UnitedHealthcare Credentialing Plan. 2019-2021

This Credentialing and Recredentialing Plan may be distributed to Physicians, other health care professionals and Facilities upon request. Additionally, a Credentialing Entity may distribute this Plan to entities that have applied for delegation of the credentialing responsibility.

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Section 1.0

Introduction.

Section 1.1 — Purpose.

The purpose of this Credentialing and Recredentialing Plan (“Credentialing Plan”) is to explain the policy of United HealthCare Services, Inc. and its affiliates (UnitedHealthcare) for Credentialing and Recredentialing. All Licensed Independent (LIPs) Practitioners and Facilities that the Credentialing Entity names as part of its Network including Leased Networks as required by Credentialing Authority are subject to the Credentialing Plan. Licensed Independent Practitioners and Facilities that provide health care services to Covered Persons under their out-of-network benefits or on an emergency basis are not subject to this Credentialing Plan.

Credentialing is a peer-review process designed to review certain information pertinent to the Credentialing Entity’s decision whether to contract with Licensed Independent Practitioner or Facility, either initially or on an ongoing basis, as determined by Credentialing Entity. The process described in the Credentialing Plan will be initiated only after the Credentialing Entity makes a preliminary determination that it wishes to pursue contracting or re-contracting with the Applicant.

The Credentialing Entity does not make Credentialing and Recredentialing decisions based on a Licensed Independent Practitioner’s race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or patients in which the Licensed Independent Practitioner or Facility specializes. Credentialing Entity also does not discriminate in terms of participation, reimbursement, or indemnification, against any Licensed Independent Practitioner who is acting within the scope of the applicable license or certification under State law, solely on the basis of the license or certification. This does not preclude the Credentialing Entity from including in its Network Licensed Independent Practitioners who meet certain demographic or specialty needs such as, but not limited to, cultural needs of its Covered Persons.

No portion of this Credentialing Plan grants rights to Covered Persons, Licensed Independent Practitioners or Facilities, nor is it intended to establish a standard of care or to be used as evidence relevant to establishing a standard of care.

Section 1.1– Credentialing Policy.

The Credentialing Entity’s credentialing policy consists of this Credentialing Plan and any Credentialing Authority’s standards (shown in Attachment E, as may be amended from time to time). To the extent this Credentialing Plan includes less stringent Credentialing standards than any applicable Credentialing Authority’s standards, UnitedHealthcare will adopt the revised or clarified standard unless otherwise amended in this Credentialing Plan.

Section 1.3 — Authority of Credentialing Entity and Changes to Credentialing Plan.

To the extent permitted by any Credentialing Authority’s standards and this Credentialing Plan, Credentialing Entity has the sole right to determine which Licensed Independent Practitioners and Facilities it will accept and maintain within its Network, and the terms on which it will allow participation.

Quality Oversight Committee has the authority to approve this Credentialing Plan. Credentialing Entity has the right to change this Credentialing Plan to meet regulatory requirements or other organizational or business need with Credentialing Entity’s Quality Oversight Committee approval. This Credentialing Plan does not limit Credentialing Entity’s or UnitedHealthcare’s rights under the pertinent Participation Agreements that govern their relationships with Licensed Independent Practitioners and Facilities.

Section 2.0

Definitions.

For the purposes of this Credentialing Plan, the terms listed below have the meanings described below and are capitalized throughout this Plan. The National Credentialing Committee has the discretion to further interpret, expand and clarify these definitions.

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- “Appeal” has the meaning given to it by any governing Credentialing Authorities or the pertinent Participation Agreement.
- “Applicant” means a Licensed Independent Practitioner or a Facility that has submitted an Application to Credentialing Entity for Credentialing or Recredentialing.
- “Application” means the document provided by Credentialing Entity (or its designee) to a LIP or a Facility which, when completed, will contain information for National Credentialing Committee to review as part of its determination whether Applicant meets the Credentialing Criteria.
- “Application Date” means the date on which the Credentialing Entity receives the signed, dated and complete Application for Network participation from a LIP or a Facility.
- “Benefit Plan” means a health benefits plan that: (1) is underwritten, issued and/or administered by Credentialing Entity, and (2) contains the terms and conditions of a Covered Person’s health benefits coverage.
- “Board of Directors” means the Credentialing Entity’s Board of Directors.
- “CMS” means the Centers for Medicare and Medicaid Services.
- “Covered Person” means a person who is covered by a Benefit Plan (i.e., members, subscribers, insureds, participants, enrollees, customers or other Covered Persons).
- “Credentialing Authorities” means the National Committee for Quality Assurance (“NCQA”), other accrediting body as applicable to UnitedHealthcare, the Center for Medicare and Medicaid Services (“CMS”), as applicable, and other applicable state and federal regulatory authorities; to the extent such authorities dictate Credentialing requirements.
- “Credential”, “Credentialing”, or “Recredentialing” means the process of assessing and validating the applicable criteria and qualifications of Licensed Independent Practitioners and Facilities to become or continue as Participating LIPs and Participating Facilities, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities.
- “Credentialing Criteria” are those found in Section 4.0, 5.0 and 7.0 as applicable, and applicable attachments to this Credentialing Plan, as it may be amended from time to time.
- “Credentialing Entity” is United HealthCare Services, Inc. or its affiliates that adopts this Credentialing Plan. When “Credentialing Entity” is required to take some action by this Credentialing Plan, it may do so through delegation to the extent permitted by any Credentialing Authorities.
- “Decision Date” is the date on which the National Credentialing Committee makes its decision to indicate approval or denial of Credentialing or Recredentialing for an Applicant.
- “Delegated Entity” is a hospital, group practice, credentials verification organization (CVO), or other entity to which Credentialing Entity has delegated specific credentialing and recredentialing responsibilities under a Credentialing Delegation Agreement.
- “Credentialing Delegation Agreement” is a mutually agreed upon contract or other document by which Credentialing Entity delegates specified Credentialing responsibilities to Delegated Entity, and requires Delegated Entity to meet certain standards related to its Credentialing and Recredentialing responsibilities.
- “Facility” includes but is not limited to hospitals and ancillary providers such as home health agencies, skilled nursing facilities, behavioral health centers providing mental health and substance abuse services (inpatient, residential and ambulatory), Federally Qualified Health Centers, Rural Health Centers, free-standing surgical centers, and multispecialty outpatient surgical centers, or as otherwise defined by Credentialing Authority.
- “Hearing Panel” means a committee created by the Credentialing Entity to provide Appeals as required by Credentialing Authorities or the pertinent Participation Agreement.

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- "Leased Network" means an existing organization of physicians, hospitals and other healthcare professionals that UnitedHealthcare contracts to allow access by Covered Persons and to which UnitedHealthcare has entered into a Credentialing Delegation Agreement.
- "Licensed Independent Practitioner" or "LIP" means any health care professional who is permitted by law to practice independently within the scope of the individual's license or certification, and includes but is not limited to medical doctors (MDs), doctors of osteopathy (DOs), dentists (DDS or DMD), chiropractors (DCs), doctors of podiatric medicine (DPM),) psychologists (PhDs), social workers, certified registered nurse practitioners (CRNPs), physician assistants (PAs, certified nurse midwives (CNMs), physical, speech, occupational therapists and all other non physician practitioners who have an independent relationship with the Credentialing Entity and provide care under a Benefit Plan.
- "Material Restriction" means a restriction that includes but is not limited to the following: a requirement to obtain a second opinion from another practitioner prior to patient diagnosis or treatment; a limitation on prescription drug writing; a limitation on providing examination, diagnosis or procedure without a second person present or approving the procedure; or restriction, suspension or involuntary termination of hospital staff privileges if the LIP's specialty normally admits patients to a hospital; a restriction on or prohibition from performing a service or procedure typically provided by other practitioners in the same or similar specialty. The restrictions listed above are not exclusive. There may be other restrictions or conditions, not specifically identified in the definition above, that rise to the level of a material restriction..
- "NCQA" means The National Committee for Quality Assurance.
- "National Credentialing Committee" means a standing committee that implements the Credentialing Plan.
- "National Peer Review and Credentialing Policy Committee" is comprised of stakeholders from multiple UnitedHealthcare regions and meets regularly. The National Peer Review and Credentialing Policy Committee has the final decision making authority on all Quality of Care disciplinary actions recommended by the regional Peer Review Committee that affect restriction, suspension or termination of Network participation status.
- "Network" means LIP's and Facilities contracted with UnitedHealthcare to provide or arrange for the provision of health care services to Covered Persons.
- "Newly Merged Network" means a network of LIP's and Facilities that had contracts to participate with an HMO, insurer or other managed care entity that was acquired by or merged into Credentialing Entity or any affiliated UnitedHealth Group company.
- "Notice" means: (1) depositing correspondence in the United States mail, using first class or certified mail, postage prepaid, addressed to the other party at the last known office address given by the party to the other party; or (2) delivering the correspondence to an overnight courier, delivery to the other party prepaid, addressed to the other party at the last known office address given by the other party; or (3) sending a facsimile transmission to the other party at the last known office facsimile number given by the party to the other party, or (4) personally hand-delivering written notice to the other party.
- "NPDB" means the National Practitioner Data Bank.
- "NTIS" is the National Technical Information Service.
- "Participating LIP/Facility" means a Licensed Independent Practitioner or Facility who has entered into a Participation Agreement with the Credentialing Entity or as an employee of a Delegated Entity.
- "Participation Agreement" means a direct or indirect (such as an IPA or PHO) agreement between the Credentialing Entity and a LIP or a Facility that sets forth the terms and conditions under which the LIP or Facility participates in the Credentialing Entity's Network.
- "PCP" means primary care physician, and always includes family practice, geriatrics, internal medicine, pediatric general practice and general practice physicians. In some states and for some Credentialing Entities, "PCP's" may also include OB/GYNs and certified registered nurse practitioners.

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- "Peer Review" is the evaluation or review of the performance of physicians, health care professionals or facilities by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician's practice by another physician).
- "Peer Review Committee (PRC)" is responsible for investigating and evaluating Covered Persons Quality of Care (QOC) Complaints and determining, or recommending to the National Peer Review and Credentialing Policy Committee, whether and what type of disciplinary action should be taken in relation to such QOC Complaints between the credentialing or recredentialing cycle. Complaints requiring investigation may involve a physician, health care professional or Facility that delivers health care to Covered Persons. The PRC shall comply with applicable state peer review requirements and is comprised of Medical Directors, participating physicians and QOC clinical staff.
- "Primary Source Verify" means to verify directly with an educational, accrediting, licensing, other entity, or NCQA approved entity that the information provided by Applicant is correct and current.
- "Protected Health Information" (PHI) has the same meaning it has under the Health Insurance Portability and Accountability Act and its implementing and interpretative regulations.
- "Quality Oversight Committee" means the Credentialing Entity committee that may review and approve changes to the Credentialing Plan required to meet regulatory requirements or other organizational and business needs. A Credentialing Entity may have a different name for this committee but the intent of the meaning applies.
- "Quality of Care (QOC)" means the degree to which health services for Covered Persons increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include, but are not limited to, the following: member perspective issues, safety of the health care environment, accessibility, appropriateness, continuity, effectiveness, efficacy and timeliness of care.
- "UnitedHealthcare Quality of Care Department" (QOC) means the department within UnitedHealthcare that receives, logs, investigates and documents resolution of quality of care and quality of service complaints.

Section 3.0

Responsibilities of Board of Directors, National Credentialing Committee, Medical Directors, Hearing Panels and Applicants.

Section 3.1 — Credentialing Entity Board of Directors (Board of Directors).

The Board of Directors is responsible for the administration of the Credentialing Plan and has delegated to the National Credentialing Committee the overall responsibility and authority for Credentialing and Recredentialing. Each Board of Directors has delegated to the Quality Oversight Committee the responsibility for providing oversight of Delegated Entities, including review and approval of Delegated Entities' credentialing policies, as further described in Section 11 and in the Credentialing Entity's Quality Improvement program description.

Section 3.2 — Medical Director.

The Credentialing Entity Medical Director is responsible for the administration of the Credentialing Plan and for other activities as defined by the Credentialing Entity or National Credentialing Committees. The Medical Director may approve initial Credentialing or Recredentialing files determined to meet all Credentialing Criteria or may determine that additional review by the National Credentialing Committee is required. The Medical Director may delegate these functions to a peer as appropriate.

Section 3.3 — National Credentialing Committee.

National Credentialing Committee has the responsibility to implement this Credentialing Plan. The National Credentialing Committee has the authority to interpret the terms of this Credentialing Plan and make any necessary professional judgments about medical practice and clinical issues.

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The National Credentialing Committee will make Credentialing decisions pursuant to this Credentialing Plan and will communicate those decisions to the Credentialing Entity. If the National Credentialing Committee determines that any LIP or Facility (Facility only where required by Credentialing Authorities) has violated the terms of this Credentialing Plan, the National Credentialing Committee has the responsibility to report adverse Credentialing decisions to the Credentialing Entity. The Credentialing Entity will then follow the processes set forth in Section 9 of the Credentialing Plan and submit any required reports as described therein.

The National Credentialing Committee will be comprised of Participating LIPs from the Credentialing Entities, UnitedHealthcare Medical Directors, and a designated Medical Director Chairperson; unless a different committee composition is otherwise required by applicable Credentialing Authorities. A quorum of the National Credentialing Committee is required to make a Credentialing decision. A quorum requires at least five (5) voting members to be present.

Section 3.4 — Process for Initial Credentialing and Recredentialing of LIPs.

Before forwarding an Application to the National Credentialing Committee, the Credentialing Entity staff will collect information to assess whether an Applicant meets Credentialing Entity's minimum requirements for practice location, specialty and any other business needs.

A list of LIPs who meet Credentialing Criteria will be submitted to the Medical Director for review and approval by electronic signature. The Medical Director reviews shall be generally performed on a daily basis during normal business hours.

LIPs who do not meet Credentialing Entity's established Credentialing Criteria are presented to the National Credentialing Committee. The information provided to the National Credentialing Committee includes the LIP's profile and all documentation related to the issue or issues in question. The information provided to the National Credentialing Committees does not include references to age, gender, race, sexual orientation or type of procedure or patients in which the practitioner specializes, so decisions are made in a nondiscriminatory manner. The National Credentialing Committee may request further information from any persons or organizations, including the LIP, in order to assist with the evaluation process.

The National Credentialing Committee will not make any decision on an Applicant without a completed Application, as outlined in Attachment A. The National Credentialing Committee has discretion to ask for missing information or to deny the Application as incomplete. The National Credentialing Committee may request further information not covered by the Application if necessary to fulfill its obligations under applicable Credentialing Authorities.

The National Credentialing Committee has given the discretion and authority to National Credentialing Center staff to cease processing and/or recommend contract termination for any LIPs who have not, after multiple documented requests, submitted a complete Credentialing application.

Upon receipt of a complete Application, the National Credentialing Committee will render a decision in accordance to the timeframes as specified by the Credentialing Authority.

The National Credentialing Committee may delay action on an Application pending the outcome of an investigation of the Applicant by a hospital, licensing board, government agency, or any other organization or institution.

Section 3.5 — Disclosing Reasons for Non-Acceptance or Termination.

When a LIP's or Facility's Application is not accepted or participation is terminated, the non-acceptance or termination letter will include the reason(s) for the decision. Each Credentialing Entity should contact its legal representative if it has questions about any specific Credentialing Authority that may require it to disclose reasons for non-acceptance or termination, or if it is not accepting an Applicant or is terminating participation for reasons relating to professional competence or conduct.

Section 3.6 — Applicant.

Applicant is responsible for timely completion of the Application, providing all requested information, and disclosing all facts that a Credentialing Entity would consider in making a reasonable Credentialing decision. Applicant or a Participating LIP or Participating Facility must inform Credentialing Entity of any material change to the information on the Application including but not limited to: any change in staff privileges, prescribing ability, accreditation, ability to perform professional duties, change in

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OIG sanction or GSA debarment status or Material Restrictions on licensure. Failure to inform Credentialing Entity immediately of a status change is a violation of this Credentialing Plan and the Participation Agreement, and may result in immediate suspension or termination from the Network.

Section 4.0

Initial Credentialing of Licensed Independent Practitioner Applicants.

Section 4.1—Scope of Licensed Independent Practitioner (LIP) Credentialing.

Credentialing is required for all LIPs to whom UnitedHealthcare directs Covered Persons to receive care under a Benefit Plan as part of UnitedHealthcare's Network of Participating LIPs, including LIPs participating through a Leased Network agreement. In the event of Leased Networks, Credentialing may be delegated and will be subject to the requirements of Section 11 of this Credentialing Plan. Credentialing is generally not required for health care professionals who are permitted to furnish services only under the direct supervision of another LIP or for hospital-based or Facility-based health care professionals who provide service to Covered Persons incidental to hospital or Facility services. However, Credentialing is required for hospital or Facility-based LIPs to whom UnitedHealthcare directs Covered Persons to receive care under a Benefit Plan or if mandated by Credentialing Authorities.

Except as otherwise required by Credentialing Authorities, the Credentialing Entity will consider Applications from LIPs with an expressed interest in Network participation if the Credentialing Entity determines: (1) it needs additional LIPs; and/or (2) that other organizational or business needs may be satisfied by including additional LIPs or a particular LIP in the Network.

Section 4.2—Credentialing Criteria/Source Verification Requirements.

Each LIP must complete an Application with Credentialing Criteria as outlined in Attachment A with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with Credentialing Authorities if it is a shorter time frame. Each LIP must meet the following Credentialing Criteria, which must be verified and approved within 180 days of the Decision Date or in accordance with Credentialing Authorities if it is a shorter time frame:

1. **Required medical or professional education and training.** MDs and DOs must graduate from allopathic or osteopathic medical school and successfully complete a residency program or other clinical training and experience as appropriate for specialty and scope of practice as determined by the Credentialing Committee. DCs must graduate from Chiropractic College; DDSs or DMDs must graduate from dental school; and DPMs must graduate from podiatry school and successfully complete a hospital residency program. All mid-level practitioners must graduate from an accredited professional school and successfully complete a training program. If Applicant claims to be board certified, Credentialing Entity will Primary Source Verify board certification from the most current edition of an NCQA approved source, but need not Primary Source Verify each level of education and training if the certifying board has already Primary Source Verified it. If Applicant is not board certified, then Primary Source Verification of the highest level of education listed on the Application is required, except that each level of education must be primary source verified for dentists.

2. **Verification of post-graduate education or training not listed in (1) above.** The Credentialing Entity will Primary Source Verify any post-graduate education or training disclosed in the Application and not considered in (1) above if relevant to LIP's scope of practice (for example Fellowship).

3. **Current licensure or certification.** The Credentialing Entity will Primary Source Verify that the Applicant maintains current, valid licensure or certification, without Material Restrictions, conditions, or other disciplinary action, in all states where the applicant practices. Any finding that results in sanctions or restrictions on the LIP from any government agency or authority, including but not limited to a state licensing authority may result in denial of Credentialing. A committee may recommend accepting a LIP to the Network if the restriction does not limit or impact the LIP's practice, except that a Committee cannot recommend accepting a LIP into the Network if the LIP has a Material Restriction.

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4. **Valid DEA or Controlled Dangerous Substance Certificate or Acceptable Substitute.** Unless the Applicant's practice does not require it, the Applicant must have a current, valid DEA or Controlled Dangerous Substance Certificate in each state where the Applicant intends to practice, or, if the Applicant has a pending DEA application, an agreement with a Participating LIP with a valid DEA certificate in each state where the Applicant intends to practice to write prescriptions of the Applicant with the pending DEA application. The Credentialing Entity will verify that the Applicant meets this requirement by obtaining a copy of the Applicant's DEA or CDS Certificate in each state where the Applicant intends to practice, visually inspecting the certificate, or confirming with CDS or NTIS that the certificate is in force at the Decision Date.

5. **Medicare/Medicaid Sanctions Review.** Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial the Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the CMS Preclusion List or other disciplinary action by any federal or state entities identified by CMS. Credentialing Entity will, at a minimum, verify reported information from the Office of Inspector General (OIG), and the CMS Preclusion list and Medicare opt out.

6. **Work History.** The Credentialing Entity will obtain a five-year work history. Gaps longer than six months must be explained by the LIP and found acceptable by the Credentialing Committee.

7. **Insurance or state-approved alternative.** The Applicant must maintain errors and omissions (malpractice) insurance through insurers licensed in their State, or show similar financial commitments made through an appropriate State-approved alternative, in the minimum amounts required by United Health Group's Provider Guidelines Credentialing Entity may require a copy of the Applicant's current Certificate of Coverage or may allow the Applicant's attestation to current, adequate insurance of state-approved alternative. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan.

8. **Malpractice History.** Credentialing Entity must obtain written confirmation of the past five years of history of malpractice settlements or judgements from the malpractice carrier or must query the NPDB. Malpractice claims history must be explained by the LIP and found acceptable by the Credentialing Entity.

9. **Passing score on site visit.** If required by Credentialing Authorities, Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice, including staff interviews, and medical record-keeping assessments, as further documented in Attachment B, and must receive a passing score for the site assessment and medical record keeping assessment. Site visit must be completed prior to the Decision Date.

   Any failed site visit will result in the Applicant being required to re-apply for Credentialing after at least six months have passed. The Credentialing Entity may agree to permit an Applicant to re-apply for Credentialing prior to the six month wait period if the Applicant can first demonstrate improvements in the areas previously found deficient by providing documentation of such improvements in an improvement action plan. If the Credentialing Entity accepts the improvement action plan, the Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice as further documented in Attachment B, and must receive a passing score for the site visit as part of the initial Credentialing Criteria.

10. **Sanction and Limitation on Licensure.** In addition to primary source verification of license or certification as noted in section 4.3(3) above Credentialing Entity will obtain information about the Applicant through a review of NPDB or FSMB and state licensing Board reports. Any finding that results in Material Restriction on the LIP from any state licensing authority may result in denial of Credentialing.

11. No prior denials or terminations. At the discretion of the Credentialing Entity, the Applicant must not have been denied initial participation or had participation terminated (for reasons other than network need) by the Credentialing Entity or any Newly Merged Network within the preceding 24 months.

12. Hospital Staff Privileges. Applicant must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary actions, at a minimum of one Participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing

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Entity determines that Applicant's practice requires such privileges. The Applicant's attestation is sufficient verification of this requirement unless otherwise required by Credentialing Authority. The National Credentialing Committee may recommend accepting a LIP to the Network if the restriction does not limit or impact the LIP's practice.

13. Affirmative responses to Disclosure Questions on the Credentialing Application. Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by a Medical Director, and at the discretion of the Medical Director, may be reviewed by Credentialing Committee for a determination of LIP's acceptance into Credentialing Entity's Network.

Section 4.3—Status of Applicant after National Credentialing Committee Decision Date.

Acceptance of an Applicant into the Credentialing Entity's Network is conditioned upon the Applicant's signature on the pertinent Participation Agreement. Indication by the National Credentialing Committee that the Applicant meets the Credentialing Criteria does not create a contract between the Applicant and the Credentialing Entity. The Applicant is not considered a Participating LIP on the Decision Date and is not entitled to treat Covered Persons or receive payment from Credentialing Entity until the Participation Agreement is signed by both parties with a specified Effective Date, and the Applicant's Agreement and demographic information are entered into all pertinent information systems.

Section 4.4—Consequences of License Suspension.

During any time period in which the Participating LIP's license is suspended Credentialing Entity will initiate immediate action to terminate provider from the Network in accordance with the Participation Agreement.

Section 5.0

Recredentialing of Participating Licensed Independent Practitioners.

Section 5.1—Recredentialing Participating LIPs: Application.

LIPs will be Recredentialed at least every 36 months. Participating LIPs must complete an Application with criteria as outlined in Attachment A.

Section 5.2—Recredentialing Criteria of Participating LIPs.

Each Participating LIP must continue to meet the following Credentialing Criteria to be considered for continued participation:

1. Applicants must meet all initial Credentialing Criteria as set forth in Section 4.2 at the time of the recredentialing Decision Date, with the exception that education (for LIPs that are not board certified) and work history need not be re-verified.
2. An Applicant for Recredentialing must have demonstrated compliance with all terms of the Participation Agreement, specifically including completion of individual action plans requested by Credentialing Entity.
3. Credentialing Entity must obtain written confirmation of the past three years of history of malpractice settlements or judgments from the malpractice carrier or must query the NPDB. Malpractice claims history must be explained by the LIP and found acceptable by the Credentialing Committee.
4. History of Quality of Care/quality of service concerns within the Recredentialing cycle will be reviewed by the Credentialing Committee and if substantiated the Applicant may be subject to denial of recredentialing.
5. Site visit if required by Credentialing Authority as outlined in Attachment E. Refer to Attachment B for site visit requirements.
6. Specialty change. A LIP who requests a specialty change must provide documentation of training and/or education in that specialty that conforms to the requirements by the Credentialing Entity for other specialists in the same area, and that information will be Primary Source Verified by the Credentialing Entity. Credentialing Entity is not required to accept a request for specialty change unless there is a Network need.

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Section 6.0

Licensed Independent Practitioner Site Assessment.

If required by Credentialing Authority the Credentialing Entity will conduct a Site Assessment, including Medical Record Keeping Practices Assessment as outlined in Attachment B. See State and Federal Regulatory Addendum (Attachment E).

Section 7.0

Credentialing and Recredentialing of Facilities.

Section 7.1 — Criteria for Credentialing and Recredentialing Facilities.

Each Facility must meet the following criteria to be considered for credentialing or recredentialing:

1. Current required license(s).
2. Insurance. The Applicant must maintain general/comprehensive liability insurance as well as errors and omissions (malpractice) insurance for at least the "per occurrence" and aggregate limits established by UnitedHealth Group's Provider Guidelines with an insurer licensed to provide medical malpractice insurance in the Applicant's state of practice, or show similar financial commitments made through an appropriate State approved alternative, as determined by the Credentialing Entity. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan.
3. Medicare/Medicaid Sanctions Review. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, the Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration (GSA) and the CMS Preclusion list or other disciplinary action by any federal or state entities identified by CMS.
4. Appropriate Accreditation or Satisfactory Alternative. Credentialing Entity must obtain a copy of the accreditation report or evidence from the Accrediting Body.
    a. If the Applicant is not accredited by an agency recognized by the Credentialing Entity in Attachment C, a site visit of the organization is required and results must be found to be satisfactory as defined by the Credentialing Entity in Attachment D.
    b. In lieu of a site visit by the Credentialing Entity, a CMS or State quality review may be used if it is not more than three years old. The organization must provide evidence in the form of a final report or letter from CMS or the State, stating that it has been reviewed and passed inspection.

Section 7.2 — Recredentialing Periodically Required.

Facilities will be recredentialed at least every 36 months. Participating Facilities must complete an Application in a timely manner. The National Credentialing Committee has given the discretion and authority to National Credentialing Center staff to cease processing and/or recommend contract termination for any Facilities who have not, after multiple documented requests, submitted a complete Credentialing application.

Section 7.3 — Status of Applicant after National Credentialing Committee Decision.

Any acceptance of an Applicant into the Credentialing Entity's Network is conditioned upon the Applicant's agreement to accept the Credentialing Entity's terms and conditions of participation and sign the pertinent Participation Agreement. Indication that the Applicant meets the Credentialing Criteria does not create a contract between the Applicant and the Credentialing Entity. The Applicant is not considered a Participating Facility on the Decision Date and is not entitled to treat Covered Persons or receive payment from Credentialing Entity until the Participation Agreement is signed by both parties with a specified Effective Date, and the Applicant's Agreement and demographic information are entered into all pertinent information systems.

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Section 8.0

Confidentiality and Applicant Rights.

Section 8.1 — Confidentiality of Applicant Information.

The Credentialing Entity believes information obtained in the credentialing process should be protected by the peer review privilege. Credentialing Entity will therefore maintain mechanisms to appropriately limit review of confidential credentialing information. Credentialing Entity will also contractually require Delegated Entities to maintain the confidentiality of credentialing information.

Section 8.2 — Applicant Rights.

Applicants have the right to review certain information submitted in connection with their credentialing or recredentialing Application, including information received from any primary source and to correct erroneous information that has been obtained by Credentialing Entity. The Credentialing Entity will notify Applicant via phone call, fax or email of identification of any information that varies substantially from the information provided by the Applicant. At the time of notification, the Applicant will be advised where and within what time frame the Applicant must respond. Applicants must submit any corrections in writing as directed by the Credentialing Entity within 30 days of the Applicant's notification of the discrepancy, pending where the file is in process.

Applicants also have the right to obtain information about the status of their Application upon their request. The Applicant can check on the status of an application by calling the Enterprise United Voice Portal at 877-842-3210. Provide the TIN, and then follow the prompts. Credentialing Entity is not required to allow an Applicant to review personal or professional references, or other information that is peer review protected. Applicants have the right to be notified of the credentialing decision within 60 calendar days of the National Credentialing Committee's decision and recredentialing denials within 60 days of decision date, notwithstanding this provision, credentialing time frames and notification will not exceed timelines required by the Credentialing Authority.

Section 8.3 — Appeal Process.

The Credentialing Entity will permit Appeals from adverse credentialing or sanctions monitoring decisions only to the extent required by Credentialing Authority. The Credentialing Authority requirements will govern any request for an Appeal. Any appeal process related to the termination, suspension or non-renewal of Practitioners will be communicated to the affected Practitioner with the notice of termination, suspension or non-renewal.

Section 9.0

Ongoing Monitoring and Reporting.

Section 9.1 — National Peer Review and Credentialing Policy Committee.

Whenever the Credentialing Entity's Quality of Care Department staff receives information suggesting that suspension, restriction, or termination of a LIP's participation may be warranted based on a potential Quality of Care concern, it should compile all pertinent information and refer the matter to the Medical Director for review. If the Medical Director, determines that a failure to take action may present an urgent risk to patient health for any Covered Person, the Medical Director in conjunction with the Regional Peer Review Committee chairperson and the regional chief medical officer may summarily restrict or suspend the LIP's participation status in the network, as set out in the Summary Actions section of the Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions Policy. If the Medical Director determines that immediate action is not warranted, the information is referred to the Peer Review Committee. If the Peer Review Committee decides that further information is needed, the Committee should obtain it from the LIP or from any other relevant and accessible source.

Following its deliberations, if the Peer Review Committee decides that no corrective action needs to occur, the meeting minutes should reflect the reasons for this decision. Alternatively, if the Peer Review Committee in its sole discretion decides to recommend to the National Peer Review and Credentialing Policy Committee a specific compliance improvement work plan

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or the suspension or termination of a LIP's participation, the meeting minutes should reflect this recommendation and the reasons for it. After receiving recommendations from the Peer Review Committee, the National Peer Review and Credentialing Policy Committee decides whether or not to approve the recommendations and whether or not to offer the LIP an opportunity to appeal. (See Section 9.4 of the Credentialing Plan for a description of the appeal process for adverse actions based on Quality of Care concerns.

Section 9.2 — Action by the National Peer Review and Credentialing Policy Committee.

The National Peer Review and Credentialing Policy Committee may affirm, reverse or modify the recommendation of the Peer Review or Hearing Panel, or it may return the matter to the appropriate committee for reconsideration.

If the National Peer Review and Credentialing Policy Committee acts to suspend, restrict, or terminate for cause a LIP's Network participation, the LIP should be notified in writing of the action. If the LIP was not previously offered an opportunity to request a hearing, the National Peer Review and Credentialing Policy Committee shall offer the LIP an opportunity to appeal the determination. (See Section 9.4 of the Credentialing Plan for a description of the appeal process for adverse actions based on Quality of Care concerns.)

Section 9.3 — Fair Process Considerations.

To encourage and support the professional review activities of physicians and dentists and other practitioners, the Health Care Quality Improvement Act of 1986 ("HCQIA" or the "Act") was enacted. The HCQIA provides that the professional review bodies of health care entities (such as the Peer Review Committee and National Peer Review and Credentialing Policy Committee) and persons serving on or otherwise assisting such bodies are generally offered immunity from private damages in a civil lawsuit when they conduct professional review activities in the reasonable belief that they are furthering the quality of health care and with proper regard for fair process. HMOs and PPOs fall within the definition of "health care entity."

To receive immunity protection, a professional review action regarding the professional competence or professional conduct of a physician or dentist or other practitioner must be taken in accordance with all of the following standards:

- In the reasonable belief that the action is in the furtherance of quality health care;
- After a reasonable effort to obtain the facts of the matter;
- After adequate notice and hearing procedures are afforded to the LIP involved or after such other procedures are afforded as are fair to the LIP under the circumstances; and
- In the reasonable belief that the action is warranted after exercising a reasonable effort to obtain facts and after meeting the adequate notice and hearing requirement.

Although a health care entity may immediately suspend a LIP's privileges pending an investigation of the LIP's professional competence or conduct, the health care entity can take advantage of the HCQIA's immunity protection only by affording the LIP involved adequate notice and hearing procedures, unless the suspension lasts fewer than 30 days.

The Act sets forth sample notice and hearing criteria, including time frames, that are deemed to satisfy the adequate notice and hearing requirement. These criteria are incorporated into the Plan. Failure to follow the criteria will not, in itself, constitute failure to meet the notice and hearing requirement; provided that the procedures afforded the LIP under review are reasonable under the circumstances.

Section 9.4 — Hearing Panel.

A. NPDB Reporting.

The National Peer Review and Credentialing Policy Committee establishes the Hearing Panel when the National Peer Review and Credentialing Policy Committee grants an appeal of an adverse action based on quality of care concerns. The Hearing Panel's responsibility is to conduct hearings or reviews and make determinations:

1. To uphold or overturn a decision of the National Peer Review and Credentialing Policy Committee to suspend, restrict or terminate an LIP's participation, or

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2. To uphold or overturn a decision by a Medical Director, regional Peer Review Committee chairperson and regional chief medical officer to take summary action to suspend, restrict or terminate an LIP's participation per the Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions Policy.
3. To uphold or overturn a decision of the National Practitioner Sanctions Committee to suspend an LIP's participation per the Imminent Threat to Patient Safety Policy.

The hearing is held before a Hearing Panel comprised of three (3) physicians or health care professionals who are appointed by UnitedHealthcare, who are not in direct economic competition with the physician or health care professional, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. At least one (1) person on the panel must be a peer of the affected physician or health care professional. For a physician who is contracted to provide healthcare services to UnitedHealthcare enrollees/members enrolled in a Medicare Advantage benefit plan, the panel will be comprised of a majority of peers of the affected Physician.

The Credentialing Entity will notify the LIP and document action taken by the Peer Review Committee, National Peer Review and Credentialing Policy Committee or Hearing Panel, including, but not limited to:

- Decisions to accept, deny, restrict or terminate participation.
- Decisions to offer or deny a hearing to an Applicant.
- Decisions regarding National Peer Review and Credentialing Policy Committee reconsideration.
- Decisions regarding corrective action.

Section 9.5 — Reporting Requirements.

A. NPDB Reporting

The HCQIA requires health care entities to report to the NPDB certain professional review actions ("Adverse Action Reports") with a copy of the NPDB report required to be filed with the applicable licensing board. Health care entities are required to report such actions for physicians and dentists. Health care entities may report such actions on other health care practitioners. It is UnitedHealthcare's policy to file NPDB reports, as appropriate, on all LIPs.

1. **Reportable Actions**

   Actions taken by the Peer Review Committee or National Peer Review and Credentialing Policy Committee that fit into either of the following categories must be reported:

   - A professional review action based on the LIP's professional competence or professional conduct that adversely affects his or her clinical privileges for a period of more than 30 days.
   - Acceptance of the surrender or restriction of clinical privileges (1) while the LIP is under investigation or (2) in exchange for the health care entity not conducting an investigation relating to possible professional incompetence or improper professional conduct.
   - Revisions to any such actions described above.

The penalty to the health care entity for failing to make a required report is loss of immunity protection for three years. The Adverse Action Report must be submitted electronically to the NPDB with a copy sent to the applicable state licensing board.

The Health Care Quality Improvement Act leaves largely undefined the types of acts or omissions that relate to "competence or professional conduct." The Act, however, makes it clear that certain factors, such as membership in a professional society, fees, advertising practices, competitive acts intended to solicit or retain business, or support for allied health professionals do not relate to professional competence or conduct. Failure to attend staff meetings or to complete medical records are not viewed as related to competence or professional conduct, unless they reach the point of adversely affecting the health or welfare of patients. The legislative history of the Act indicates that felonies or crimes of moral turpitude, illicit transactions

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involving drugs, serious sexual offenses, violent behavior and other similar acts are activities that could adversely affect patients. The form for reporting adverse actions offers some additional guidance by listing adverse action classification codes for certain types of activities.

If the action being taken is solely because of the LIP's failure to meet the minimum administrative requirements for credentialing and recredentialing or the termination is solely based on contractual noncompliance or breach, the action is not reportable to NPDB. Even if the action is being taken because of professional competence or conduct, the action is only reportable if the action or recommendation will reduce, restrict, suspend, revoke, or deny the LIP's status as a participant for a period longer than 30 days.

Before taking a final action and submitting a report, the Credentialing Entity should contact the legal representative about offering the LIP an opportunity for a hearing and to determine if reporting is required.

2. **Timing of Report**
   Under the regulations, reportable actions must be submitted to NPDB within thirty (30) calendar days from the date the final adverse action was taken.

3. **Prior to Reporting**
   Credentialing Entities should contact their assigned legal representative for consultation and advice prior to any reporting action.

Section 9.6 — Ongoing Monitoring.

A. Sanctions Monitoring.

State and Federal reports will be reviewed within thirty days of their release in order to identify Participating LIPs who have had OIG sanctions on Medicare or Medicaid participation, GSA debarments, or other sanctions against their license or certification. If Credentialing Entity identifies a professional license that is not valid, an OIG sanction on Medicare or Medicaid participation, GSA debarment, CMS Preclusion List or other sanction against a license or certification, action shall be taken as outlined in the pertinent Participation Agreement. Sanction monitoring, tracking and reporting will be done in accord with UnitedHealthcare's policy. (See Section 8.3 of the Credentialing Plan for a description of the appeal process for adverse actions based on credentialing and sanctions monitoring determinations.)

B. Quality Monitoring.

Credentialing Entity will monitor Participating LIPs and Facilities for complaints, potential quality concerns or identified adverse events. Identified concerns will be identified, tracked and resolved in accord with Credentialing Entity's policy.

Compliance with Participation Agreement. An Applicant for recredentialing must have demonstrated compliance with all terms of the Participation Agreement, specifically including successful participation in quality improvement initiatives or completion of individual action plans requested by Credentialing Entity.

C. Imminent Threats to Patient Safety.

When Credentialing Entity is notified of a publicly verifiable report that a government agency has initiated an investigation related to a Participating LIP, which raises concerns regarding the potential for imminent harm to the safety of members/enrollees (Accusation), the matter will be investigated pursuant to Imminent Threat to Patient Safety Policy (the Policy). The government agency investigations may include but are not limited to: licensing board investigations, arrests and indictments. The Accusation will be referred to the Medical Director when there is a potential risk to patient safety. Pursuant to the Policy the Credentialing Entity may take action up to and including a suspension of LIP's participation status when it determines that there is an imminent threat to patient safety. (See Section 9.4 of the Credentialing Plan for a description of the appeal process for adverse actions based on Quality of Care concerns.)

D. Quality Site Visit.

As required by Credentialing Authority, Credentialing Entity in conjunction with the UnitedHealth Quality of Care Department or its designee (collectively "QOC Department") monitors complaints concerning Participating LIPs/Facilities. Complaints about an office site and Facilities are recorded, investigated and appropriate follow-up is conducted to assure that Covered Persons receive care in a clean, accessible and appropriate environment.

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Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice, including, but not limited to, physical accessibility, physical appearance, adequacy of waiting and exam rooms, availability of appointments and adequacy of medical record-keeping and must receive a passing score for the site assessment and medical record keeping assessment. Applicants whose office site or facility does not meet thresholds for site assessment and medical record keeping assessment will be offered actions to improve office site and facilities and effectiveness of offered actions will be assessed at least every six months. Credentialing Entity, in conjunction with the QOC Department, will monitor complaints concerning Applicant's practice and document follow-up visits that have had subsequent deficiencies.

E. Quality and Efficiency Performance Management.

UnitedHealthcare has committed to our customers, consumers and care providers to support the Triple Aim of Improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. In order to drive continuous improvement in the quality (such as HEDIS or STARS measures) and efficiency of healthcare, the Credentialing Entity may, from time to time, send reports to Participating LIPs regarding the LIP's performance, as compared to peers. To support physicians in their efforts, when practice patterns are identified that may represent opportunities to improve quality, and reduce unwarranted variation, UnitedHealthcare will identify those practice patterns and provide identified physicians with the tools and information to improve resource utilization in a way that is consistent with evidence-based medicine guidelines. In the event that unwarranted variation does not improve UnitedHealthcare may take actions up to and including termination of participation status.

Section 9.7 — Use of Participating Facilities.

Participating LIPs must be able to show Credentialing Entity that for services performed in a facility, they have admitting privileges and perform such procedures in an in-network facility. In the event that the facility in which they treat UnitedHealthcare enrollees becomes out of network and is no longer contracted with United Healthcare, the Participating LIP is expected to find another in-network facility to which they will admit UnitedHealthcare enrollees and perform facility based procedures. UnitedHealthcare will monitor such activity. An LIP's network participation may be terminated in the event that they are found to have no admitting privileges at an in-network facility at which they are able to perform facility based procedures.

Section 10.0

Newly Merged Networks.

Section 10.1 — Newly Merged Networks.

Because the need to minimize disruption of services to Covered Persons often does not allow for an immediate Credentialing of all LIPs and Facilities in a Newly Merged Network, the "to be merged" entity's Credentialing and Recredentialing activities and delegation oversight will be reviewed to assess its ability to meet Credentialing Authorities and UnitedHealthcare's Credentialing standards. A Delegation Agreement between the Credentialing Entity and "to be merged" entity is not necessary unless otherwise required by Credentialing Authorities. If the "to be merged" Credentialing activities meet Credentialing Entity's standards, Credentialing Entity will place the LIPs and Facilities of the Newly Merged Networks on this Credentialing Plan's regular monitoring and Recredentialing schedule. If the "to be merged" entity's Credentialing plan was less rigorous than this Credentialing Plan, Credentialing Entity may place Newly Merged Network's LIPs and Facilities on an expedited Recredentialing schedule. In the event the "to be merged" entity's Credentialing activities do not meet Credentialing Entity's requirements, Credentialing Entity will require every LIP or Facility in the "to be merged" entity to meet the Credentialing requirements under this Credentialing Plan before becoming eligible to participate in its Network. LIPs and Facilities of Newly Merged Networks are subject to this Credentialing Plan.

Section 10.2 — Status of "merged" LIPs and Facilities.

Any acceptance of a LIP or Facility who was a participant in a Newly Merged Network into the Network is conditioned upon the LIP or Facility signing the pertinent Participation Agreement. The "merged" LIP or Facility is not considered a Participating LIP or Facility on the Decision Date or after special administrative review, and is not entitled to treat Covered Persons or receive payment from Credentialing Entity, until the Participation Agreement is signed or assigned to Credentialing Entity and the LIP's or Facility's contract and demographic information is entered into all pertinent information systems.

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Section 11.0

Delegated Credentialing.

Section 11.1 — Delegated Credentialing Authorized.

Credentialing Entity may delegate responsibility for specific Credentialing and Recredentialing functions to another entity (the Delegated Entity), although Credentialing Entity retains the ultimate right to sign a Participation Agreement with, reject, terminate or suspend LIPs or Facilities from participation in the Network.

Section 11.2 — Credentialing Delegation Agreement.

Any delegation of responsibility by the Credentialing Entity must be evidenced by a Credentialing Delegation Agreement that requires compliance with Credentialing Authorities and includes, but is not limited to:

- The responsibilities of the Credentialing Entity and Delegated Entity;
- The activities delegated, including the responsibilities for any sub-delegated activities;
- The process by which the Credentialing Entity evaluates the performance of the Delegated Entity;
- The Credentialing Entity retains the right to approve, suspend and terminate LIPs or Facilities;
- The remedies, including revocation of the delegation, available to the Credentialing Entity if the Delegated Entity does not fulfill its obligations.

If the delegated activities include the use of Protected Health Information by the Delegated Entity, the Delegation Agreement must also include the necessary provisions as defined by Credentialing Authorities and the Health Insurance Portability and Accountability Act (HIPAA).

Section 11.3 — Sub-delegation.

Under certain circumstances, Credentialing Entity may allow Delegated Entity to sub-delegate all or part of its Credentialing activities to another entity. Prior to any sub-delegation arrangement, Delegated Entity must enter into a Credentialing delegation agreement with the sub- delegate. The delegation agreement must meet the requirements of Credentialing Authorities and all Credentialing Criteria of this Credentialing Plan, including Credentialing Entity's right of final approval on any recommendations by the sub-delegate. The Delegated Entity must complete a preassessment, annual assessment and other audits of the sub-delegate for those activities it has sub-delegated to another entity in accordance with the requirements of this Credentialing Plan and Credentialing Authorities. Delegated Entity is responsible for receiving and reviewing reports on LIPs and Facilities Credentialed and Recredentialed by the sub-delegate for the delegated activities outlined in the Credentialing delegation agreement.

Credentialing Entity retains its responsibilities for conducting oversight of its Delegated Entities in accordance with Credentialing Authorities requirements.

Section 11.4 — Preassessment Responsibilities of Credentialing Entity.

The Credentialing Entity will follow Credentialing Authorities' requirements for the preassessment evaluation review and analysis of an entity being considered for delegation.

Prior to execution of the Credentialing Delegation Agreement, Credentialing Entity shall complete a preassessment evaluation to determine the potential Delegated Entity's ability to meet Credentialing Authorities' and Credentialing Entity's standards for the functions being delegated. Credentialing Entity's preassessment responsibilities are outlined below:

A. NCQA Accredited or Certified potential Delegated Entities:

1. Verification of the potential Delegated Entity's accreditation or certification by NCQA.
2. A pre-delegation assessment of the potential Delegated Entity's ability to meet Credentialing Authorities' and Credentialing Entity's standards, including, but not limited to: Credentialing and Recredentialing policies and procedures, Credentialing and Recredentialing application and attestation, and other relevant Credentialing and Recredentialing

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documents or files, including those related to suspension and/or restriction actions, termination and notification to authorities, confidentiality, provision for the protection of Protected Health Information, if applicable, and for the elements not certified or accredited by NCQA.

B. Non-NCQA Accredited or Certified potential Delegated Entities:

- Review of the potential Delegated Entity's ability to meet Credentialing Authorities' and Credentialing Entity's standards, including, but not limited to: Credentialing and Recredentialing policies and procedures, Credentialing and Recredentialing application and attestation, and other relevant Credentialing and Recredentialing documents or files, including those related to suspension and/or restriction actions, termination and notification to authorities, confidentiality, provision for the protection of Protected Health Information, if applicable, and appeals.
- Review of the potential Delegated Entity's methods and sources for collecting and verifying credentials.
- Review of the potential Delegated Entity's blinded Credentialing Committee minutes.
- Policies and Procedures related to office site assessment and medical record-keeping assessment, if required by Credentialing Authorities.

Section 11.5 — Annual Evaluation.

For Delegation Agreements that have been in effect for 12 months or longer, the Credentialing Entity will perform a file review and substantive evaluation of delegated activities against Credentialing Authorities' and Credentialing Entity expectations. For NCQA accredited or certified Delegated Entities, the annual evaluation will include an evaluation of any elements not included in the Delegated Entity's accreditation or certification, in accordance with NCQA requirements. An audit of the Delegated Entity's documents and files for the Credentialing elements that have been NCQA certified or accredited is not required; however, Credentialing elements not accredited or certified by NCQA may require oversight for additional Credentialing Entity, state, federal, or other requirements.

Section 11.6 — Review of Oversight and Monitoring Reports.

Credentialing Entity will review and analyze, at least semi-annually, reports that are designed to provide oversight and monitoring of the Delegated Entity. At a minimum, reports include a listing of newly Credentialed and terminated LIPs and Facilities and LIP and Facility demographic changes. Information about LIPs and Facilities must meet Credentialing Entity's minimum database requirements. Reports should be submitted to the Roster Manager at delprov@uhc.com or to the email address provided to the Delegated Entity from the Roster Manager.

Section 11.7 — Required Follow-up.

When Credentialing Entity's preassessment or annual evaluations, or periodic monitoring, identify opportunities for Delegated Entity to improve its compliance with the Credentialing Delegation Agreement or Credentialing Authorities' and Credentialing Entity's expectations, Delegated Entity will develop a plan for improvement that includes its performance goals and time frames to achieve them.

Section 11.8 — Process for Acceptance/Rejection of Delegated Entity's Approved LIPs and Facilities.

Acceptance of the Delegated Entities' approved LIPs and Facilities into the Credentialing Entity's Network is contingent upon the Applicant signing a Participation Agreement or otherwise participating in the Network under another Participation Agreement as required by the Credentialing Entity.

Section 11.9 — Credentialing and Recredentialing after Termination of Credentialing Delegation Agreement.

Upon termination of a Credentialing Delegation Agreement, Credentialing Entity will place the LIPs or Facilities in a queue for Recredentialing if the Delegated Entity provides Participating LIP and Facility Credentialing and Recredentialing files to the Credentialing Entity and the files are found to be compliant with Credentialing Entity requirements. If the Delegated Entity does not provide Credentialing and Recredentialing files, or the files do not meet Credentialing Entity requirements, LIPs or Facilities will be placed in a queue for initial Credentialing by the Credentialing Entity to be completed within six months of the

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Credentialing Delegation Agreement termination date. Acceptance of Credentialing or Recredentialing of LIPs and Facilities from terminated Credentialing Delegation Agreements is contingent upon the Credentialing Entity's Network needs and the LIP's or Facilities willingness to sign a Participation Agreement.

Section 11.10 — Procedure when LIP or Facility has Contracts with both Credentialing Entity and Delegated Entity.

In cases where a LIP or Facility is contracted with a Delegated Entity and also has a Participation Agreement with UnitedHealthcare, Credentialing Entity may accept the Credentialing of the Delegated Entity if Delegated Entity's Credentialing meets all the requirements of Credentialing Entity and Credentialing Authorities for the LIPs outlined in the Participation Agreements. The Delegated Entity maintains a Credentialing file and the Credentialing Entity maintains a participation contract file on that LIP or Facility.

Section 11.11 — Delegated Functions.

Unless otherwise specified in a specific Credentialing Delegation Agreement, Credentialing activities described in Sections 4.0 (with the exception of 4.2.11 and 4.3), 5.0, 6.0, 7.1, 7.2, 8.0 and 11.0 under this Credentialing Plan shall be considered delegated. UnitedHealthcare will retain the responsibility to query the CMS Preclusion List.

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Attachment A.

ALIP Application Credentialing Criteria.

1. A release granting the Credentialing Entity permission to review the records of and to contact any professional society, hospital, insurance company, present or past employer, professional peer, clinical instructor, or other person, entity, institution, or organization that does or may have records or professional information about the Applicant.
2. A release from legal liability for any such person, entity, institution, or organization that provides information as part of the application process.
3. The Application must include information on the type of professional license(s) or certification(s) held, the state where issued, certification and/or license number, effective date, and date of expiration.
4. A copy of the Applicant's current Drug Enforcement Agency ("DEA") and Controlled Dangerous Substance ("CDS") Certificate in each state where the Applicant intends to practice, if applicable.
5. A five year professional liability claims history that resulted in settlements or judgments paid by or on behalf of the Applicant, and history of liability insurance coverage, including any refusals or denials to cover Applicant or cancellations of coverage.
6. Educational history and degrees received relevant to the Applicant's area of practice, licensure, or certification, including dates of receipt. Not required at the time of recredentialing unless it has changed and will impact the LIP's specialty.
7. A listing of degrees or certifications received from appropriate professional schools, residency training programs, or other specialty training programs appropriate for the type of participation sought, if applicable. Not required at the time of recredentialing unless it has changed and will impact the LIP's specialty.
8. A listing of professional licenses received, whether current or expired, and licensing history, including any challenges, restrictions, conditions, or other disciplinary action taken against such license or voluntary relinquishment of such licensure.
9. Current certifications, where such certification is required, for participation in Medicare, Medicaid, or other federal programs and certification history for such participation, including restrictions, conditions, or other disciplinary action.
10. A five year employment history, including periods of self-employment and the business names used during this time, and a history of voluntary or involuntary terminations from employment or professional disciplinary action or other sanction by a managed care plan, hospital, other health care delivery setting, medical review board, licensing board, or other administrative body or government agency.
11. A completed Application, including a signed statement, which may be in an electronic format, attesting to:
    a. Hospital admitting privileges, or coverage arrangements.
    b. Applicant's current professional liability insurance policy, including the name of insurer, policy number, expiration date, and coverage limits;
    c. Limitations on ability to perform functions of the position with or without accommodation;
    d. History of loss or limitation of privileges or disciplinary activity;
    e. Absence of current, illegal drug use;
    f. History of loss of license and felony convictions; and
    g. Completeness and accuracy of the information provided in the Application.

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Authorization to allow Credentialing Entity to conduct a review, satisfactory to Credentialing Entity, of Applicant's practice, including office visits, staff interviews, and medical record-keeping assessments, in accordance with Credentialing Authority.

Any other documents or information that the Credentialing Entity determines are necessary for it to effectively and/or efficiently review the Applicants' qualifications.

* *The State and Federal Regulatory Addendum will include any state-mandated Credentialing forms; use of those forms, and, if necessary, any additional questions/requirements or other additional information as permitted or required by Credentialing Authority. If no state-mandated form is required, the CAQH Universal Application form includes all these criteria.

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Attachment B.

Site Assessment and Medical Record Keeping Assessment.

Credentialing/Recredentialing Requirements for LIPs.

All provider types as specified by Credentialing Authority will have an office site visit unless the office is located in an accredited or certified facility acceptable to the Credentialing Entity as outlined in Attachment C. The Credentialing Entity must verify accreditation or certification.

Any failed site visit will result in the Applicant being required to re-apply for credentialing after at least six months have passed. The Credentialing Entity or Delegated Entity may agree to permit an Applicant to re-apply for credentialing prior to the six month wait period if the Applicant can first demonstrate improvements in the areas found deficient by providing documentation of such improvements in an improvement action plan. If the Credentialing Entity or Delegated Entity accept the improvement action plan, the Applicant must agree to allow the Credentialing Entity or Delegated Entity to conduct an office site visit of Applicant's practice, including staff interviews, and medical record-keeping assessments, as further documented in Attachment B, and must receive a passing score for the site visit as part of the initial Credentialing Criteria.

Any failed site visit at the time of Recredentialing will require the LIP to demonstrated demonstrate improvements in the areas found deficient by providing documentation of such improvements in an improvement action plan.

Credentialing/Recredentialing Site Assessment Criteria and Credentialing/ Recredentialing Medical Record-Keeping Assessment.

- An office site visit must include a separate threshold for Medical Record-Keeping and Site Assessment as well as a composite score of the following:
- Physical accessibility to the building, exam rooms, and bathrooms including accommodations for the handicapped.
- Physical appearance to provide a safe clean environment for patients, visitors and staff
- Adequacy of waiting room space to accommodate the average number of patients seen per LIP per hour
- Adequacy of exam room space including provisions for privacy during examinations or procedures
- Availability of appointments if applicable
- Adequacy of medical/treatment record-keeping

The Credentialing Entity will conduct an assessment of the medical record-keeping practices on all provider types as specified by applicable law or regulation or pursuant to Participation Agreement unless the office is located in an accredited or certified facility acceptable to the Credentialing Entity. The Credentialing Entity must verify accreditation or certification. A medical record-keeping assessment of one blinded medical record or one model medical record will be reviewed to address the extent to which medical record-keeping practices support the following:

- Confidentiality of the record
- Consistent organization of the record

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Attachment C.

Facility Required Credentialing.

Facility	Most Common Accrediting Bodies
Hospitals	JC, AOA, HFAP, AAAHC, DNV NIAHO, CIHQ
Skilled Nursing Facility, Nursing Home	CARF, CHAPS, JC
Home Health Care	CHAPS, JC, ACHC
Surgi-Care Centers	AAAASF, AOA, HFAP, AAAHC, IMQ, JC
Hospice	ACHC
Clinical laboratories	AABB, A2LA, ASHI, CAP, CLIA Certification* * * COLA, JC
Comprehensive outpatient rehabilitation facilities (CORF)	CARF
Outpatient physical therapy providers	* *
Speech pathology providers	JC
End-stage renal disease services providers	JC
Outpatient diabetes self-management training providers	* *
Portable x-ray suppliers	ACR
Rural health clinics (RHC)	*JC
Federally qualified health centers (FQHC)	*JC

* Individual physicians/providers will be credentialed if the FQHC or RHC is contracted for UnitedHealthcare Community Plan (Medicaid).
* * Individual providers may be credentialed rather than the facility.
* * * Evidence of acceptable accreditation or evidence of CLIA certification is required for all free standing commercial labs.

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Acceptable Accreditation Entities:

AABB	American Association of Blood Banks/Immigration DNA Diagnostic Center
A2LA	American Association for Laboratory Accreditation
AAAASF	American Association for Accreditation of Ambulatory Surgery Facilities
AAAHC	Accreditation Association for Ambulatory Health Care
ACHC	Accreditation Commission for Health Care, Inc.
ACR	American College of Radiology
AOA	American Osteopathic Association
ASHI	American Society for Histocompatibility and Immunogenetics
CAP	College of American Pathologists
CARF	Commission on Accreditation of Rehabilitation Facilities
CHAPS	Community Health Accreditation Program
CIHQ	Center for Improvement in Healthcare Quality
COLA	Commission on Office Laboratory Accreditation
DNV NIAHO	Det Norske Veritas National Integrated Accreditation for Healthcare organizations
HFAP	Healthcare Facilities Accreditation Program
IMQ	Institute for Medical Quality
JC	Joint Commission

Organizations Not Accredited.

If the Organization is not accredited by an agency recognized by the Credentialing Entity, a site visit of the organization prior to contracting is required by the Credentialing Entity. Results must be found to be satisfactory as defined by the Credentialing Entity.

In lieu of a site visit by the Credentialing Entity, a CMS or State quality review may be used if it is not more than three years old. The Credentialing Entity by virtue of approval of this Credentialing Plan has certified that CMS requirements for facilities fully meet the Credentialing Entities facility site requirements. The Credentialing Entity must obtain a copy of the CMS or State Agency's report from the Facility.

Attachment D.

Facility Site Visits for Credentialing/Recredentialing.

If the Facility is not accredited or certified by an agency recognized by the Credentialing Entity, a site visit is required and the Facility must pass with at least 85% of the possible score. Any failed site assessment (defined as a less than 85% score) will result in the Applicant being required to reapply for credentialing after a waiting period of at least six months or the Facility can demonstrate improvements in the areas previously found deficient.

The following minimum criteria must be reviewed:

- Physical accessibility to the building, exam rooms, and bathrooms including accommodations for the handicapped.
- Physical appearance to provide a safe clean environment for patients, visitors and staff.
- Adequacy of waiting and exam room space including provisions for privacy during examinations or procedures.
- Presence of medical equipment logs.
- Safety of medication administration including assessing expiration dates of medications and drugs including samples are inaccessible to patients or other unauthorized personnel.
- Office or facility staffing including the numbers, qualifications, competence and training of clinical staff.
- Acceptable verification of licensure for all licensed clinical staff with applicable licensing board.
- CLIA and/or appropriate radiology certification/licensure, if lab and or radiology services performed in the facility.
- Medical Staff Services or other credentialing and privileging policies for the Facility's LIPs.

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Attachment E.

State and Federal Regulatory Addendum.

The attached State and Federal Regulatory Addendum includes credentialing requirement variation based on:

- State specific insurance and HMO regulation
- State Specific Medicaid regulatory or contractual requirements
- Federal requirements

UnitedHealthcare reserves the right to revise the Credentialing Plan and the associated regulatory amendments to comply with requirements of Credentialing Authorities.

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Attachment F.

UnitedHealthcare Community Plan Peer Review Addendum.

This UnitedHealthcare Community Plan Peer Review Addendum replaces, for select UnitedHealthcare Community Plans, Sections 9.1 and 9.2 of the Credentialing Plan.

UnitedHealthcare Community Plan has the right to restrict, suspend or terminate any Licensed Independent Practitioner's or Facility's participation in the network for issues relating to the Quality Management Program, including Quality of Care Concerns (as defined in Section 2.0).

The Community Plan Quality Management (QM) staff will refer all potential Quality of Care Concerns to a UnitedHealthcare Community Plan Medical Director and/or designee. When a Quality of Care Concern is identified, the QM staff notifies the appropriate provider(s), including where appropriate the Medical Group for practitioners who participate under a Medical Group Agreement, and requests a response, along with any supporting documentation, within a specified period of time in accordance with the relevant State requirements.

UnitedHealthcare Community Plan may terminate a provider's (See Section 2.0 for definitions of UnitedHealthcare Community Plan and for Provider) participation in the network for failure to comply with certain contractual obligations or Quality Management requirements. Depending on the circumstances, termination may be immediate or allow for an appeals process.

UnitedHealthcare may immediately terminate a provider's participation in the network if it determines that immediate termination of the Provider's agreement with UnitedHealthcare is in the best medical interest of the members as in instances of imminent threat to an enrollee/member's safety. UnitedHealthcare Community Plan may also initiate termination proceedings for the provider's failure to implement and comply with his/her corrective action plan or refusal to make medical records available for examination.

In the case of immediate termination and terminations for failure to comply with Quality Management requirements Medical Director will send the provider a certified letter notifying him/her of the intent to terminate his/her network participation privileges. Terminations, suspensions and restrictions due to competence or professional conduct will be reported to the appropriate federal and state authorities, as required, including the National Practitioner Data Bank (NPDB), as appropriate and as outlined in Section 9.4.

Addition to Section 2.0 Definitions

"UnitedHealthcare Community Plan" refers to UnitedHealthcare's health plans and managed care organizations that hold contracts with various States to coordinate health care services for Medicaid and related government health care programs (including, but not limited to, Children Health Insurance Programs or CHIP, Family Health Plus Programs and certain Dual Eligible (Medicare and Medicaid) Programs).

UnitedHealthcare Community Plan "Provider" is any Licensed Independent Practitioner or Facility.

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Additional State and Federal Credentialing Requirements

The information contained in the attached amendments supplements the detailed credentialing criteria identified in the UnitedHealthcare Credentialing Plan.

UnitedHealthcare

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Alabama (AL) Administrative Code (section 420-5-6-.11) requires Health Maintenance Organizations (HMOs) to:

1. Recredential licensed independent practitioners every two years.*(On June 24, 2003, UnitedHealthcare of Alabama was issued an exception to the Alabama State Board of Health Chapter 420-5-6.11.4. (c) allowing the recredentialing of providers every three years.)
2. Update expired professional license, drug enforcement agency, controlled substance certificate and professional liability insurance for licensed independent practitioners upon expiration.
3. Have a medical director with a current license to practice medicine granted by the Medical Licensure Commission of Alabama.
4. An AL HMO may delegate credentialing, with oversight. Delegation must be approved by the AL Department of Public Health.

AL Insurance Code (section 27-56-4)

HMOs and Preferred Provider Organizations may not require an eye care provider (optometrist and ophthalmologists) to hold hospital privileges as a condition of participation in or receiving payment from the policy, plan, or contract.

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No additional credentialing requirements.

Alaska UnitedHealthcare Community Plan Requirements

Federal database checks on Practitioners and Facilities of the Office of Inspector General List of Excluded Individuals/ Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of ALASKA MEDICAL ASSISTANCE EXCLUDED PROVIDER LIST is required for Practitioners and Facilities: http://dhss.alaska.gov/Commissioner/Pages/ProgramIntegrity/default.aspx

Contracted providers need to be registered with the State (DHHS) as an approved services provider consistent with screening/enrollment requirements under provision 42 CFR 438.608(b). Medicaid enrollment required for network participation, but not considered a credentialing decision element as managed through Provider Contract & Data Management (PCDM) operations.

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Arizona

Health Maintenance Organizations (HMOs) are required to review the performance of and recredential contracted free-standing urgent care centers at least once every two years. (ARS 20-1077).

Effective December 31, 2018:

Credentialing; loading; timeliness; exceptions A.R.S. 20-3403

1. Health insurer shall conclude the process of credentialing and loading the applicants information into their billing system within one hundred calendar days after the date the insurer receives a complete application.
2. Health Insurer shall provider written or electronic notice of an approval or denial of a credentialing application to an applicant within seven calendar days after the conclusion of the credentialing process.
3. Health insurer is not responsible for compliance with the above timelines if the applicant is subject to delegated credentialing. Health insurer shall conclude the loading process for the applicant within ten calendar days after the health insurer receives a roster of demographic changes related to newly credentialed, terminated or suspended participating providers.

Acknowledgement of receipt of an application; notification of incomplete applications A.R.S. 20-3404

1. Health insurer shall promptly review and provide written or electronic acknowledgement to an applicant within seven days after the health insurer's receipt of the applicant's application.
2. Health insurer shall notify the applicant in writing or by electronic means that an application is incomplete within seven calendar days after the date the health insurer received the application. Health insurer shall include detailed list of items required to complete the application.
3. Health insurer may deem the application withdrawn if applicant does not provide complete application after thirty calendar days if the request for information.
4. Health insurer will send the applicant a proposed contract that is complete and ready for execution upon receipt of complete application.
5. Health insurer that participates in a health insurer credentialing alliance is deemed to be in compliance with this section, A.R.S. 20-3404.

Arizona UnitedHealthcare Community Plan Requirements[1,2]

UnitedHealthcare Community Plan participates with the Arizona Association of Health Plans (AzAHP) credentialing alliance[3] which provides for

- One common application;
- One common verification;
- One common recredential date;
- One common site visit at the time of initial credentialing for primary care physicians (PCPs) and obstetricians and gynecologists (OB/GYNs)

Arizona Community Plan requirements include:

1. Site visits at the time of initial credentialing for primary care physicians (PCPs) and obstetricians and gynecologists (OB/GYNs).

[1] Requirements of the State Medicaid Contract.

[2] Chapter 900, Policy 950 of Arizona Health Care Cost Containment System (AHCCCS)

[3] Credentialing delegates are not required to use the Alliance

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2. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)).
3. Must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process. [Temporary or provisional credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. This includes providers in a Federally Qualified Health Center (FQHC) and hospital-employed physicians. Contractor shall have 14 days from receipt of a complete application, accompanied by minimum documents identified in initial credentialing.
4. Timely verification of information must be conducted timely, by evidence of approval or denial of a provider within 90 days of a receipt of complete application. Inclusion of information from quality improvement activities at the time of recredentialing.
5. Claims payment system load time 90% within 30 calendar days of credentialing approval. Effective date should be no later than the date of the Credentialing Committee decision or the Contract effective date, whichever is later.
6. All Credentialing decisions are reviewed and approved by the Arizona Provider Advisory Committee which is the local credentialing committee. Committee members consist of participating Arizona Medicaid Providers and the Committee is chaired by the Local Medical Director. The local Medical Director(s) may approve initial Credentialing and/or Recredentialing files which have been determined to meet state-specific requirements, or may request additional review by the Arizona Provider Advisory Committee.
7. Credentialing/Recredentialing files may include state-specific information and/or data to be utilized in Credentialing/Recredentialing determinations. This state-specific information and/or data may be established and maintained separately from the criteria described in the UnitedHealthcare Credentialing Plan used to evaluate Credentialing/Recredentialing determinations. State-specific information and/or data are defined in the local health plan credentialing policies,
8. Credentialing of behavioral health residential placement settings that utilize behavioral health technicians and behavioral health paraprofessional staff in accordance with Chapter 900, Policy 950 of the AHCCCS Medical Policy Manual (AMPM)

DRAFT

Arkansas

1. The Arkansas (AR) State Medical Board's Centralized Credentialing Verification Service (ASMB – CCVS) is mandated for primary source verification for credentialing physicians. (Arkansas Code Archive section 17-95-107.) Physicians include M.D., D.O and M.B. only. (Arkansas Code section 17-95-202.) Insurers, Health Maintenance Organizations (HMOs) and managed care organizations are:
   a) Prohibited from seeking credentialing information from the physician or sources other than the Arkansas State Medical Board that is available from the ASMB-CCVS; and
   b) Required to collect credentials information from the ASMB-CCVS, as long as the ASMB-CCVS:
      - is an National Committee for Quality Assurance (NCQA) -certified Credentials Verification Organization (CVO);
      - complies with Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). CVO standards;
      - complies with credentialing rules and regulations of the AR Division of Health of the Department of Health and Human Services;
      - maintains evidence of compliance with the standards set forth; and
      - charges fees in compliance with AR law.
2. Health care insurers (including HMOs) are required to make a credentialing decision:
   a) for providers other than physicians, within 180 days of receiving a completed application; and
   b) for physicians, within 60 days of receiving a completed application. The 60-day time frame is suspended (or tolled) from the time the health care insurer requests credentialing information from the ASMB-CCV until the time that ASMB-CCV notifies the health care insurer that the file is complete and available for retrieval. (Arkansas Code Archive 23-99-411)
3. Health care insurers (including HMOs) are required:
   a) to send written acknowledgment of an application from any provider within ten (10) days of receipt.
   b) to notify applicant in writing within 15 days if application is incomplete.
      i) notice to include list of items required for application to be complete.
      ii) if notice is not sent within required time frame, application is deemed to be complete.
      iii) if requested information is not received within 90 days, application may be treated as abandoned and credentialing may be denied.
   c) to notify network physicians in writing at least 90 days before the deadline to submit a recredentialing application.
      i) required to give at least 45 days written notice prior to terminating physician for failure to submit a recredentialing application.
      ii) if the physician submits the recredentialing application during the 45 day period, the termination shall not take effect.
      iii) during the 45 day period, insurer prohibited from notifying members or general public that physician will be terminated unless termination is for reason other than failure to recredential. (Arkansas Code Archive 23-99-411 – effective July 22, 2015.)
4. If a credentialed physician changes employment or location, opens an additional location, or joins a new group or clinic, health care insurer may only require submission of the new information as is necessary to continue the physician's credentials, and may not require a new credentialing application.

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California

California Health & Safety Code (CA H&SC) 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

California Code 28 CCR1300.74.16 (e) establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

In order to comply with this regulation, at the time of credentialing, recredentialing and on an annual basis, we identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

For the purposes of this section an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:

(1) Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or

(2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or

(3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:

(A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and

(B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or

(4) Meets the following qualifications:

(A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and

(B) Has completed any of the following:

1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

California UnitedHealthcare Community Plan Requirements

Site visits at initial credentialing and recredentialing for primary care physicians (PCPs). Reference UnitedHealthcare Community Plan Facility Site and Medical Record Review Policy.

Additional query of State Medi-Cal Suspended and Ineligible Provider List is required for Practitioners and Facilities: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp

Credentialing/Recredentialing must receive National Provider Identifier Number (NPI) information from every network provider, but does not need to verify this information through a primary source.

Inclusion of data from quality improvement activities at the time of recredentialing.

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Colorado

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the Colorado (CO) health care professional Credential Application.
   (CO Revised Statutes sect. 25-1-108.7.) Application can be found at 6 CCR 1014-4.
2. HMOs are required to credential and recredential providers as often as necessary, but no less frequently than once every 36 months.

Credentialing/recredentialing requirements: License verification, necessary and appropriate certification and accreditation[4].

If the HMO contracts with health care professionals affiliated with a delegated entity which conducts credentialing for its personnel, verification shall, at a minimum, take the form of ascertaining that the delegated entity's credentialing and recredentialing process is in compliance with the requirements of the regulation. (6 CCR 1011-2(VIII)(A)).

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[4] Outlined in UnitedHealthcare's Credentialing Plan and NCQA Standards

Connecticut

Managed care organizations are required to credential providers, but there are no specific credentialing criteria identified. (CT Annotated Statutes sect. 38a-478-c (a) (5))

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Delaware

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to obtain primary source verification of professional liability coverage[5] and hospital privileges at initial credentialing and on recredentialing. (Code of DE Regulations 18-1400-1403 sect. 11.2.4)

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[5] A copy of professional liability declaration sheet will serve as evidence of primary source verification.

Florida

Florida (FL) Annotated Statutes (section 641.495) require Health Maintenance Organizations (HMOs):

1. to designate a medical director licensed in FL; and
2. to maintain a copy of the current medical license for each participating physician. (MD, DO, DC and DPM). (Note: physician defined in FL Annotated Statutes section 6.41.19(12) (a)).

Physicians who choose not to carry malpractice insurance, as allowed by Florida law, are required to submit a copy of UnitedHealthcare's "Physicians Responsibility for Medical Malpractice Agreement," demonstrating that they have met the state requirements.

Florida UnitedHealthcare Community Plan Requirements[6,7]

Florida UnitedHealthcare Community Plan requirements include:

1. Site visits at initial credentialing and recredentialing for primary care physicians (PCPs) only.

To include the following elements:

a) Must include evidence that the following documents are posted in the provider's waiting room/reception area: the Agency's statewide consumer call center telephone number, including hours of operation, and a copy of the summary of Florida's Patient's Bill of Rights and Responsibilities, in accordance with s. 381.026, F.S. The provider must have a complete copy of the Florida Patient's Bill of Rights and Responsibilities, available upon request by an enrollee, at each of the provider's offices (Eff 12/01/09)

b) Each site should be assessed against the Delegate's office site criteria and shall include:

c) Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place;

Evidence that the provider's medical record keeping practices were assessed.

2. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)) and the National Plan and Provider Enumeration System (NPPES) and Agency for Health Care Administration (AHCA) Public Record Search online tool.
3. Current Curriculum Vitae or completed credentialing application with a five-year working history must be obtained at both initial credentialing and recredentialing.
4. Only board certified pediatricians or family physicians may be contracted as primary care physicians for the Florida Healthy Kids product.
5. Verification on good standing of privileges at the hospital designated as the primary admitting facility by the physician or good standing at the hospital by another physician with whom the physician has entered into an arrangement for hospital coverage.
6. Attestation on total active patient load is no more than three thousand (3,000) patients per physician.
7. Obtain and maintain a contractual relationship with CAQH (ProView).
8. Participate in workgroups with other Managed Care Plans, the Agency and other stakeholders to focus on reducing redundancies in the provider onboarding process.

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[6] Requirements of the State Medicaid Contract.

[7] All documents requiring primary source verification and evidence of professional liability insurance (PLI) or acceptable alternative must be available in the credentialing file.

9. All providers to be fully enrolled/onboarded within 60-days. The 60-day metric will be measured by the number of days between the day the Managed Care Plan receives a full and complete provider enrollment application and the day the Agency successfully receives the provider on the Managed Care Plan's Provider Network Verification (PVN) file. The Managed Care Plan agrees to submit the date it receives full and complete provider applications to the Agency on the PNV file when requested.
10. Agree to allow the Agency to procure a provider enrollment and/or credentialing vendor for entire Medicaid program, including Managed Care Plan onboarding and credentialing, as determined by the Agency.

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Georgia

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to credential providers according to established standards, but no specific credentialing requirements are identified. (GA Comp. Rules and Regulations sect. 120-2-80-.08(2) (f).

HMOs are required to maintain the current license[8] or registration number for all licensed independent practitioners (LIPs). (GA Comp. Rules and Regulations sect. 290-5-37-.07(4) (d)).

UnitedHealthcare also accepts the Georgia credentialing forms found at the following link: http://www.georgiacredentialing.org/applications.html

DRAFT

[8] Licenses will be verified at the time of initial credentialing, recredentialing and upon expiration.

Hawaii

No additional credentialing requirements.

Hawaii UnitedHealthcare Community Plan Requirements

Additional query of HI Med-Quest Medicaid Provider Exclusion List is required for Practitioners and Facilities: http://www.med-quest.us/providers/ProviderExclusion_ReinstatementList.html

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Idaho

No additional credentialing requirements.

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Illinois

Laws and regulations apply to health care plans such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Insurance Companies, etc.

Requirements with respect to health care professionals, such as physicians and chiropractors. Please see the Health Care Professional Credentials Data Collection Act:

1. Health care plans are required to accept, from health care professionals, the Illinois Uniform Health Care Credentials form and may require the health care professional to submit any additional credentials data requested.
2. Each health care plan must complete the process of credentialing or recredentialing of the health care professional within 60 days after submission of all credentials data and completion of verification of the credentials data. 410 ILCS 517/15(f); 77 Ill. Adm. Code 965.140(b).
3. a) All health care plans must obtain recredentialing data on a health care professional according to the single credentialing cycle except when a:
   - health care professional submits initial credentials data to a health care plan;
   - health care professional's credentials data change substantively; or
   - health care plan requires recredentialing as a result of patient or quality assurance issues. (410 ILCS 517/20; 77 Ill. Adm. Code 965.300)

   b) Data collection for health care plans will coincide with a single credentialing cycle that entitles health care plans to collect recredentialing data once, and not more than every three years, except as noted in Section 3(a). (77 Ill. Adm. Code 965.300).

   c) Data collection:
   - will be based on the last digit of each health care professional's Social Security number;
   - will provide for a one-month notification period for each digit during which each health care plan notifies those persons being recredentialed of the time period during which data is expected to be submitted; and
   - will provide for a two-month collection period for each digit during which each health care plan receives data from those persons being recredentialed. (77 Ill. Adm. Code 965.300)

   d) The single credentialing cycle reflects a six month "OPEN" period when health care plans cannot collect data from a health care professional, except as noted in Section 3(a). (77 Ill. Adm. Code 965.300)

   e) Once recredentialing has begun in accordance with the single credentialing cycle, a health care plan may continue to request data from a health care professional outside of the published single credentialing cycle if it is not submitted by the deadline date. (77 Ill. Adm. Code 965.300).

   f) Illinois law does not preclude a health care plan from meeting any quality assurance requirement of an entity related to credentialing for the purpose of accreditation or otherwise. (77 Ill. Adm. Code 965.300).

   g) A health care plan may apply to the Director of Insurance via letter for an exemption from the single credentialing cycle. (77 Ill. Adm. Code 965.310).
4. Health care plans may delegate credentialing and recredentialing activities as long as the delegated entity follows the requirements set forth in the Health Care Professional Credentials Data Collection Act. (410 ILCS 517/15(k); 77 Ill. Adm. Code 965.140(e)).

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Indiana

Insurers, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to (pursuant to Indiana (IN) statutes: 27-13-43-2 (HMO), and 27-8-11-7(Insurer/PPO) :

1. Use the Uniform Credentialing Application from the Council for Affordable Quality Healthcare (CAQH), and:
    - Notify a provider of any deficiency within 30 days of receiving the completed application;
    - Notify the provider of the status of the completed credentialing application no later than 60 days after receiving the completed application; and
    - Notify the provider every 30 days until the credentialing determination is final.

Effective July 1, 2018 IN statutes for HMOs (13-43-3) and Insurers/PPOs (27-8-11-7):

Insurer or HMO required to provisionally credential provider if credentialing determination is not issued within 30 days after receiving a complete credentialing application AND the provider meets all of the following criteria:

1. The provider has submitted a completed and signed credentialing application form and any required supporting material; and
2. The provider was previously credentialed in IN by the insurer/HMO in the same scope of practice for which the provider has applied for provisional credentialing (no time frame for previous credentialing is noted); and
3. The provider is a member of a participating provider group; and
4. The provider is [currently] a network provider with the insurer/HMO.

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Iowa

A health insurer is responsible to notify a physician of its credentialing determination within 90 days of receiving a completed initial credentialing application from the physician.
(191 Iowa Adm. Code 70.10(514F) (3) (b)).

Iowa UnitedHealthcare Community Plan Requirements[9]

Inclusion of data from quality improvement activities at the time of recredentialing.

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of State Medicaid Provider Sanctions List is required for Practitioners and Facilities: http://dhs.iowa.gov/ime/about/aboutime/program-integrity

Credentialing of providers applying for network provider status shall be completed as follows: Eighty-five percent (85%) within thirty (30) calendar days; Ninety-eight (98%) percent within forty-five (45) calendar days. The start time begins when all necessary credentialing materials have been received. Credentialing timeliness is measured to include any and all necessary functions performed after complete credentialing packet materials are submitted by the provider, including but not limited to credentialing committee and onsite provider reviews. If the Contractor requests additional materials, not already submitted by the provider, as a result of committee review the time shall not be measured while the Contractor is waiting for the requested materials. Completion time ends when written communication is mailed or faxed to the provider notifying them of the decision.

Standard required to receive incentive payment. Credentialing of providers applying for network provider status shall be completed as follows: Ninety percent (90%) within twenty (20) calendar days; One hundred (100%) percent within thirty (30) calendar days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the decision.

The Iowa Medicaid Universal Provider Enrollment Application must be accepted on Practitioner and Facility Providers in lieu of the UnitedHealthcare Credentialing Application. Request for additional information is allowed on elements not contained in the Iowa Medicaid Universal Provider Enrollment Application in order to consider the application complete.

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[9] Requirements of the State Medicaid Contract.

Kansas

No additional credentialing requirements.

Kansas UnitedHealthcare Community Plan Requirements[10]

Complete the credentialing process of all service providers applying for participating provider status within sixty (60) calendar days of receipt of complete application. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the provider notifying them of the credentialing decision. Credentialed providers must be entered/loaded into the claims payment system within thirty (30) calendar days of credentialing committee approval.

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of KS Medicaid Terminated Provider List is required for Practitioners and Facilities: http://www.kdheks.gov/hcf/medicaid_program_integrity/index.htm. The Kansas Joint Credentialing Application must be accepted on Facility Providers in lieu of the UnitedHealthcare Credentialing Application.

KMAP ID – UHN network recredentialing provider listings supplied to C&S Operations for validation function.

The State may decide to contract with or require the contractor to contract with a single credentialing verification organization (CVO) to standardize provider credentialing and re-credentialing processes across the KanCare program. The contractor shall work with the State on implementing any new processes related to centralize credentialing.

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[10] Requirements of the State Medicaid Contract.

Kentucky

Insurers, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are:

1. Required to accept either the Council for Affordable Quality Healthcare (CAQH) provider application or the Kentucky (KY) Application for Provider Evaluation and Reevaluation Part A (KAPER-1). (KY Administrative Regulations – 806 KAR 17:480.) Insurer/HMO/PPO may accept the CAQH application in lieu of KAPER-1.
2. When KAPER-1 is used, additional information that is not relevant to the scope of practice, health care setting, or service of the health care provider, is not to be requested and may not recredential more frequently than every three years.
   a) Within 30 days of receipt of a complete KAPER-1 (12/05), Part A, electronically or in writing:
      i) Notify the health care provider of any omitted and questionable information included on the form; and
      ii) Offer assistance to the provider.
   b) Within 60 days of receipt of KAPER-1 (12/05), Part A, provide notification electronically or in writing to the health care provider of the status of credentialing. This time period may be extended if, due to extenuating circumstances:
      i) Additional time is required by the insurer to consider information submitted on the KAPER-1 (12/05), Part A; and
      ii) The health care provider is informed of the need for more time, including information relating to the extenuating circumstance which caused the delay. Provide electronic or written notification as established in paragraph C of this sub-section every 30 days after the initial notification until a final determination regarding credentialing has been issued to the health care provider.
   c) Provide electronic or written notification every 30 days after the initial notification until a final determination regarding credentialing has been issued to the health care provider.
3. When CAQH is used an insurer issuing a managed care plan shall notify an applicant of its determination regarding a properly submitted application for credentialing within 90 (HB 69, Section 8 amends KRS 302.17A- 576 Effective 1.1.2019 – 45 days) days of receipt of an application containing all information required by the most recent version of the CAQH credentialing form. Effective July 15, 2008, nothing in this section shall prevent an insurer from requiring information beyond that contained in the credentialing form to make a determination regarding the application. (304.17A-576).
4. Required to appoint a KY-licensed medical director (KY Revised Statutes section 304-17A-545).
5. The recredentialing process is to include an assessment of data collected through quality improvement activities. (KY Revised Statutes section 304.17A-545(4) (d).).

Kentucky UnitedHealthcare Community Plan Requirements

1. All affiliated Providers delivering Covered Services must currently be enrolled and active as providers in the Kentucky Medicaid Program.
2. If a potential Provider is not enrolled in Medicaid, we shall help facilitate the provider's application to enroll with the Department.
3. Credentialing shall be completed within ninety (90) Days of receipt of all relative information from the Provider, or within forty-five (45) Days if the Provider is providing substance use disorder services.
4. In compliance with KRS 205.532, the Department will contract with one or more Credentialing Verification Organizations (CVO's) to conduct enrollment, credentialing, and recredentialing services for the Medicaid managed care program.
   - UnitedHealthcare shall work with the Department and/or CVO designated by the Department on implementing any new processes related to centralize credentialing and receiving verified credentialing packets from the CVO.
   - Determination to be completed whether to contract with the provider within thirty (30) Days of receipt of the verified credentialing packet from the CVO.
   - Provider information will be loaded into the claims processing system within ten (10) days of an executed contract. Notification to the provider will occurr if additional time beyond the required ten (10) days is needed to load the provider contract, which shall not exceed an additional fifteen (15) days.
   - Provider credentialing and verified information shall be accepted from the Department, or the Department's contracted CVO, and shall not request a provider to submit additional credentialing information without the Department's written prior approval. The Contractor is not prohibited from collecting additional information to inform the Contractor's contracting process.
   - A provider's Claims become eligible for payment as of the date of the provider's Credentialing Application Date.

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Louisiana

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept either the Louisiana (LA) Standardized Credentialing Application form, or its successor, or the current form used by the Council for Affordable Quality Healthcare (CAQH).
   (LA Revised Statutes sect. 22:1009(B) (3)).
2. Notify provider applicants of all defects rendering the application incomplete within 30 days of receipt. (LA Revised Statutes sect. 22:1009(B) (2) (a)).
3. If the information is not received, notify the provider applicant within 60 days of request for additional information. (LA Revised Statutes sect. 22:1009 (B) (2) (b)).
4. Complete credentialing process within 90 days from receipt of all information needed for credentialing. (LA Revised Statutes sect. 22:1009 (B) (1)).

Louisiana UnitedHealthcare Community Plan Requirements[11]

1. The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean review, approve and load applicants to its provider files in its claims processing system.
2. If the MCO declines request of providers to be included in the network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR §438.12(a)(1)]
3. In accordance with DHH's credentialing requirements DHH will have final approval of the delegated entity.
4. UnitedHealthcare Community Plan encourages all participating physicians who are not yet board certified to become board certified.
5. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
6. Additional requirements for verification of sanctions on Practitioners and Facilities through the Louisiana Exclusion Database. https://adverseactions.dhh.la.gov/
7. Recredentialing (L.A.Revised Statutes sect. 46:§ 460.72 – MCO shall comply with the following notice provisions regarding contracted provider re-credentialing:
   a) MCO shall provide a minimum of three written notices to a contracted provider with information regarding the re-credentialing process, including requirements and deadlines for compliance. The first notice shall be issued by the MCO no later than six months prior to the expiration of the provider's current credentialing. The notice shall include the effective date of termination if the provider fails to meet the requirements and deadlines of the re-credentialing process.
   b) The MCO shall send the written notice to the last mailing address and last email address submitted by the provider.
   c) If the provider fails to submit all required documents and meet all re-credentialing requirements, the MCO shall send a termination notice via certified mail to the provider's last mailing address with an effective date of termination to be fifteen days after the date of the notice.

[11] Requirements of the State Medicaid Contract.

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Maine

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Obtain primary source verification of hospital privileges on initial credentialing and recredentialing. (Code of Maine (ME) Rules 02-031-850 sections (7) (G) (8) (b) and (7)(G)(10)(b)).
2. Obtain primary source verification, or secondary verification from the National Practitioner Data Bank (NPDB), of the health professional's license history for the preceding 10 years in ME and all other states, including a chronological history of the license, dates, times and places of all applications for license privileges, any action taken on the application, any challenges to licensure or registration, or the voluntary or involuntary relinquishment of a license.
   (Code of ME Rules 02-031-850 section (7)(G)(9)(a)).
3. Make credentialing decisions within 60 days of receipt of a completed credentialing application. Time period may be extended upon written notification to provider that the application requires additional time for verification. All credentialing decisions must be made within 180 days of receipt of a completed application. ((Code of ME Rules 02-031-850 section (7)(G)(2)).
4. Offer an appeal procedure, including the right to a hearing, for dealing with provider concerns relating to the denial of credentialing for not meeting the objective credentialing standards of the plan and the contractual relationship between the provider and HMO/PPO. (24 A.M.R.S. § 4303).

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Maryland

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the uniform credentialing form, and are prohibited from requesting additional information. This also applies to credentialing Delegated Entities that are not hospitals or academic medical centers. (Code of Maryland (MD) Regulations sections 31.10.26.01 et. seq. and MD Ins. Code sect. 15-112.1(c)).
2. Return incomplete applications to applicants within 10 days of receipt, identifying additional information required. (MD Insurance Code section 15-112(d)(4)).
3. Upon receipt of a completed application, notify applicants within 10 days that application is complete. If the application is received via an online credentialing system (e.g. Council for Affordable Quality Healthcare), and the online credentialing system notifies the applicant that the application has been received by the carrier, the HMO/PPO is not required to notify the applicant directly. (MD Insurance Code 15-112 (d)(4)(I)).
4. Notify applicants within 30 days of receipt of completed application of intent either:
   a) to continue to process the application, or
   b) to reject application. (MD Insurance Code section 15-112(d)(3)(i)).
5. Process accepted applications within 120 days of notice. Inform providers that the application will be processed, with final determination of whether application accepted or rejected.
   (MD Insurance Code section 15-112(d)(3)(iii)).
6. Verify whether or not provider is accepting new patients at initial credentialing and recredentialing, and update online directory accordingly. (MD Insurance Code sections 15-112(b)(4) and (j)).[12]
7. Maintain an application log with the following information:
   - Name of provider requesting application
   - Date provider requested application
   - Date application sent or delivered to provider
   - Date application received from provider
   - Date application returned to provider with request for additional information
   - Date received back from provider following request for additional information
   - Date provider notified of rejection or intent to continue credentialing process
   - Date of acceptance or rejection upon completion of credentialing process
     (Code of MD Regulations sect. 31.10.16.03(D).)
8. Maintain application log for a minimum of three years or until the next market conduct exam, whichever occurs last. Shall:
   - Date stamp an application received from a provider upon initial receipt, and
   - Maintain a copy of each application, and any correspondence regarding the application, for a minimum of three years or until the next market conduct exam, whichever occurs last.

HMOs are also required to assess performance of physicians and nurse practitioners on recredentialing based on an analysis of data obtained through quality improvement activities.

Maryland UnitedHealthcare Community Plan Requirements[13]

1. Site visits at the time of initial credentialing for primary care physicians (PCP), to include assessment of Americans with Disabilities Act (ADA) compliance.
2. Assessment of ADA compliance for any new office site for primary care physicians.

[12] Open panel status is not a criterion for participation

[13] Requirements of the State Medicaid Contract.

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3. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including National Practitioner Data Bank (NPDB), Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (GSA-EPLS)).
4. Additional query of MD Medicaid Providers Sanctioned List is required for Practitioners and Facilities: https://mmcp.dhmh.maryland.gov/pages/Provider-Information.aspx
5. Review of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Certification as applicable. EPSDT Applies to PCP only. (General Practitioner, Family Practitioner, Pediatrics, and Nurse Practitioners).

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Massachusetts

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to (211 Code of Massachusetts. Regulations. 52.09):

1. Comply with National Committee for Quality Assurance Managed Care Organization accreditation standards for credentialing and recredentialing, and are permitted to adopt additional credentialing criteria.
2. Accept credentialing/recredentialing applications in a format specified by the Commissioner, and submitted in paper or electronic format, including facsimile and electronic mail. An online process for the purpose of processing credentialing applications may be implemented. A credentialing application which is appropriately signed and dated by the Provider, and which includes all of the applicable information requested from the Provider by the Carrier. The Massachusetts credentialing forms can be found at the Massachusetts Medical Society website: http://www.massmed.org/Physicians/Practice-Management/Practice-Ownership-and-Operations/Massachusetts-Uniform-Credential-Applications/#.WfzCIdLfPcs
3. Notify the applicant if application is incomplete no later than 20 business days after receipt.
4. Notify initial credentialing applicant within 75 days of receipt of the status of the application, including reasons for any delay in completion and a timeline of the expected resolution of the application.
5. Complete 95% of clean and complete initial credentialing applications within 60 days of receipt.
6. Complete 95% of clean and complete recredentialing applications within 120 days of receipt.
7. A Carrier that delegates to or contracts with another entity for the performance of some or all of the functions governed by 211 CMR 52.00 shall be responsible for ensuring compliance by said entity with the provisions of 211 CMR 52.00. (211 CMR 52.01.)

Massachusetts UnitedHealthcare Community Plan Requirements[14]

Inclusion of data from quality improvement activities at the time of recredentialing.

Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)).

Additional query on List of Suspended or Excluded MassHealth Providers is required for Practitioners and Facilities: http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/list-of-suspended-or-excluded-masshealth-providers.html

Primary Care Physicians in the Senior Care Options Product, (MDs/DOs, NPs and PAs practicing as Internal Medicine, Family Practice, Geriatric Medicine, and/or OB/GYN) are required to complete annual continuing medical education (CME) units in geriatric practice and at least two years of experience in the care of people over the age of 65.

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[14] Requirements of the State Medicaid Contract.

Michigan

Health Maintenance Organizations (HMOs) are required per

(Michigan Compiled Laws Service sections 500.3528 and 500.3531 to:

1. Obtain primary verification of health professional's current professional liability coverage[15], and status of hospital privileges, if applicable.
2. Obtain primary verification of: current professional liability coverage and status of hospital privileges, if applicable, every three years.
3. Monitor delegated entities for compliance with these requirements.

Michigan UnitedHealthcare Community Plan Requirements[16,17]

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional requirements for Practitioner and Facility verification of sanctions including but not limited to the Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA)Sanctioned Provider List.

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[15] A copy of professional liability declaration sheet will serve as evidence of primary source verification.

[16] If the provider is enrolled directly with the MI Medicaid program (proof of which is verified and contained in the credentialing file) there is no further requirement that the health plan query certain databases such as the NPPES, Death Master File or the MDCH.

[17] Requirements of the State Medicaid Contract.

Minnesota

No additional credentialing requirements.

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Mississippi

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to follow Weil's Code of Mississippi Rules 28 000 072. reg. 98.1 to:

1. Accept the state uniform credentialing application from physicians for initial credentialing and recredentialing.
2. Augment the uniform credentialing application with additional information on supplemental form.
3. Obtain prior approval from the Commissioner of Insurance for supplemental form to the uniform credentialing application.
4. Obtain primary verification of hospital privileges to practitioner's primary admitting hospital at initial credentialing and subsequent recredentialing.
5. Obtain primary or secondary verification of hospital privileges to hospitals other than practitioner's primary admitting hospital at initial credentialing and recredentialing.
   (MS Code Ann. Section 83-41-409).

Mississippi UnitedHealthcare Community Plan Requirements[18]

1. Initial site visit to be conducted during credentialing on PCP's & OB/GYN's.
2. CLIA certificate/waiver to be collected on practitioners providing laboratory services at time of credentialing and recredentialing. CLIA number must correspond with the CLIA number on the CAQH application.
3. CLIA certificate/waiver to be collected on facility providers that bills for laboratory services.
4. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
5. All documents requiring primary source verification and evidence of professional liability insurance/ malpractice insurance must be available in credentialing file of practitioner and facility providers.
6. Nurse practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility
7. Contractor shall credential all completed application packets within ninety (90) calendar days of receipt. In cases of network inadequacy, the Contractor shall credential all completed application packets within forty-five (45) calendar days of receipt. The Contractor shall notify the Division of any Provider applications requiring longer than ninety (90) calendar days via monthly report.
8. The Health Plan shall notify the Division within ten (10) calendar days of the denial of a Provider credentialing application either for program integrity-related reasons or due to limitations placed on the Provider's ability to participate for program integrity-related reasons. Contractor will load Provider information into its claims processing system within thirty (30) calendar days of credentialing approval.
9. Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing
10. Additional query of State Medicaid Provider Sanctioned List is required for Practitioners and Facilities: http://www.medicaid.ms.gov/wp-content/uploads/2014/03/SanctionedProvidersList.pdf

[18] Requirements of the State Medicaid Contract.

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11. Credentialing and recredentialing files should contain a copy of the original attestation with signature for regulatory audits. Electronic re-attestments from CAQH are acceptable as long as a copy of original signature is in the file.
12. All credentialing decisions are reviewed and approved by the Provider Advisory Committee (PAC) which is the local credentialing committee. Committee members consist of participating Mississippi Medicaid Providers and the Committee is chaired by the Local Chief Medical Officer.
13. Disclosure of Ownership Form needs to be collected on practitioner and facility providers. This information needs to be reflected in the credentialing/recredentialing files.

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Missouri

Laws and regulations apply to health carriers, meaning, Health Maintenance Organizations (HMOs).

Requirements with respect to health care professionals, such as physicians, chiropractors, dentists and any other health care practitioners who are licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law:

1. The Universal Credentialing Datasource form (Form UCDS), incorporated by reference and published on October 31, 2006, by the Council for Affordable Quality Healthcare (CAQH), has been adopted and shall be used by all health carriers and their agents when credentialing or recredentialing health care professionals in a managed care plan. (20 CSR 400-7.180 (2011))
   a) If the health carrier receives the CAQH credentialing form via fax or mail, the health carrier is required to send notice of receipt to the practitioner. (376.1578(1) R.S. Mo.)
   b) If the CAQH credentialing form is submitted electronically, the health carrier is required to provide notice of the status via provider web portal. (376.1578(1) R.S. Mo.)
2. Health carriers may request additional information to explain or provide details regarding responses obtained on the standard form. Health carriers are prohibited from routinely requiring additional information from health care professionals. (20 CSR 400-7.180(3)).
3. If the health carrier demonstrates a need for additional information, the director of the Department of Insurance may approve a supplement to the standard credentialing form. All forms and supplements must meet all requirements as defined by National Committee for Quality Assurance (NCQA).
§ 354.442 R.S.Mo.
4. An onsite examination by the health carrier or their agent of the health care professional's place of business must not, in itself, be considered a routine request for additional information.
(20 CSR 400-7.180(4)).
5. A health carrier may require a health care professional to sign an affirmation and release of the health carrier's own design. (20 CSR 400-7.180(5)).
6. Health carrier required to disclose to enrollees a listing by specialty of all participating providers, including facilities. (Sect. 354.442 (14) R.S.Mo.) Per NCQA, the organization would not need to credential facility based practitioners since members are being directed to the facility even though the practitioners are required to be in the directory per the state law referenced above. The organization should provide the regulatory requirement when it submits its survey documentation.[19]
7. Health carrier required to make a decision whether to approve or deny a practitioner's credentialing application within 60 business days of receipt of completed credentialing application. (Rev. Stat. MO sect. 376.1578(2).
   a) The 60 business day deadline shall not apply if the credentialing application or subsequent verification indicates that the practitioner has:
      i) a history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;
      ii) Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;

[19] Per NCQA email 6/28/18

[20] Credentialing turn-around time is not applicable to the delegated entities.

[21] Advanced directive policy determined by the Health Plan.

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iii) Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or

iv) A judgment or judicial award [but not a settlement] against the practitioner arising from a medical malpractice liability lawsuit. (376.1578(2)(1-4) R.S. Mo.)

Missouri UnitedHealthcare Community Plan Requirements

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of MO Medicaid Terminations List is required for Practitioners and Facilities: http://mmac.mo.gov/providers/provider-sanctions/

Credentialing process shall not take longer than sixty (60) business days pursuant to RSMo 376.1578[19]

The Health Plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a participant and billed to the health plan by the provider:

- Newly credentialed provider attached to a new contract within ten (10) business days after completing credentialing;
- Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing;
- Newly credentialed provider attached to an existing contract within five (5) business days after completing credentialing;
- Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) business days after completing re-credentialing;
- Change in existing contract terms within ten (10) business days of the effective date after the change.

Inclusion of performance monitoring information on records related to advance directives on Primary Care Providers during the time of recredentialing.[20]

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[19] Credentialing turn-around time is not applicable to the delegated entities.

[20] Advanced directive policy determined by the Health Plan.

Montana

No additional credentialing requirements.

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Nebraska

The Health Care Credentialing Verification Act applies to health carriers such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Insurance Companies, that offer closed plans, meaning plans that require covered persons to use participating providers under the terms of the managed care plan, or combination plans having a closed component.

Requirements with respect to health care professionals such as physicians or any other health care practitioners who are licensed, certified, or registered to perform specified health services consistent with state law:

1. A health carrier must obtain primary verification of:
   a) Current level of professional liability coverage, if applicable.
   b) Status of hospital privileges, if applicable.
   c) Current federal Drug Enforcement Agency registration certificate, if applicable;
   d) Graduation from a health care professional school; and completion of postgraduate training, if applicable. (R.R.S. Neb. § 44-7007(1)).
2. At least every three years, the health carrier must obtain primary verification of participating health care professionals:
   a) Current level of professional liability coverage, if applicable.
   b) Status of hospital privileges, if applicable.
   c) Current federal Drug Enforcement Agency registration certification, if applicable.
3. Whenever a health carrier contracts to have another entity perform the credentialing functions required by the Health Care Professional Credentialing Verification Act or applicable rules and regulations, the Director of Insurance must hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of the act and applicable rules and regulations are met. (R.R.S. Neb. § 44-7009).

Nebraska UnitedHealthcare Community Plan Requirements[22]

1. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)).
2. The health plan will notify the Medicaid Agency of any disclosures made by providers related to persons convicted of crimes within 10 working days from the date of the MCO receives the information[23]
3. Completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. Completely process means: review, approved, and load approved providers to its provider files in its system or deny, notify provider, and ensure provider is not used for services.
4. MCO must accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.
5. Inclusion of data from quality improvement activities at time of recredentialing.
6. Additional query of Nebraska Medicaid Excluded Providers List is required for Practitioners and Facilities: http://dhhs.ne.gov/medicaid/Pages/med_pi_sanc.aspx

[22] Requirements of the State Medicaid Contract.

[23] Provider Disclosures including disclosure of ownership form and criminal history are collected prior to contract execution following standard health plan procedures

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Nevada

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to accept the Nevada (NV) Division of Insurance provider application, and may only use a supplemental form to collect additional information required by the state or federal government or an accrediting body.

(NV Adm. Code 679B.0405).

Nevada UnitedHealthcare Community Plan Requirements

Additional query of NV Exclusions/Sanctions is required for Practitioners and Facilities: http://dhcfp.nv.gov/Providers/PI/PSExclusions/

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New Hampshire

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) per Revised Statutes of New Hampshire (NH) Annotated 420-J:4 – effective Aug. 10, 2007) are:

1. Required to notify a health care provider within 15 business days if a credentialing application is incomplete.
2. Upon receipt of a clean and complete credentialing application, required to finalize the credentialing process within 30 calendar days for primary care physicians (PCP) and 45 days for specialists. “Clean and complete” means that the application is signed and appropriately dated by the health care provider and includes all applicable information required, as well as affirmative responses on questions related to quality and clinical competence.
3. Required to allow on-call coverage for a participating provider by health care providers who have submitted clean and complete applications, and have a valid license from the respective state licensing board and have been credentialed by the hospital.[24]
4. Required to allow a health care provider to deliver services to covered persons when the health care provider has a valid license from the respective state licensing board, and has been credentialed by the hospital, and the health care provider has been credentialed by the health carrier in another state or in the health carrier’s NH network based on employment with a particular health care entity.
5. When credentialing verification functions are delegated, the carrier is responsible for monitoring the delegated entity and ensuring that the requirements of this section are met.

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[24] Network requirement not related to the credentialing process.

New Jersey

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) ("Carriers") are required to:

1. Accept the New Jersey (NJ) Universal Physician Application.
   (NJ Adm. Code 11:24C-1.3).
   a) May accept other applications, but required to notify physicians of the NJ Application available on the Department of Insurance website.
   b) May access physician credentialing information from a recognized, national credentialing database, but prohibited from requiring physicians to use a national database.
2. Required to comply with the following response times:
   a) For physicians who apply by submitting the NJ Universal Physician Application, notify the applicant within 60 days, following the receipt of the application, that the application is incomplete, specifying in writing the information that is missing, otherwise the application shall be deemed complete. (NJ Adm. Code 11:24-3.9)
   b) For practitioners who apply via the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource, notify the applicant within 45 days whether the application is complete or incomplete. Notice may be provided electronically if application contains an e-mail address. In the absence of an e-mail address, notice shall be in writing. If application is incomplete, the notice shall:
      i) Specify the additional information required and the due date; and
      ii) Include the phone number and e-mail address of Carrier's department responsible for accepting information required to complete the application and for providing assistance regarding the credentialing process and the status of the credentialing application. Carriers shall respond to credentialing inquiries within five (5) business days. (NJ Adm. Code 11.24C-1.3(a) (1) and (2).)
3. Complete the initial credentialing process within no more than 90 days of receipt of the complete application. (NJ Adm. Code 11:24-3.9) and NJ Adm. Code 11:24C-1.3)

New Jersey UnitedHealthcare Community Plan Requirements[25]

1. Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing.
2. Inclusion of performance data, including but not limited to quality indicators and utilization management at the time of recredentialing.
3. Site visits at the time of credentialing for primary care physicians, obstetricians and gynecologists, and dentists (to include American's with Disabilities Act (ADA) assessment).[26]
4. Verification of admitting privileges in good standing at a participating hospital
5. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
6. Additional query of NJ Medicaid Debarment List is required for Practitioners and Facilities: http://nj.gov/comptroller/divisions/medicaid/disqualified/

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[25] Requirements of state Medicaid contract.

[26] Attestation to ADA compliance and compliance with medical record keeping practices is required. Additional mechanisms other than site visits may be considered as meeting this requirement.

7. Credentialing process shall include notification to practitioners of errors in the credentialing application within three (3) business days of receipt or identification of an error. The credentialing committee shall meet to review credentialing applications monthly and notify each applicant of the status of their application within five (5) business days of the meeting.
8. A dentist with certification in the following specialties: Endodontics, Oral and Oral Maxillofacial Surgery, Periodontics and Prosthodontics must have or have confirmations of application submission, of vaild DEA and CDS certificates. As required by the State of New Jersey, any provider that holds a valid DEA or CDS certificate must submit it.

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New Mexico

Requirements for Health Maintenance Organizations (HMOs) and Group Health Insurance. (NM Statutes Annotated section 59A-23-14 and 59A-46-54, and NM Administrative Code sections:13.10.21.9, 13.10.28.10, 13.10.28.11 and 13.10.28.13)

1. When credentialing functions are performed by another entity, the Managed Health Care Plan is required to monitor the delegated entity for compliance with state credentialing/recredentialing regulations.
2. Shall not use any health professional credentialing application form other than the uniform Hospitals Service Corporation or Council for Affordable Quality Healthcare credentialing/recredentialing forms, in electronic or paper format, as determined by the health carrier. Exception to use of these credentialing applications is made for health professionals who practice outside of NM and who prefer to use the credentialing form required by their respective states.
3. Shall notify applicants of its decision to approve or deny the credentialing application within 45 days of receipt of a completed application and all supporting documentation:
   a) in writing via US mail at the physical address listed in the application; and
   b) by e-mail if an email address has been provided.
4. Each carrier shall establish an internal process for resolving disputes regarding credentialing between the health carrier and providers. When a provider has not received a decision regarding a credentialing application within 45 days of submitting the completed uniform credentialing application, the provider may request a review of the credentialing application according to the health carrier's internal dispute process.
5. Notify the applicant in writing via U.S. certified mail within 10 working days:
   a) That the credentialing application has been received; and after receipt of an incomplete application requesting any information or supporting documentation that is required in order to approve or deny the credentialing application. The notice will contain a name, address and telephone for credentialing staff who serve as applicant's point of contact.
6. If additional information or documentation is required from the provider and is requested via certified mail, health carrier shall inform the applicant:
   a) that the 45-day time period shall be tolled pending receipt of the requested information or documentation.
   b) In the event that any needed verification or a verification supporting statement has not been received within 60 days of the health carrier's request; and
   c) If at the end of 90 days an application remains incomplete and the provider has been unresponsive, the health carrier shall return the application and attached materials with a statement of rejection.
7. Health carrier shall not require applicant to submit information not required by the uniform credentialing form, other than information or documentation that is reasonably related to information on the application.
8. Health carriers required to establish program that verifies provider credentialing before accepting the provider into the network and listing the provider in the directory.
9. Health carrier not obligated to approve all credentialing applications and may deny any application based on existing network adequacy, issues with application, failure by provider to complete credentialing application, or another reason.
10. Each carrier shall develop and adopt a written credentialing plan to support the credentialing verification program, and which shall be provided to the superintendent of insurance upon request.

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11. Each carrier shall submit a report to the superintendent of insurance regarding its credentialing process every two years. The report shall include the following: the amount of time taken to review and reach a determination on an application and the number of: applications made to the plan, applications approved by the plan, applications rejected by the plan, and providers terminated for reasons of quality.
12. Recredentialing may not be required more frequently than every three years. Health carrier will notify applicant at least 120 days in advance of all items necessary to complete recredentialing. The recredentialing process must be completed within 45 days of receipt of the applicant's complete recredentialing application and all supporting documents. If application is approved provisionally, then recredentialing shall be required annually. Nothing in this section shall be construed to require a health carrier to credential or provisionally recredential any provider. A health carrier may not require a participating provider to be recredentialed based on a change in provider's TIN or TIN of provider's employer, a change in provider's employer if the new employer is a participating provider or also employs other participating providers.

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New York

In New York (NY), Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to notify health care professionals within 60 days of receipt of a completed application as to: (i) whether the provider is credentialed; or (ii) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, a health plan shall make every effort to obtain such information as soon as possible and shall make a final determination within 21 days of receiving the necessary documentation.
(NY Con. Law Svc. Ins. 4803)(a) and NY Public Health Law section 4406-d (1)(a)).

Additionally, NY HMO and PPOs are required to provisionally credential health care professionals under the following conditions:

1. If the insurer, within 60 days of submission of the completed application, has neither approved nor declined the application of a newly-licensed health care professional who joins a participating group practice; or
2. If the insurer, within 60 days of submission of the completed application, has neither approved nor declined the application of a health care professional who has not previously practiced in NY and has recently relocated to NY from another state, to join a participating group practice; and
3. The group practice notifies the insurer in writing that, should the health care professional's application ultimately be denied, the health care professional or the group practice:
   a) Refund any payments made by the insurer for in-network services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the member's coverage plan with the insurer; and
   b) Not pursue reimbursement from the member, except to collect the copayment or coinsurance that otherwise would have been payable had the enrollee received services from a health care professional participating in the insurer's network.
4. However, a provisionally credentialed physician may not be designated as a member's primary care physician until such time as the physician has been fully credentialed.
   (NY Con. Law Svc. Ins. 4803(b). and NY Public Health Law section 4406-d (1)(b)).

New York UnitedHealthcare Community Plan Requirements[27]

Additional query of state Medicaid Sanctioned Provider List is required on Practitioners and Facilities in addition to state licensing boards query.(http://omig.state.ny.us/data/content/view/72/52/; (10NYCRR 98.12(1)).

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

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[27] Requirements of state Medicaid contract

North Carolina

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the state uniform provider credentialing application for licensed health care practitioners. (North Carolina (NC) Gen. Stat. 58-3-230)
2. Notify the practitioner within 30 days if the application is not accepted for reasons not related to credentialing.
3. Make a credentialing determination within 60 days of receipt of completed application. (NC Gen. Stat. sect. 58-3-230(a);11 NC Adm. Code 20.0405).
   a) If the application is incomplete, it is required to notify the provider within 15 days of all missing or incomplete information or supporting documents.
   b) If the missing information is not received within 60 days, it is acceptable to close the application or delay the final review pending receipt of the necessary information.
   c) If insurer has not approved or denied the application within 60 days of receipt of the completed application, within five business days of receipt of a written request from the applicant, the insurer is required to issue a temporary credential to the applicant if the applicant has a valid NC professional or occupational license.
      i) The insurer shall not issue a temporary credential if the applicant has reported a history of: malpractice claims, substance abuse, mental health issues, or licensing board disciplinary actions.
      ii) The temporary credential is effective upon issuance and will remain in effect until the credentialing application is approved or denied.
4. Whenever credential verification activities are delegated to a contracting entity, require the contracting entity to comply with all applicable requirements in the NC Adm. Code related to credentialing. (NC Adm. Code 20.0410)

North Carolina UnitedHealthcare Community Plan Requirements

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of the North Carolina Medicaid Provider Termination and Exclusion list is required for Practitioners and Facilities: https://medicaid.ncdhhs.gov/providers/excluded-providers

Credentialing to be completed ninety percent (90%) of providers within thirty (30) calendar days of the Committee's receipt of complete credentialing and verified information for consideration; and one hundred percent (100%) of providers within forty-five (45) calendar days of the Committee's receipt of complete credentialing and verified information for consideration of the Provider Network Participation Committee's determination.

The Health Plan shall provide written notice of credentialing Quality Determinations to providers within five (5) business days of the Provider Network Participation Committee's determination.

The NC Department of Health and Human Services (the Department) will establish a centralized credentialing process including a standardized provider enrollment application and qualification verification process.

The Department will engage a Provider Data Management/Credential Verification Organization (PDM/CVO), where the CVO is certified by the National Committee on Quality Assurance (NCQA), to facilitate the enrollment process including the collection and verification of provider education, training, experience and competency.

The information gathered by the Department will be shared with the Health Plans to use the information to make Credentialing Quality Determinations for network contracting purposes.

The Health Plan shall accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department's written prior approval.

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The Health Plan shall make a Quality Determination based solely upon the credentialing information provided by the Department and shall not require a provider to submit any additional information to be used in the Quality Determination.

Health Plan shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.

Health Plan shall establish and maintain a Provider Network Participation Committee to make Quality Determinations. Chief Medical Officer (CMO) or CMO designee shall serve as the chair of the Provider Network Participation Committee. The chair must be a North Carolina licensed physician.

Health Plan may establish criteria to define a provider's file as a clean file and a review process for clean files. The review process must include that a clean file is reviewed by the Chief Medical Officer, but review by the Provider Network Participation Committee is not required.

Prohibit contracting with providers who are not enrolled with the Department as NC Medicaid providers consistent with screening and enrollment requirements of 42 C.F.R. Part 455 Subparts B and E.

The Health Plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the health plan by the provider:

- Newly credentialed provider attached to a new contract within ten (10) business days after completing credentialing;
- Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing;
- Newly credentialed provider attached to an existing contract within five (5) business days after completing credentialing;
- Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) business days after completing re-credentialing;
- Change in existing contract terms within ten (10) business days of the effective date after the change; and
- Changes in provider service location or demographic data or other information related to Member's access to services must be updated no later than thirty (30) calendar days after the PHP receives updated provider information. (End bullets here)

The Health Plan shall submit any significant policy changes to Objective Quality Standards to the Department for review and approval at least sixty (60) calendar days prior to implementing such changes.

The Health Plan shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements.

- The Health Plan shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information with fifty (50) days of suspension, the Department will terminate the provider from Medicaid.

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North Dakota

No additional credentialing requirements.

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Ohio

Laws and regulations apply to a health insuring corporation such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Insurance Companies.

The following laws (ORC Ann. 3963.01, 3963.05 and 3963.06) apply to a "contracting entity," meaning, any person that has a primary business purpose of contracting with participating providers for the delivery of health care services (e.g. HMOs, PPOs, Insurance Companies).

Requirements with respect to what constitutes a "Provider". A "Provider" can be a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. A "Provider" is not a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds. (ORC Ann. 3963.01(P)).

1. The Department of Insurance must prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format for physicians. Also, the Department of Insurance must prepare the standard credentialing form for all other providers, except hospitals. (ORC Ann. 3963.05(A) and (E)).

   The Ohio Department of Insurance (OH DOI) has adopted the CAQH credentialing form, in electronic or paper format, for credentialing of physicians and non-physician individual providers. (Referred to as "Department of Insurance Part A credentialing form.) (OH Adm. Code 3901-1-58(C).)

   OH DOI has designated the DOI Part B credentialing form to be used to credential hearing aid dealers, home health agencies, hospice care providers and all other providers that are not individuals, with the exception of hospitals. Copies of this form may be obtained from the OH DOI. (OH Adm. Code 3901-1-58(C).)

2. A contracting entity must use the applicable standard credentialing form described in the preceding paragraph when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services. (ORC Ann. 3963.05.)
3. A contracting entity cannot require a provider to supply additional information other than what is required by the applicable standard credentialing form described in paragraph 1 above in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services. (ORC Ann. 3963.05.)
4. The credentialing process outlined in Ohio (OH) law does not prohibit a contracting entity from limiting the scope of any participating provider's basic health care services, specialty health care services, or supplemental health care services. (ORC Ann. 3963.05).
5. If a provider, upon the oral or written request of a contracting entity to submit a credentialing form, submits a credentialing form that is not complete, the contracting entity that receives the form must notify the provider of the deficiency electronically, by facsimile, or by certified mail, return receipt requested, no later than 21 days after the contracting entity receives the form. (ORC Ann. 3963.06).
6. If a contracting entity receives any information that is inconsistent with the information given by the provider in the credentialing form, the contracting entity may request the provider to submit a written clarification of the inconsistency. The contracting entity must send the request described in this section electronically, by facsimile, or by certified mail, with return receipt requested. (ORC Ann. 3963.06).

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7. a) Except as otherwise provided in section 7B below, the credentialing process starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity, and the provider must submit the credentialing form to the contracting entity electronically, by facsimile, or by certified mail, with return receipt requested. Subject to section 7C, a contracting entity must complete the credentialing process not later than 90 days after the contracting entity receives the credentialing form from the provider. The contracting entity must allow the provider to submit a credentialing application prior to the provider's employment. (ORC Ann. 3963.06).

   b) The credentialing process for a Medicaid-managed care plan starts when the provider submits a credentialing form and the provider's national provider number is issued by the Centers for Medicare and Medicaid Services. (ORC Ann. 3963.06).

   c) The requirement that the credentialing process be completed within the 90 day period specified in section 7A does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity is a hospital. (ORC Ann.3963.06).

   d) Any communication between the provider and the contracting entity must be electronically, by facsimile, or by certified mail, with return receipt requested. (ORC Ann. 3963.06).

   e) If the state medical board or its agent has primary source verified the medical education, graduate medical education, and examination history of the physician, or the status of the physician with the educational commission for foreign medical graduates, if applicable, the contracting entity may accept the documentation of primary source verification from the state medical board's website or from its agent and is not required to perform primary source verification of the medical education, graduate medical education, and examination history of the physician or the status of the physician with the educational commission for foreign medical graduates, if applicable, as a condition for initially credentialing or recredentialing the physician. (ORC Ann. 3963.06).

Health plans doing business with the State of Ohio are prohibited from using any off-shore resources. This would include credentialing and recredentialing functions. (Executive Order 2011-12K).

Facility credentialing in Ohio requires use of a state-mandated facility application.

Ohio UnitedHealthcare Community Plan Requirements[28]

Additional requirements for verification of sanctions on Practitioners and Facilities including but not limited to: Office of the Inspector General List of Excluded Individuals and Entities and National Practitioner Data Bank, OH Department of Job and Family Services website.

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[28] Requirements of state Medicaid contract

Oklahoma

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the Department of Health Uniform Application for credentialing for all health care practitioners and permitted to require supplemental information. (63 Oklahoma (OK) Stat. 1-106.2).
2. Make information on criteria available to provider and provide applicant with a checklist of material required in the application process.
3. Notify practitioner within 10 days of receipt if application is incomplete, specifying the portion of application that is at issue.
4. Initiate credentialing process within seven days when application is complete.
5. Shall complete the credentialing process within 45 days upon receipt of the primary source verification and malpractice history on a "clean application." A clean application means:
    a) There is no defect, misstatement of facts, improprieties, lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing; and
    b) Professional liability carriers are required to respond to inquiries from health benefit plans within 21 days; the OK State Insurance Commissioner may assess a penalty against a professional liability carrier that fails to respond to a health benefit plan within the 21 day time frame.
6. Permitted to extend credentialing/recredentialing process for 60 days if unable to credential/recredential due to application not being "clean."
    a) If still awaiting documentation at the end of the 60-day extension, required to notify practitioner by certified mail of reason for delay.
7. Practitioner may request an extension of the 60-day period but must do so within 10 calendar days; otherwise the application shall be deemed withdrawn.
8. Under no circumstances shall the entire process exceed 180 calendar days.

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Oregon

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Credential providers, but no specific credentialing requirements identified. (Oregon Revised Statutes sections 743.918(2); Oregon Administrative Rules sect. 836-053-1170(1)(c)(B)).

2. Accept the Oregon Practitioner Credentialing and Recredentialing Applications.
   (Oregon Administrative Rules 333-505-0007 and 409-045-0000)

   The Oregon Credentialing App can be found at the following Oregon.gov link: http://www.oregon.gov/oha/HPA/OHIT-ACPCI/Documents/2012credappglossary.pdf

3. Approve or reject a provider credentialing application within 90 days of receipt of a complete application containing all required credentialing information.
   (Oregon Revised Statutes 743.918(2))

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Pennsylvania

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to include data from quality improvement activities at the time of recredentialing. (28 PA Code 9.761).

All individual contracted providers are subject to United Healthcare's credentialing and recredentialing process per the current UnitedHealthcare Credentialing Plan in order to be considered participating in the provider network. UnitedHealthcare does not have a credentialing requirement for non-participating providers. (28 PA Code 9.763)

Upon written request, a UnitedHealthcare shall disclose relevant credentialing criteria and procedures to health care providers that apply to become participating providers or who are already participating. (28 PA Code 9.761)

UnitedHealthcare shall submit a report to the Pennsylvania Department of Health regarding its credentialing process every 2 years. The report shall include the following:

1. The number of applications made to the plan.
2. The number of applications approved by the plan.
3. The number of applications rejected by the plan.
4. The number of providers terminated for reasons of quality.

The next report will be due in 2020. (28 PA Code 9.761)

UnitedHealthcare shall not exclude or terminate a health care provider from participation in the plan due to any of the following:

1. The health care provider engaged in any of the following activities:
   a) Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care.
   b) Filing a grievance pursuant to the procedures set forth in this article.
   c) Protesting a decision, policy or practice that the health care provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the health care provider's ability to provide medically necessary and appropriate health care.
2. The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.
3. The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds. (28 PA Code 9.761

UnitedHealthcare's credentialing policies shall comply with 40 P.S. §991.2121. and 28 PA Code 9.761, 762 and 763.

Pennsylvania UnitedHealthcare Community Plan Requirements[29]

1. Assessment of Americans with Disabilities Act (ADA) compliance required as part of initial credentialing for primary care physicians (PCP) and dentists.
2. Certified Registered Nurse Practitioners, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team must submit a copy of collaborative agreement with a physician.
3. Additional requirements for verification of sanctions on Practitioners and Facilities including but not limited to the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)) and State Medicaid MediCheck database.

[29] Requirements of state Medicaid contract.

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4. Federal database check on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES)
5. Credentialing must be completed within sixty (60) days of receipt of the application packet if the information is complete.
6. Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach.
7. PCP qualifications: evidence of continuing professional medical education[30]
8. Facility credentialing may include Pediatric Residential Care Centers.
9. Cannot delay processing the application if the provider does not have an Medicaid ID (PROMISe) number that is issued by the DHS.
10. Process cannot be complete until the provider has received its Medicaid ID (PROMISe) number from DHS.
11. Must notify the provider of the status of their credentialing application as follows:
    a) First Correspondence: The PH-MCO must provide an Acknowledgment of Application notification to the provider within ten (10) calendar days of receipt.
    b) Second Correspondence: The PH-MCO will send an Application Status to the provider within thirty (30) calendar days stating:
        i) Their application is clean and is being submitted through the credentialing process or;
        ii) Their application is not clean with a list of items needing to be addressed. If a provider's Medicaid ID (PROMISe) number is not in place at the time of this notification, it may be noted as an outstanding item.
    a) Third Correspondence: A Credentialing Approval/Denial notice will be sent within a maximum of sixty (60) calendar days. If the provider application is denied, the correspondence should include all of the requirements that were not met.
    b) First and Second Correspondence must include language reminding providers that credentialing cannot be completed until their Medicaid Number (PROMISe ID) is in place.
    c) Provider communications electronically is encouraged.

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[30] Criteria are covered under State Board of Medicine – Chapter 16 State Board of Medicine General Provisions

Puerto Rico

No additional credentialing requirements.

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Rhode Island[31]

1. When a health plan terminates a provider agreement, it is required to offer appeal rights. (216 Code of RI Rules sect. 40-10-21.7(L).)
2. Both Drug Enforcement Administration Certificate (DEA) and State -Controlled Dangerous Substances Certificate required.[32] (216 Code of RI Rules sect.40-10-21.7(G)(2)(c)(4).)
3. If any health plan responsibility, in whole or in part, is delegated to another organization/agent, the health plan shall maintain oversight and accountability for all delegated activity through a formal agreement describing the delegated function(s) and oversight program. Health plans may not sub-delegate the responsibility of oversight. (216 Code of RI Rules sect.40-10-21.4(F).)
4. Required to issue a decision no later than 45 days after receipt of a complete credentialing or recredentialing application. Required to establish written standard defining what elements constitute a complete credentialing application, make the standard available on company website, and distribute standard with written version of the credentialing application. (RI General Laws, Chapters 27-18-83 and 27-41-87.)
5. Required to respond to inquiries from applicants regarding status of a credentialing application as follows: (a) provide automated application status updates at least once every 15 days, informing applicant of any missing application materials until application deemed complete; (b) inform applicant within five (5) business days that the credentialing application is complete; and (c) if credentialing application is denied, notify provider in writing and note any and all reasons for the denial. (RI General Laws, Chapters 27-18-83 and 27-41-87.)
6. During the recredentialing process, required to establish effective communications with in-network licensed independent practitioners, including without limitation:
   a) A two-way communication to assure the provider is informed of the need for recredentialing;
   b) Adequate due diligence in obtaining the current and correct mailing address or other provider-preferred mode of communication to directly communicate with the network provider;
   c) A mechanism to follow up with network providers who have not responded to the initial recredentialing communications with a diligent effort to validate the current physical and/or electronic address used as the mode of communication and confirm receipt of the initial recredentialing communication;
   d) Health care entities shall not terminate a provider if the Plan has failed to properly adhere to these recredentialing requirements.
7. Effective date for billing privileges shall be the next business day following approval of the credentialing application. (RI General Laws, Chapters 27-18-83 and 27-41-87.)
8. For credentialing applications received from resident graduates, required to offer transitional/conditional approval process such that a resident graduate who has submitted an otherwise complete application and met all other criteria may be conditionally approved effective upon successful graduation from training program. (RI General Laws, Chapters 27-18-83 and 27-41-87.)
9. A health care entity shall establish a transitional or conditional credentialing approval processes in any provider category where there is an established "need" (geographic "need" or "need" by specialty type such as resident graduates, primary care providers, behavioral health providers or certain specialist providers), and shall include:
   a) "Need" shall be assessed by the Commissioner considering continuity of care for beneficiaries, insufficient network by provider type and/or the inability of the entity to provide timely access to covered services to its beneficiaries.
   b) To be considered for a transitional or conditional credentialing approval, the provider must have:
      i) Submitted an otherwise completed credentialing application and met all other credentialing criteria;

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ii) Successfully graduated from the training program; and

iii) Includes a mechanism to ensure that providers with transitional, conditional or temporary credentialing approval receive an effective date for billing privileges of the first business day after the transitional, conditional and/or temporary credentialing approval.

10. A health care entity may utilize an alternative credentialing program approved by the Commissioner.

Rhode Island UnitedHealthcare Community Plan Requirements[33]

Primary Care Qualifications Attestation for Advanced Practice Practitioners Certified Nurse Practitioners, and/or Physician Assistants. Advanced Practice Practitioners who wish to become PCPs shall submit documentation of evidence of a collaborative relationship with a Primary Care Physician, in which this physician agrees to share responsibility for the care of patients, and particularly assume responsibility for components of care which are beyond the scope of practice and/or expertise of the Advanced Practice Practitioner. The designated physician shall also agree to collaborate with the Advanced Practice Practitioner to ensure that members receive specialty and other referrals as necessary.

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[31] Credentialing files must contain copies of license, DEA, CDS or copies of verification sources

[32] National Committee for Quality Assurance primary source verification requirements that apply to both documents.

[33] Requirements of the State Medicaid Contract.

South Dakota

- If a health insurer (or other entity credentialing on its behalf) receives a request from a health care professional for a credentialing application, then the insurer or entity is required to send the application form to the professional within 10 business days, unless the application is available electronically on a public website.
- Within 90 days of receiving a complete credentialing application, the health insurer (or other entity credentialing on its behalf) must provide the applicant with electronic or written notice of its determination.
  - If an incomplete application is received, the insurer or entity must notify the health care professional of such as soon as possible, but no more than 30 days after receipt, and the notification must itemize everything still needed to make the application complete. The insurer or entity may request additional information if the information provided is inaccurate, incomplete, or unclear.
- The insurer or entity may take additional time beyond the 90 days if a special review (as defined) is require
  - "Special Review" means a supplemental review of a health care professional's completed application for credentialing or change request by a health insurer or other entity responsible for credentialing of health care professionals necessitated by credible evidence received by a health insurer or other entity responsible for credentialing of health care professionals as it relates to investigation of the following: action taken against the applicant's licensure status, action taken against the applicant's professional society status, verified complaints to facilities, or licensing agency regarding the applicant; the applicant's non-completion of training programs; a criminal proceeding brought against the applicant a malpractice claim brought against the applicant; loss of a Drug Enforcement Administration certificate or state-controlled substance certificate; loss of a Medicare or Medicaid certification status; or involuntary termination of credentialing by a different health insurer.

2014 HB 1157.

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Tennessee

Insurers, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are:

1. Required to accept the Council for Affordable Quality Healthcare (CAQH) provider application in addition to the health insurance entity's own application. (Tennessee (TN) Code Ann. 56-7-1009).
2. If health insurance entity is a participating organization with CAQH, it's required to accept either the electronic application or a paper application. (TN Code Ann.56-7-1009)
3. Required to respond within 90 days to providers who submit "clean" CAQH application. A "clean" CAQH application means there is no defect, misstatement of facts, improprieties, lack of required substantiating documentation or particular circumstance requiring special treatment that impedes prompt credentialing. (TN Code Ann. 56-7-1001).
4. Unless otherwise required by a national accrediting body, a health insurance entity shall accept and begin processing a completed credentialing application as early as ninety (90) calendar days before the anticipated employment start date of the health care provider. (TN Code Ann. 56-7-1009(b).)
5. Cannot require activation of malpractice coverage prior to effective date of participation. (TN Code Ann. 56-7-1001(c)).
6. For HMOs only: recredentialing procedure to include data from quality improvement activities. (Tenn. Comp R & Regs. R. 1200-8-33-06(12))
7. For HMOs only: required to monitor and evaluate delegated credentialing activities on an ongoing basis. (Tenn Comp. R & Regs. R. 1200-8-33-06(12)).
8. For HMOs only: the attestation must not be older than 180 calendar days at the time of the credentialing decision. (Tenn. Comp. R. & Regs. R. 1200-8-33-.06(2).
9. For new provider applicants joining a participating medical group,:
   a) Provide group with list of all information and supporting documentation required for credentialing application of a new provider applicant to be considered complete.
   b) Notify new provider applicant in writing of status of credentialing application no later than five (5) business days of receipt of the application. Notice shall indicate if application is complete or incomplete, and if incomplete, shall indicate information or documentation needed to complete the application.
   c) If application is incomplete and new provider applicant submits additional information or documentation to complete the application, health insurance entity shall notify the new provider applicant in writing of the status of the credentialing application no later than five (5) business days of receipt of the additional information or documentation.
   d) Notify new provider applicant of the results of the credentialing application within ninety (90) days after notification from the health insurance entity that the application is complete.
   e) If the new provider applicant fails to submit a complete credentialing application within thirty (30) calendar days of notice of an incomplete application, then the application is deemed incomplete and credentialing is discontinued. (TN Code Ann. 56-7-1001(f).)

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Tennessee UnitedHealthcare Community Plan Requirements[34]

1. The Contractor shall completely process credentialing applications within (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the Contractor shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the Contractor.
2. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES) prior to credentialing/recredentialing decision.
3. Additional query of TennCare Terminated Provider List is required for Practitioners and Facilities: https://www.tn.gov/tenncare/topic/terminated-provider-list

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[34] Requirements of the State Medicaid Contract.

Texas

The standards set out in section four of the National Credentialing Plan set the baseline credentialing standards for licensed independent practitioners (LIP) and components in all markets. In addition to these national standards, in Texas, compliance is also required with the following state laws/regulations:

- **Standardized Credentialing Form:** Physicians, Advance Practice Nurses and Physician Assistants. Hospitals and Health Maintenance Organizations (HMOs) are required to use the form. (TX Ins. Code 1452.052, 28 TX Adm. Code 21.3201).
- **HMO Credentialing Files:** Credentialing files are included in the list of documents required to be available at the HMO offices in TX. (28 TX Adm. Code 11.303 (c)(11))
- **HMO Quality Improvement Program:** HMOs are required to implement a documented process for selection and retention of contracted physicians and providers. The HMO's credentialing process, and that of the HMO's delegate where credentialing is delegated, must comply with National Committee for Quality Assurance (NCQA) standards to the extent the NCQA standards do not conflict with TX state requirements. (28 TAC section 11.1902(4) and (7)).

"The HMO is required to have procedures for detecting deficiencies **subsequent to the initial site visit…**" (Emphasis added. 28 TAC section 11.1902(5)(A)).

The HMO Medical Director [28 TAC 11.1606] is required to:

- Be licensed in Texas (§11.1606 (c)(1)
- Reside in Texas (§11.1606 (c)(2)
- Demonstrate active involvement in all quality management activities (§11.1606 (c)(4)
- Be subject to HMO's credentialing requirements (§11.1606 (c)(5)

HMOs are required, during the annual application period only, to respond to physician and provider applications for participation within 90 days of receipt of the application for participation. (28 TX Adm. Code 11.1402(c)). Notification to physician or provider will be given in writing.

Preferred Provider Organizations (PPOs) Provider Contracting Requirements

(28 TX Adm. Code 3.3706):

- All LIPs and components must be eligible to apply and be afforded a fair, reasonable and equitable opportunity to become a preferred provider.
- Notify annually all LIPs in the service area of the opportunity to apply to participate. The notice may be made by publication or individual writings to all affected LIPs.
- Designation as a preferred provider may not be unreasonably withheld, but the PPO may reject an application on the basis of sufficient qualified providers already in the network.
- Provide the specific reason for denials to LIPs and components.
- All denials of LIP initial credentialing applications must offer the right to a review of the denial by an advisory review panel.
  - The advisory review panel shall be composed of three or more participating LIPs in the service area, at least one of whom is an LIP in the same or similar specialty as the applicant.
  - The PPO may make a determination that is contrary to the recommendation of the advisory review panel.
  - The PPO is required to provide a written explanation of denied applications.
  - Upon request of the LIP, the advisory panel recommendation must be provided.
- Notices of terminations of agreements with LIPs and components must include the reason for the termination.

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- For terminations of LIP agreements, the PPO is required to offer review by an advisory review panel, following the same procedure noted above, except in cases of:
  - Imminent harm to patient health, or
  - Action by any state licensing board which impairs an LIP's ability to practice, or
  - Fraud or malfeasance.

HMOS and PPOs (TX Ins. Code 1452.103 – effective September 2007)

When an applicant physician who joins a medical group, medical school or teaching hospital that already participates in the managed care plan's network, the applicant physician is considered eligible for "expedited credentialing" when the managed care plan has:

- Verified that the applicant physician is licensed in good standing with the Texas Medical Board, and
- Determined that all credentialing information necessary to initiate the credentialing process for the applicant physician has been submitted.

During expedited credentialing:

- The managed care plan is not obligated to list the applicant physician in the provider directory, and
- The applicant physician is not considered to be a primary care physician for selection by HMO members until the full credentialing process is completed.

Upon completion of the managed care plan's standard credentialing process:

- The plan may reject the applicant physician's application if they do not meet standard credentialing requirements, and
- Managed care plans are explicitly protected from liability for damages based on the expedited credentialing process of applicant physicians.

Texas UnitedHealthcare Community Plan Requirements[35]

1. Inclusion of data from quality improvement activities at the time of recredentialing.
2. Additional requirements for verification of sanctions on Practitioners and Facilities including but not limited to the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)) and the Texas Office of the Inspector General List of Medicaid Exclusions:oig.hhsc.state.tx.us/Exclusions/Search.aspx.
3. The MCO must complete the credentialing process for a new provider and its claims system must be able to recognize the provider as a Network Provider no later than 90 calendar days after receipt of a completed application.
4. If an application does not include all required information, the MCO must provide the provider with written notice of all missing information no later than 5 Business Days after receipt.
5. If a provider qualifies for expedited credentialing the claims system must be able to recognize the provider as a Network Provider no later than 30 calendar days after receipt of a completed application even if the MCO has not yet completed the credentialing process. (The MCO must comply with requirements of Texas Chapter 1452 Sub-chapter C, D, and E regarding expedited credentialing and payment of physicians, podiatrists and therapeutic optometrists who have joined established medical groups or professional practices that are already contracted with the MCO.)

New applicants who are joining a participating network provider group that is already contracted to provide services to Medicaid beneficiaries are required to submit all required documentation and information for the credentialing process to be initiated.

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Upon submission of the required documentation and information, the managed care organization is required to treat the applicant as if the applicant were in-network.

If the applicant does not pass credentialing, the managed care organization may not recover any payments made prior to the completion of credentialing.

If the applicant does not pass credentialing and the managed care organization determines that the applicant made fraudulent claims in the credentialing application, the managed care organization may recover the entire amount of any payment made to the applicant.
(TX Govt Code section 533.0064.)

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[35] Requirements of the State Medicaid Contract.

Utah

Pursuant to Utah Code Annotated section 31A-45-304, managed care plans are:

1. Required to establish credentialing criteria for participating providers, which must be filed with the state and made available to any provider upon request.
2. Required to make a decision on the provider application within 120 days of receipt of the application and all necessary information.
3. Prohibited from rejecting applicants, or terminating participation, based solely on the provider's staff privileges at a general acute care hospital not under contract with the managed care organization.

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Vermont

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

(Code of VT Rules 21-040-010 et. seq.)

- The Medical Director, required to be licensed in VT, is responsible for and required to participate in provider credentialing verification process.

1. Primary source verification is required for the following elements for initial credentialing: Professional Liability Insurance certificate from the carrier, status of hospital privileges, DEA Certificate or State Controlled Dangerous Substances Certificate require primary source verification, work history.[36]
2. Primary source verification of Drug Enforcement Administration (DEA) Certificate or State Controlled Dangerous Substances Certificate from the carrier for recredentialing.
3. Recredentialing process needs to include performance appraisal of provider, review of data from member complaints, and results of quality reviews, utilization management reviews and member satisfaction surveys.

Vermont adopted the Council on Affordability and Quality Healthcare (CAQH) credentialing form as its Uniform Credentialing Application. (18 VT Statutes Annotated 9408(a); 192 VT Government Register 43).

1. Health care insurers and HMOs are required to notify providers of deficiencies on completed applications within 30 business days of receipt of the application by the insurer.
2. Health care insurers and HMOs are required to act upon and finish the credentialing process within 60 calendar days of receipt of a completed application. An application is considered complete once the insurer has received all information and documentation necessary to make its credentialing decision. (18 VT Statutes Annotated 9408(a).)

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Virgin Islands (U.S.)

No additional credentialing requirements.

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[36] A copy of professional liability declaration sheet will serve as evidence of primary source verification. A review of the attested credentialing application will serve as primary source verification of work history.

Virginia

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Notify applicant within 60 days of receipt, and if information is missing rendering the application incomplete. (12 Virginia Administrative Code 5-408-170(D)(6)).
2. Complete credentialing process within 90 days of receipt of additional information. (12 Virginia Administrative Code 5-408-170(D)(6)).
3. Complete credentialing process within 120 days for clean applications. (12 Virginia Administrative Code 5-408-170(D)(6)).
4. Complete initial credentialing process before: applicant enters into contract with the health plan, begins to see enrollees, or is listed in provider directory. (12 Virginia Administrative Code 5-408-170(F)).
5. Include data from quality improvement activities at recredentialing. (12 Virginia Administrative Code 5-408-170(G)(5).
6. Active medical staff privileges or admitting privileges are waived for podiatrists provided that the podiatrist has a delineation of privileges that enables such podiatrist to perform the type of services that are covered by the PPO or HMO at a designated hospital or hospitals. (Va. Code Ann. § 38.2-3407.6).

Virginia UnitedHealthcare Community Plan Requirements

Inclusion of data from quality improvement activities at the time of recredentialing.

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing

The Contractor and its network providers shall comply with all applicable Federal and State laws assuring accessibility to all services by individuals with disabilities pursuant to the Americans with Disabilities Act (ADA) (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Members.

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Washington D.C.

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).are required to accept the district's uniform credentialing form for credentialing and recredentialing.
(D.C. Code sections 31-3252 and 31-3251; Code of D.C. Municipal Regulations sections 26-4201 and 26-4299.)

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Washington

(Washington Administrative Code sections (WAC 284-170-411.) (WAC 284-170-390.) (Rev. Code WA 48.165.005, 48.165.010 & 48.165.035.)

1. Effective June 1, 2018, health carriers shall use the uniform electronic process (the database) to accept and manage credentialing applications from health care providers. (Rev. Code WA 48.43.750.)
   a) Determinations to approve or deny a credentialing application shall be made no later than 90 days after receiving a completed credentialing application.
   b) Effective June 1, 2020, approval or denial determinations made by the health carrier must average no more than 60 days.
   c) Does not apply to health care entities that utilize credentialing delegation arrangements in the credentialing of their health care providers with health carriers.
2. For health plans issued or renewed on or after Jan. 1, 2016 but before Jan. 1, 2017, health plans that delegate credentialing agreements to contracted health care facilities must accept credentialing for pharmacists employed or contracted by those facilities.
   (Rev. Code WA 48.43.XXX (3) – Senate Bill 5557(2015).)

Washington UnitedHealthcare Community Plan[37]

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of WA Provider Termination and Exclusion List is required for Practitioners and Facilities: http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/provider-termination-and-exclusion-list

Contractor must notify providers within fifteen (15) calendar days of the credentialing committee decision.

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West Virginia

W. VA. CSR § 114-53-4 Requirements of a Quality Assurance Program:

4.1. A Health Maintenance Organization (HMO) shall develop a quality assurance program which adheres to all applicable state and federal laws, federal regulations and state rules.

a. An HMO that has obtained full accreditation or equal status from a nationally recognized accreditation and review organization approved by the commissioner pursuant to West Virginia Code §33-25A-17a is deemed to be in compliance with this rule.

"Credentialing entity" means any health care facility, payor or network that requires credentialing of health care practitioners; "credentialing entity" has the same meaning ascribed to "health care entity" in W. Va. Code of St. Rules 64, 114CSR3.4. (W. VA. CSR 64-89B-2.4)

"Health Care Practitioner" or "practitioner" means a health care provider who is licensed, certified, or otherwise authorized to provide health care services, as designated by the Secretary and Commissioner to be subject to the uniform credentialing and recredentialing forms. (W. VA. CSR 64-89B-2.6)

Shall use the uniform credentialing form developed by the committee for credentialing health care practitioners and the uniform recredentialing form developed by the committee for recredentialing health care practitioners. (W. Va. CSR § 64-89-4) Applications can be found at http://www.wvinsurance.gov/UniformCredentialing.aspx

A health care entity may request information in addition to the information provided in the uniform credentialing or uniform recredentialing forms. A request for additional information may not require repetition of the information required in, or substitute another form for, the uniform credentialing or uniform recredentialing forms. Additional information shall be requested by the health care entity on supplemental sheets attached to the uniform forms. (W. Va. CSR § 64-89-4.4)

When the uniform credentialing form or uniform recredentialing form is amended as provided in Section 5 of this rule, all health care entities shall use the amended uniform forms to credential or recredential health care practitioners. (W. VA. CSR 64-89-4.5)

Any credentials data collected or obtained by a health care entity during the credentialing or recredentialing process shall constitute confidential peer review information, as provided by W. Va. Code §30-3C-3, and shall not be disclosed by the health care entity except as provided by law. (W VA CSR § 64-89-6).

When a contract with a statewide CVO has been executed by the state of WV, the following paragraph will apply. As of March 2018, the WV Department of Insurance has advised that the state-wide CVO has not yet been established.

Except as provided in subsection 8.3 of this section, during the third year after the completion of a practitioner's initial credentialing, each practitioner is subject to recredentialing by the last day of the practitioner's birth month and by the same date every third year thereafter. (W. Va. CSR § 64-89B-8.1) The CVO shall be responsible for notifying each practitioner of their recredentialing date in a timely manner. (W. Va. CSR § 64-89B-8.2)

Nothing in this rule may be construed to prohibit a health care entity from delegating credentialing or recredentialing activities to another entity, such as a certified verification organization, as long as the entity to whom the activities have been delegated follows the requirements of this rule. (W. Va. CSR § 64-89-7)

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[37] Requirements of the State Medicaid Contract.

Wisconsin

No additional credentialing requirements.

Wisconsin UnitedHealthcare Community Plan Requirements[38]

Inclusion of data from quality improvement activities at the time of recredentialing.

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Wyoming

Health Maintenance Organizations (HMOs) are required to credential licensed individual practitioners and hospitals, but no specific credentialing requirements identified.
(Wyoming Statutes Annotated sections 26-34-108(b)(ii)(G)).

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[38] Requirements of the State Medicaid Contract.

Federal Requirements for Medicare Participation[39]

UnitedHealthcare's Credentialing plan for Medicare and Medicaid managed care plans adheres to managed care standards at 42 CFR §438.214 and 42 CFR §422.204. This addendum outlines only those additional requirements that are not already covered within the body of the Credentialing plan.

1. The information collected and verified must be no more than 180 calendar days old at the time of the Credentialing Committee decision.
2. The provider must not be excluded or debarred from participation in Medicare via a query of the General Services Administration/SAM database.
3. Delegation agreements must address Medicare Advantage (MA) contracting and delegation requirements, including but not limited to a requirement to comply with all applicable MA credentialing requirements. (See 42 CFR 422.504(i) and Medicare Managed Care Manual, Chapter 11, Sections 100.5 & 110).
4. Verification that licensed individual practitioners have not opted out of participation with Medicare.
5. Credentialing required for additional facility types as outlined in the Credentialing Plan (Attachment C), including but not limited to credentialing Federally Qualified Health and Rural Health Clinics as facilities.
6. Those facilities listed in Attachment C of the Credentialing Plan must have a provider agreement with CMS (e.g., Medicare CMS certification). See also Medicare Managed Care Manual, Chapter 6.

Additional information available at:
cms.gov/Manuals/IOM/list.asp

- Medicare Managed Care Manual, Chapter 6.
- Medicare Program Integrity Manual, Chapter 15
- Medicare Benefit Policy Manual, Chapter 15, Section 40

http://www.npdb.hrsa.gov/

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[39] 42 CFR 422.204 and 42 CFR 438.214 applies to all Medicare and Medicare/Medicaid dual eligible products

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Rev 07/2011, 08/2011, 03/2012, 11/2012, 11/2013, 5/2014, 10/2014, 3/2015, 08/2015,12/2015, 03/2016, 06/2016,11/2016, 2/2017, 6/2017, 11/2017, 01/2018, 07/2018, 10/2018, 01/2019, 3/2019

Insurance and/or HMO regulations apply to all Commercial, Medicare and Medicaid products/health plans sold in each applicable state.

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