 calendar days should undergo the initial credentialing process.

Standard: Ongoing Monitoring and Interventions

Humana monitors practitioner sanctions, complaints and quality issues between recertification cycles and ensures that corrective actions are undertaken and effective when it identifies occurrences of poor quality (refer to Humana's Provider Quality Review Process).

Ongoing monitoring and appropriate interventions up to and including removal from the network are implemented by collecting and reviewing the following information within 30 calendar days of its release:

- Medicare and Medicaid sanctions and exclusions
- CMS Medicare preclusion list (Medicare only)
- Current Medicare opt-out list (Medicare only)
- Sanctions and limitations on licensure
- Complaints
- Identified adverse events

Evidence of sanction and exclusion reviews is available from the Credentialing Operations Department. Evidence of practitioner complaint and identified adverse-events reviews are available from the Quality Management Department.

Standard: Notification to Authorities and Practitioner Review Rights

When the Credentials Committee recommends an adverse action lasting longer than 30 days against a practitioner, Humana must offer the applicant the right to request a hearing in accordance with the Humana provider quality-review process. Humana must report to the National Practitioner Data Bank all final adverse actions against practitioners lasting longer than 30 days after hearing and review. Humana also may be required to report certain actions to state authorities and must do so in accordance with applicable state laws.

For details pertaining to hearing and reporting requirements, please refer to the Humana Provider Quality Review Process.

For all required hearings on credentialing decisions, the following definitions in the Humana provider quality review process are changed as follows:

- All references to the "HMD" (the Humana Health Plan Market Medical Director) shall mean the credentialing medical/dental director.
- All references to "Peer Review Committee" shall mean the Credentials Committee.

Standard: Assessment of Organizational Providers

Humana evaluates the quality of organizational providers with which it contracts. All organizational providers requiring evaluation should complete the assessment process before a provider's effective date is assigned, except where otherwise required by state regulations. Additionally, an organizational provider will print in the provider directory and provide care to members only after assessment is complete. Organizational providers are reassessed at least every three years thereafter. This assessment includes:

- Confirmation that the provider is in good standing with state and federal regulatory bodies (state license, where required; Medicare/Medicaid intermediaries; OIG and GSA)
- Confirmation that the provider has been reviewed and approved by an accrediting body and/or certified by Medicare*
 - The Joint Commission (TJC)
 - Accreditation Association for Ambulatory Health Care (AAAH)
 - Commission on Accreditation of Rehabilitation Facilities (CARF)
 - Continuing Care Accreditation Co (CCAC)
 - Community Health Accreditation Program (CHAP)
 - Accreditation Commission for Healthcare (ACHC)
 - Healthcare Facilities Accreditation Program (AOA HFAP)
 - American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
 - American College of Radiology (ACR)
 - National Integrated Accreditation for Healthcare Organizations (DNV-NIAHO)
 - Council on Accreditation (COA)
 - Clinical Laboratory Improvement Amendments (CLIA)
 - Clinical Laboratory Accreditation (COLA, Inc.)
 - American Association of Diabetes Educators (AADE)

- Indian Health Service (IHS)
- Commission on Accreditation for Home Care New Jersey (NJCAHC)
- Commission for the Accreditation of Birth Centers (CABC)
- Intersocietal Accreditation Commission (IAC)
- Performance of an onsite quality assessment if the provider is not accredited**

Pharmacy assessment also includes:

- Confirmation of National Council for Prescription Drug Programs (NCPDP)/National Association of Boards of Pharmacy (NAPB) number
- Current and valid DEA or form attesting pharmacy does not have a DEA
- Current malpractice coverage

Organizational providers to be assessed include, but are not limited to:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing surgical centers
- Hospices
- Clinical laboratories
- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy and speech pathology providers
- Pharmacies
- Providers of end-stage renal disease services
- Providers of outpatient diabetes self-management training
- Portable X-ray suppliers
- Rural health clinics and federally qualified health centers

Behavioral healthcare facilities providing mental health or substance abuse services in the following settings are also assessed:

- Inpatient
- Residential
- Ambulatory

Assessment may be documented in the form of a checklist, spreadsheet or record and should include the prior validation date and current validation date for licensure, accreditation status, CMS or state reviews or site visits (if applicable) for each organizational provider.

For organizational providers, ongoing monitoring and appropriate interventions are implemented by collecting and reviewing quality reports from The Leapfrog Group, at least quarterly.

*Providers in Humana's Medicare network(s) must be Medicare-certified. Humana will verify an organizational provider's Medicare certification status by obtaining the certification letter CMS issues to the provider. The CMS certification letter may not be more than three years old at the time of verification and must include the CMS certification number (CCN).

**If an organizational provider is not accredited, Humana may substitute a CMS or state review in lieu of performing its own onsite quality assessment. Humana will verify that an onsite quality assessment has been completed by a state agency or CMS by obtaining the assessment report or certification letter. The CMS or state review may not be more than three years old at the time of verification. If the CMS or state review is older than three years, Humana will conduct its own onsite quality review. If the state or CMS has not conducted a site review of the provider and the provider is in a rural area (as defined by the U.S. Census Bureau), Humana may choose not to conduct a site visit.

NOTE: The Practitioner Office and Facility Location Survey tool is used in cases where a site visit is required.

Standard: Assessment of Long-Term Services and Support Provider

Humana evaluates the quality of LTSS providers with which it contracts. All LTSS providers requiring evaluation should complete the assessment process before their effective date is assigned, except where state regulations require otherwise. Additionally, an LTSS provider will print in the provider directory and provide care to members only after assessment is complete. LTSS providers are reassessed at least every three years thereafter.

LTSS providers to be assessed include, but are not limited to:

- Adult day care centers (ADC)
- Assisted living facility services (ALF)
- Adult family care homes (AFCH)
- Case management agencies
- Chore providers, including pest-control contractors
- Suppliers of consumable supplies
- Environmental accessibility contractors
- General contractors
- Home-delivered meal services
- Home health agencies
- Home medical equipment (HME) services
- Homemaker/companion services
- Hospices
- Non-emergent/non-traditional transportation service providers
- Nurse registry
- Nutritionist/dietician
- Skilled nursing facility
- Therapy services (occupational, physical, respiratory and speech)

Assessment includes:

- Confirmation the provider is in good standing with state and federal regulatory bodies (state license, Medicare/Medicaid intermediaries, OIG and GSA)
- For provider types not licensed by a state medical regulatory board, confirmation the provider has a current, valid occupational license or other evidence of authority to do business within the scope of contracted service(s)
- Confirmation the provider has been reviewed and approved by an accrediting body, as applicable (AAAHHC, CARF/CCAC, CHAP, AOA, CMS, TJC or Occupational Safety and Health Administration [OSHA])
- Performance of an onsite quality assessment if the provider is not accredited*
- Confirmation the provider is compliant with abuse, neglect, exploitation and chore training, as applicable per state requirement.
- Confirmation of current liability and/or worker's compensation insurance coverage, as applicable per state requirement

Documentation of the assessment may be in the form of a checklist, spreadsheet or record and include the prior validation date and current validation date for licensure, accreditation status, CMS or state reviews or site visits (if applicable) for each organizational provider.

*If an LTSS provider is not accredited, Humana may substitute a CMS or state review in lieu of accreditation. Humana should obtain a state report or CMS letter to verify that the review has been performed. The CMS or state review may not be more than three years old at the time of verification. **EXCEPTION:** Accreditation, CMS or state-agency review will not be substituted in lieu of an on-site visit if a program's contract requires verification of defined characteristics unique to certain provider types.

Procedures:

N/A

References:

Provider Manual for Physicians: [Humana.com/providermanual](https://www.humana.com/providermanual)

Owner: Shari Debroux**Executive Team Member:** James Augustus**Accountable VP / Director:** Eric Lehenbauer**Disclaimer:**

Humana follows all federal and state laws and regulations. Where more than one state is impacted by a particular issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source to ensure no modifications have been made.

Non-Compliance:

Failure to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over any and all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Policy Source site of Humana's secure intranet on Hi! (Sites/View Full Site Directory/Tools and Resources/Policy Source).

Humana Policy and Procedure(s)



Delegation Policy

Original Date:	December 2001	Last Reviewed Date:	January 17, 2020
Last Revised Date:	January 17, 2020	Accountable Dept.:	10906- Licensure and Business Partner Compliance

Summary of Changes:

Added the phrase, “medical, dental and/or behavioral health,” to the “Scope” statement

Overview:

This policy describes the oversight process for any activity or function for the Medicare, Medicaid, Commercial and Specialty lines of business that have been delegated by Humana to another entity. Humana remains responsible for the performance and compliance of any function that is delegated. Functions that may be delegated include, but are not limited to:

- Claims Processing
- Claims Repricing
- Credentialing
- Clinical Health Services for medical and behavioral health
 - Utilization Management (UM)
 - Complex Case Management (CCM)
 - Disease Management (DM)
 - Quality Improvement (QI)
- Special Needs Plan (SNP)

The following standards are part of this Delegation Policy:

- Pre-Delegation Audit
- Annual Delegation Audit
- Corrective Action Plan
- Delegation Services Addendum and Delegation Attachments
- Provisions for Protected Health Information (PHI)
- Sub-Delegation
- Termination of Delegation
- Additional Delegated Functions

Scope:

This Delegation Policy governs Humana’s relationships with any medical, dental and/or behavioral health entity that has been delegated by Humana to perform an activity or function on its behalf.

Definitions:

Additional Delegated Functions- Any additional activity or function that has been delegated by Humana.

Annual Delegation Audit- Method to evaluate an entity’s contractual, regulatory and accreditation organization compliance and performance capacity annually.

BAA- Business Associate Agreement

CAC- Contract Approval Committee

CAP- Corrective Action Plan

Humana Internal

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Claims Processing- The process to receive, investigate and act on a claim filed by a provider or an insured. It involves multiple administration and customer service layers that include review, investigation, adjustment, and remittance of payment or denial of a claim. Delegation of claims processing is whereby Humana delegates all of these processes to another entity.

Complex Case Management- Coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Concurrent- A review for an extension of a previously approved, ongoing course of treatment or number of treatments.

Corrective Action Plan- Issued to a Delegated Entity when they fail to meet established thresholds of compliance.

Credentialing- The process of obtaining and reviewing the documentation provided by the applicant and/or obtained during the process for the purpose of determining participation privilege status in the health plan.

Delegated Entity- An entity contracted to perform a function on behalf of Humana

Delegation- A formal process whereby a health plan gives a qualified contracted provider group the authority to perform certain business functions on its behalf.

Delegation Attachment- A legal document that covers the specific performance requirements based on the function being delegated.

Delegation Council- A cross-functional group to review and vet proposals that involve clinical or claim delegation

Delegation Services Addendum- An additional document not included in the main part of the contract. It contains additional terms, obligations and information regarding the delegation of specific functions to an entity.

Disease Management- A multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions.

HIPAA- Health Insurance Portability and Accountability Act

HITECH- Health Information Technology for Economic and Clinical Health Act

OIG – Office of Inspection General

Pre-Delegation Audit- Method to evaluate an entity's compliance and performance capacity prior to the execution of a delegation contract.

Preclusion – CMS preclusion list

SAM – System for Award Management

SNP- Special Needs Plan

Sub-Delegation- An entity contracted with a Delegated Entity to perform a function on behalf of the delegate.

Utilization Management- A formal evaluation (pre-service, concurrent, or post service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.

Requirements: Pre-Delegation Audit

To evaluate the entity's capability to perform the requested delegated function(s) according to contractual, state, federal, accreditation organization and Humana standards and requirements to ensure compliance.

This Delegation Standard governs Humana's relationships with any entity that has been recommended for delegation by a Humana contractor to perform an activity or function on Humana's behalf.

The Delegation Compliance department will perform a pre-delegation audit prior to any function being delegated to a prospective entity upon receipt of the Request for Delegation form and the Pre-delegation Questionnaire (claims delegation only). The pre-delegation audit will include evaluation of a prospective delegate's compliance and performance capacity against state, federal,

accreditation and Humana standards which will include a review and approval of the following applicable items of the prospective delegate:

- Delegation Council review of proposed clinical health services and claims delegation
- Contract Approval Committee (CAC) approval for claims delegation
- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreements
- Downstream provider agreements
- Audit of contracted sub-delegate's program including policies, procedures and program documents
- Letters of accreditation
- Financial solvency
- File audit
- Federal/state exclusion screenings
- OIG, SAM, Preclusion List
- Offshore contracting

If a delegate requests a change of a subcontractor at any point, Humana's Delegation Compliance department will review and approve the subcontractor's policies, procedures and program documents, either directly or by review and approval of the delegate's audit of the proposed sub-delegate. These reviews will be conducted prior to contracting and require the subcontractor to comply with all Humana, federal, state and accreditation requirements.

Results of the pre-delegation audit are recorded on a standardized audit tool and then scored to determine the prospective delegate's ability to meet compliance requirements according to the following compliance thresholds::

- Prospective delegates with a pre-delegation audit score of less than 70% must be referred to the appropriate committee, market leadership, compliance leadership, or business owner for additional evaluation and final determination on the entity's ability to meet Humana requirements to assume a delegated function.
- Prospective delegates with a pre-delegation audit score of 70%- 94% or those missing critical elements as identified on the applicable functional audit tool may only be approved if a Corrective Action Plan (CAP) is implemented. Refer to the Corrective Action Plan standard.
- Prospective delegates with pre-delegation audit score of 95% or higher may be approved without requiring a CAP, although potential opportunities for improvement should be documented and communicated to the delegate.

Requirements: Annual Delegation Audit

To review annually the functions of all delegated entities against contractual, state, federal, accreditation organization and Humana standards and requirements to ensure compliance.

This Delegation Standard governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

The Delegation Compliance department will perform an annual delegation audit to evaluate all delegates' continued ability to meet delegation compliance and performance capacity against state, federal accreditation and Humana standards and requirements, which will include a review and approval of the following applicable items of the delegate:

- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreements
- Audit of contracted sub-delegate's program including policies, procedures and program documents
- Letters of accreditation
- Financial solvency
- File audit
- Member and provider written communications applicable to the delegated function
- Confirming no offshore contracting

If a delegate requests a change of a subcontractor at any point, Humana's Delegation Compliance department will review and approve the subcontractor's policies, procedures and program documents, either directly or by review and approval of the delegate's audit of the proposed sub-delegate. These reviews will be conducted prior to contracting and require the subcontractor to comply with all Humana, federal, state and accreditation requirements.

Results of the annual audit are recorded on a standardized audit tool and then scored to determine the delegate's ability to meet compliance requirements according to the following compliance thresholds:

- Delegates with annual delegation audit scores of 70% or less must be referred to the appropriate committee, market leadership, compliance leadership or business owner for additional evaluation and final determination on appropriate and necessary next steps which may include; additional corrective measures, cancellation of a particular delegated function by termination of a delegation attachment, or termination of the delegation services addendum.
- Delegates with annual delegation audit scores of 70%-94% may only be approved if a Corrective Action Plan (CAP) is implemented. Refer to Corrective Action Plan standard.
- Delegates with annual delegation audit scores of 95% or higher may be approved without requiring a CAP, although potential opportunities for improvement should be documented and communicated to the delegate.

Audit results are reported to the appropriate committee, market leadership, compliance leadership or business owner.

Delegation Compliance will continue to monitor all delegated entities through the collection of periodic applicable reporting.

Requirements: Corrective Action Plan

To formally identify and document any contractual, regulatory or accreditation organization performance requirements or other issues, provide an explanation of how the delegate is determined to be non-compliant and provide a plan of action to bring the delegate into compliance.

This Delegation Standard governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

The Delegation Compliance department will issue a Corrective Action Plan (CAP) when the delegate fails to meet established compliance thresholds, contractual requirements, or other requirements. Specific deficiencies resulting in a CAP include, but are not limited to:

- Failure to achieve an overall audit score of 95%, or
- Failure to achieve required threshold for any single-item score
- Failure to meet compliance thresholds for critical elements as specified on standardized audit tool, during a pre-delegation, annual delegation audit, or contractual review.

A CAP should contain:

1. The identified issues and deficiencies
2. Root cause analysis
3. The corrective actions required, and
4. The timeframes for performance of the corrective actions and achieved results.

The delegate's performance under the CAP will be monitored by Delegation Compliance. Monitoring frequency is dependent upon the potential risks identified, and will occur until the delegate has achieved the required results.

If a delegate fails to achieve the required results within the timeframe provided, the delegate's results will be referred to the appropriate committee, market leadership, compliance leadership or business owner for additional evaluation and a final determination on appropriate and necessary next steps, which may include; additional corrective measures, cancellation of a particular delegated function by termination of a delegation attachment, or termination of the delegation services addendum.

Requirements: Delegation Services Addendum and Delegation Attachments

To establish a legally enforceable contractual arrangement between Humana and a Delegated Entity that outlines the legal obligations mutually agreed upon between the parties to the agreement.

This Delegation Standard governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Upon approval of delegation pursuant to the pre-delegation audit standard, Humana and delegate must execute Humana's Delegation Services Addendum and Delegation Attachment for each delegated function. The written Delegation Services Addendum and Delegation Attachment(s) must:

- Be mutually agreed upon.
- Describe the activities and the responsibilities of Humana and the Delegated Entity.
- Requires at least semiannual reporting by the Delegated Entity to Humana.
- Describe the process by which Humana evaluates the Delegated Entity's performance.
- Describe the remedies available to Humana if the Delegated Entity does not fulfill its obligations, including revocation of the Delegation Attachments.
- Retain for Humana the right to approve, suspend and terminate any delegated or sub-delegated function, including but not limited to the termination of individual practitioners, providers and provider sites where credentialing decision making is delegated.
- Retain for Humana pre-approval rights for any proposed sub-delegation.

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- Contractually require that delegate shall provide sufficient oversight of the subcontractor to ensure that the subcontractor shall comply with all of the terms and conditions of the Delegation Services Addendum and Attachments, or allow Humana to perform direct oversight of sub-delegate.
- Require delegate to comply with Humana, state and federal law and accreditation organization requirements.
- Comply with 45 CFR 156.340 and permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through audit, inspection, or other means, to the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of 45 CFR 156.340 until 10 years from the final date of the agreement period.

The Delegation Compliance department will maintain the Delegation Services Addendum with applicable Delegation Attachment(s).

Requirements: Provisions for Protected Health Information (PHI)

To protect the confidentiality, integrity, and availability of electronic PHI when it is stored, maintained, or transmitted.

This Delegation Standard governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

If a delegation arrangement involves the use of protected health information (PHI), Humana and delegate must execute Humana's Business Associate Agreement (BAA). The BAA should be mutually agreed upon and describe the following information:

- A list of allowed uses of PHI.
- A description of delegate safeguards to protect the information from inappropriate use or further disclosure.
- A stipulation that the delegate will ensure that sub-delegates have similar safeguards.
- A stipulation that the delegate will provide individuals with access to their PHI.
- A stipulation that the delegate will inform the organization if inappropriate uses of the information occur.
- A stipulation that the delegate will ensure that PHI is returned destroyed or protected if the delegation agreement ends.
- All other requirements under HIPAA/HITECH Act statutes and regulations.

The Business Associate Agreement (BAA) template should be maintained by the Humana's Privacy Office and a copy of the BAA to the Delegation Compliance department.

Requirements: Sub-Delegation

To establish requirements if a delegate chooses to sub-delegate any activities that are currently delegated to them by Humana.

This standard governs the sub-delegation by any delegate of a delegated function.

The delegate will request Humana's approval to sub-delegate any portion of the delegated functions or activities. The delegate will demonstrate to Humana a plan for adequate oversight of the sub-delegate or request oversight by the Delegation Compliance department prior to approval of the sub-delegate.

If Humana approves the sub-delegation, the delegate will provide Humana documentation of a written sub-delegation agreement (and, as applicable, a Business Associate Agreement) that:

- Is mutually agreed upon.
- Describes the activities and the responsibilities of the delegate and the sub-delegated entity.
- Requires at least semiannual reporting of the sub-delegated entity to the delegate.
- Describes the process by which the delegate evaluates the sub-delegated entity's performance.
- Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the delegation agreement.
- Allows Delegation Compliance access to all records and documentation pertaining to monitoring and oversight of the sub-delegates delegated activities.

If it retains oversight responsibilities, the delegate will provide evidence of annual oversight of sub-delegated entity.

Requirements: Termination of Delegation

To mitigate any risks the delegate may impose on Humana due to failure to comply with regulatory, contractual and other compliance requirements.

This Delegation Standard governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

A delegate's failure to perform or comply with the terms of the Delegation Services Addendum and Attachments will result in Delegation Compliance referring the delegate's noncompliance or unacceptable performance status to the appropriate committee,

market leadership, compliance leadership, or business owner recommending termination of delegation. Specific deficiencies that may lead to termination include, but are not limited to:

- Failure to comply with state and federal laws, rules and regulations.
- Failure to comply with Humana or accreditation organization standards.
- Failure to cooperate with Humana's delegation audit process.
- Failure to comply with any term of the Delegation Services Addendum or delegation attachment(s).
- Failure to comply with the terms of any implemented Corrective Action Plan.
- Failure to submit accurate and timely delegation reports, as specified in the Delegation Services Addendum and Attachments.
- Placement on any federal/state government programs exclusion lists.

Either the termination of the Delegation Services Addendum and/or a rescission of the delegated function/service should be initiated.

Requirements: Additional Delegated Functions

To identify functions that could be delegated to an entity that would be out of scope for the Delegation Compliance department to oversee and/or monitor.

This Delegation Standard governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

The following additional activities or functions may be delegated by operational areas within Humana when the operational area assumes responsibility for oversight of that function or activity:

- Network Management
 - Provider access and availability
 - Provider contracting

Oversight of these additional activities or functions should meet the requirements of Humana's Delegation Policy and all standards therein.

Procedures:

N/A

References:

45 CFR 156.340

Owner: Michelle Phillips

Executive Team Member: Samir Deshpande (Sam)

Accountable VP / Director: Devin Prather

Disclaimer:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by a particular issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source to ensure no modifications have been made.

Non-Compliance:

Failure to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over any and all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Policy Source site of Humana's secure intranet on Hi! (Sites/View Full Site Directory/Tools and Resources/Policy Source).

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