

Review of Practitioner Credentialing and Recredentialing Information

MVP will execute a participation agreement and complete the initial credentialing and recredentialing (including primary-source verification of submitted information) for practitioners applying for participation or continued participation in MVP's practitioner network. Practitioners must be credentialed and contracted before being listed in MVP's Participating Practitioner Directory. MVP does not make credentialing or recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, or sexual orientation. MVP does not make credentialing or recredentialing decisions based solely on the types of procedures performed or the types of patients the provider sees. MVP will retain all verification information for credentialing and recredentialing purposes, pursuant to state and federal data requirements.

To be compliant with NCQA credentialing guidelines and MVP policy, we are required to credential and then recredential our contracted practitioners every three years. MVP contracts with and credentials the following practitioner types:

- Physicians (MDs and DOs)
- Naturopaths (ND) (Vermont only)
- Podiatrists Chiropractors
- Neuropsychologists (providing neuropsychological testing under the medical benefit)
- Oral Surgeons (providing services under the medical benefit)
- Ancillary and mid-level practitioners: including, but not limited to, Optometrists, Physical Therapists, Occupational Therapists, Certified Nurse Midwives, Lay Midwives (Vermont), Diabetes Educators, Massage Therapists, Acupuncturists, Speech/Language Pathologists, Audiologists, Dietitians/Nutritionists, Nurse Practitioners (NP) independent in specialty areas approved by New York State Public Health Law, NPs in a physician practice with a PCP specialty who wish to practice as a primary care provider (PCP) (NY Only), Registered Nurse First Assistants (NY Only-excludes Medicare line of business) working in an outpatient setting, and behavioral health practitioners as defined below.

In New York:

Licensed Clinical Social Workers (LCSW)

Licensed Mental Health Counselors (LMHC), based on MVP's network need

Licensed Psychologist (PsyD, PhD, or EdD)

Independent Psychiatric Nurse Practitioners

In Vermont:

Licensed Clinical Mental Health Counselor (LCMHC)

Licensed Marriage and Family Therapist (LMFT)

Licensed Clinical Social Worker (LCSW)

Master's-prepared Psychologist (MA, MS, or MACP)

Licensed Alcohol and Drug Counselor (LADC)

Licensed Psychologist (PsyD, PhD, or EdD)

Psychiatric Advanced Practice Registered Nurses approved for solo practice by the State of Vermont (APRN) may be considered for credentialing based on network need.

To streamline the administrative credentialing and recredentialing processes for our participating practitioners, MVP joined the Council for Affordable Quality Healthcare (CAQH) credentialing initiative. MVP uses the CAQH Universal Credentialing DataSource application for credentialing and recredentialing. The CAQH Universal Credentialing DataSource is a free online service that allows practitioners to fill out one application to meet the credentialing and recredentialing data needs of multiple health plans. Once the online application is complete, practitioners only need to update information that has changed or expired and attest to the accuracy of the data three times per year. To register with CAQH or learn more about the Universal Credentialing DataSource, visit <https://proview.caqh.org> and select the *Provider Sign In* link.

Registered Practitioners

MVP is not required to credential all practitioner types per state and federal regulations and/or accreditation standards. Certain Mid-Level practitioner types, such as Certified Nurse Midwives (CNM), Physicians Assistants (PA), Certified Registered Nurse Anesthetist (CRNA) and Registered Nurse First Assistant (RNFA) are subject to MVP's registration process in lieu of credentialing. Variations may exist regarding Mid-Level registration, depending on individual state laws and/or IPA bylaws as below:

University of Vermont Health Center-Credentialing and EnrollmentNetwork UVHN-C &E Locum Tenens (LT) practitioners **are required** to go through a credentialing process in order to receive payment for services provided to MVP members. A medical group must ensure that the practitioner's Coalition for Affordable Quality Healthcare (CAQH) application is complete and accurate. You can contact the University of Vermont Health Network at 1-802-847-8161 for further information about the credentialing of Locum Tenens.

NYS/VT The following hospital-based inpatient practitioner types must undergo a registration process: Hospitalists* (Internal Medicine, Pediatric and Family Medicine), Emergency Department Physicians*, Pathologists, Anesthesiologists*, Neonatologists*, Intensivists*, Certified Registered Nurse Anesthetists, non-independent Nurse Practitioners, Registered Nurse First Assistants, and Physician's Assistants.

***Exceptions:** Anesthesiologists who want to be designated as a Pain Medicine specialist, Neonatologists and Intensivists who will provide services outside of the NICU or ICU and Hospitalists who provide outpatient services. Emergency Physicians who also provide services in an urgent care center, or any other outpatient setting, must be credentialed. Exceptions may vary based on IPA requirements. Registration forms may be found in the provider section of the MVP website at <https://www.mvphealthcare.com/providers/forms/>

Excluded Individuals

In the event Medicare or Medicaid has sanctioned a practitioner, MVP may decide not to credential or recredential the practitioner or may terminate the practitioner from the appropriate lines of business. In the event that Medicare or Medicaid has excluded the practitioner, MVP will administratively deny or terminate the practitioner from participation in the Medicare/Medicaid lines of business, as applicable.

Criteria for Admission

To participate with MVP, the following are required:

- The appropriate education to obtain state licensure in the relevant practice area and completion of one of the following residency programs: Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), the Royal College of Family Physicians of Canada (RCFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC), as applicable to the profession.
- Specialty listings will also be granted based on completion of one of the following recognized fellowship programs: ACGME, AOA, RCFPC, or the RCPSC, as applicable to the profession.
- A valid license in the state where MVP patients are seen.
- A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate for physicians (MD, DO), Naturopath (ND), Podiatrists (DPM), Oral Surgeon, Nurse Practitioner (NP-NY only), Independent Advanced Practice Registered Nurse (APRN-VT only) and Certified Nurse Midwife (CNM) applicants for all states in which they treat MVP patients. Practitioners with these degree/certification types who maintain they do not require a DEA or CDS as they do not prescribe medications must submit a description of their scope of practice to be considered for an exception to this requirement.
- Provide a minimum of five years' work history. The practitioner must clarify employment gaps of six months or longer.
- A complete history of professional liability claims, including claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner.
- Proof of current malpractice insurance coverage with minimum coverage amounts of \$1 million per incident and \$3 million annual aggregate.
- Absence of excessive malpractice claims for the area and type of practice as determined by the MVP Credentialing Committee.
- A completed CAQH application containing a signed attestation statement and release that includes:
 - a. A history of loss of license and/or felony convictions.
 - b. History of loss or limitation of privileges or disciplinary activity.
 - c. Reasons for any inability to perform the essential functions of the position, and which could impact the ability to deliver adequate care to MVP members, with or without accommodation.
 - d. Certification that physician/practitioner is free of any physical or mental conditions that could impact his/her ability to deliver adequate care to MVP members.
 - e. Certification of a lack of present illegal drug use.
 - f. Current malpractice insurance coverage.
 - g. The correctness and completeness of the application.

- Reasonable office hours in order to maintain adequate access to care. Primary Care Providers who provide care to MVP Medicaid members must maintain a minimum of 16 hours per week at one location.
- Physicians, Oral Surgeons, Podiatrists, NPs, and Certified Nurse Midwives must maintain clinical privileges in good standing, as appropriate to their specialty, on the medical staff of an MVP-participating hospital designated by the practitioners as the primary admitting facility, or demonstrate proof of coverage for admissions and/or inpatient coverage as outlined in MVP criteria.
- Oral Surgeons must possess a valid and current anesthesia certificate and proof of current Advanced Cardiac Life Support (ACLS) certification.
- Comply with MVP medical record, accessibility and office site standards. MVP will conduct an assessment of all practice sites for all primary care practitioners including NPs credentialed as a PCP, and practitioners providing OB/GYN services, including Certified Nurse Midwives, and potential high volume behavioral health practitioner offices that have not been previously reviewed (and/or other practitioner offices as may be deemed appropriate from time to time).

Note: Board certification is not required of applicants unless it is a prerequisite for state licensure/certification. However, applicants claiming board certification must be certified in accordance with the definition of their particular specialty board. MVP recognizes the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), the Royal College of Family Physicians of Canada (RCFPC) and Royal College of Physicians and Surgeons (RCPSC) boards for physicians and other appropriate boards for Certified Nurse Midwives, Lay Midwives, Diabetes Educators, Registered Dietitians/Nutritionists, Podiatrists, Nurse Practitioners, Registered Nurse First Assistants, and Oral Surgeons.

If the physician practices in an IPA region, then participation with MVP may be contingent upon their admission into the IPA, as per the contractual relationship between MVP and each IPA. The IPA criteria for admission are specific to each IPA, and the admission criteria for each IPA may differ.

These criteria may change periodically. Contact your Professional Relations representative for the most current criteria.

Notification Time Frames for New Applicants

MVP will comply with the state regulatory notification time frames in processing applications for participation as specified by the state in which the practitioner is located.

State of New York

- MVP shall complete review of the health care professional's application to participate in the in-network portion of MVP's network and shall, within 60 days of receiving a Completed Application* and all required documentation to participate in the MVP's network, notify the health care professional as to:
 - a. Whether s/he is credentialed; or

- b. Whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instance where additional time is required because of a lack of necessary documentation, the 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.

Note: For applicants that are (1) newly licensed health care professionals or (2) a health care professional who has recently relocated to New York from another state and has not previously practiced in New York; and who are joining a participating group in which all members of the group currently participate with MVP, the applicant shall be eligible for provisional credentialing as of the 61st day of the application if:

- The applicant has submitted a Completed Application and any requested supporting documentation; and
- The applicant provided written notification to the MVP Director of Credentialing, including a statement that in the event the applicant is denied, the applicant or the applicant's group practice:
 - a. Shall refund any payments made for in network services provided during the period of provisional credentialing that exceed out-of-network benefits under the insured's contract with MVP; and
 - b. Shall not pursue reimbursement from the insured, except to collect the copayment or coinsurance that otherwise would have been payable had the insured received services from a participating MVP practitioner.

Completed Application* for Credential and Recredential includes: a complete and accurate CAQH application, re-attested to within the last 90 days, including all supporting documentation including, but not limited to malpractice insurance certificate, continuity of care arrangements that meet MVP criteria for specialty, explanation of any affirmative responses including malpractice suits, an explanation of any work history gaps of over six months, a re-entry plan for all gaps over one year, and MVP's receipt of all verifications from third party sources. The practitioner is obliged to provide MVP with information sufficiently detailed to render an opinion regarding any affirmative response.

State of Vermont

- An insurer or a hospital shall notify a practitioner concerning a deficiency on a credentialing application form submitted by the practitioner no later than 30 business days after the insurer or hospital receives the completed credentialing application form.
- An insurer or hospital shall notify a practitioner concerning the status of the practitioner's completed credentialing application not later than:
 - 60 days after the insurer or hospital receives the completed credentialing application form; and
 - Every 30 days after the notice is provided until the insurer or hospital makes a final credentialing determination concerning the practitioner.

Delegated Credentialing

In the instance where a delegation arrangement exists, MVP may give the delegate the authority to act on its behalf in matters of approval, termination, and appeal. MVP remains accountable for the overall credentialing function. MVP retains the right to approve, suspend, or terminate individual practitioners.

Directory Listing

Prior to being listed in MVP's practitioner directories and/or marketing or member materials, the following must be in place:

- An executed participation agreement with MVP or with an affiliated IPA/PO/PHO or contracted group or facility practice.
- A completed credentialing application has been reviewed and approved by the MVP Credentialing Committee.

Physician applicants who are not ABMS, AOA, RCFPC or RCPSC board-certified or have not completed an accredited training program recognized by MVP will need to supply additional information in support of their request for a specialty listing. MVP only lists the ABMS/AOA specialties and the ABMS/AOA sub-certificates of the specialties in physician specialty listings. MVP may recognize other specialties if mandated to do so by state and/or federal regulations.

Confidentiality of Practitioner Information

MVP complies with all applicable state and federal laws regarding the confidentiality of practitioner data and information. Steps taken to safeguard practitioner information include, but are not limited to, maintenance of files in locked cabinets, password protected databases, limiting access to data to appropriate personnel and confidentiality/conflict of interest statements are signed by MVP personnel and Credentials Committee members annually.

Right of Practitioners to be Informed of Application Status

Applicants have the right to be informed of the status of their credentialing or recredentialing application. MVP, upon direct verbal or written request from the applicant, will notify the applicant of their application's status.

Right of Practitioners to Review Information

Applicants have the right to review the information obtained from any outside primary source that is presented to the Credentials Committee in support of their credentialing and/or recredentialing application. Upon written request, MVP will make its credentialing and recredentialing criteria available to all applicants. Release of information obtained from a third party will be subject to the consent of the third party. Recommendations, letters of reference and other peer review protected information are not subject to this disclosure. MVP also acknowledges that information obtained from the National Practitioner Data Bank or other outside entity that is not allowed to be released will not be released to the practitioner.

Right to Correct Erroneous Information Submitted by Another Party

MVP will notify the applicant of any information obtained during the credentialing and/or

recredentialing process that varies substantially from the information given to MVP by the practitioner. The applicant will have 7 calendar days from notification to clarify and/or correct such discrepancies.

Change in Information

MVP requires applicants and participating practitioners to immediately notify the health plan in writing of any change in information relative to their application. This information includes, but is not limited to, demographic changes to their practice, malpractice coverage, new malpractice actions or updated information on a previously pending action, as well as any adverse actions taken by state or federal agencies, hospitals or other health plans.

MVP Credentialing Committee

The MVP Credentialing Committee, which reports to the MVP Quality Improvement Committee, reviews applicants' credentials for affiliation or continued affiliation with MVP. The Committee considers the recommendations of the IPA credentials/membership committees in the process of credentialing and recredentialing, as applicable.

Non-compliance with Recredentialing

Failure to meet the recredentialing criteria or non-compliance with the recredentialing process will result in termination of participation. Non-compliance is defined as not responding to or returning requests for the recredentialing application (a CAQH application which has been re-attested to within the past 90 days and to which MVP has been authorized access) and all supplemental information within 14 calendar days from the date of request.

Non-compliance Policy

MVP monitors practitioner compliance with company policies and procedures. The following categories represent potential practitioner non-compliance issues that MVP reviews and investigates:

1. Contractual Violations Issues – violations of MVP direct or PHO/PO/IPA contracts
 - a. Accessibility-of-care issues involving MVP members.
 - b. Balance billing of members by MVP physicians/practitioners.
2. Utilization Management Issues
 - a. Unauthorized non-emergent surgical procedures and procedures pre-authorized in less than the five-business-day time frame.
 - b. Unauthorized out-of-plan referrals.
 - c. Failure to obtain prior authorization for services when required by MVP policy.
 - d. Refusal to cooperate with the UM/QI process. (e.g., refusal to speak with the MVP medical director or UM/QI staff.)
3. Verbal abuse of MVP employees.

Performance Monitoring

To ensure that all practitioners continue to meet MVP guidelines, MVP tracks performance through each practitioner's three-year recredentialing cycle. Information related to individual and organizations' provider performance is collected by the Quality Improvement (QI) Department and includes site visit scores, QI investigations, member complaints and issues related to non-compliance with MVP policies, as well as various quality metrics as determined by the QI Department. In addition, quality reports will be generated for groups in the high volume specialties of OB/GYN, Cardiology and Gastroenterology. The data are reported to the Credentials Committee at the time a practitioner is due for recredentialing and are used by the Committee in its decision-making process. In some cases, the QI Department will perform immediate intervention, including but not limited to a request for a corrective action plan or early review by the Credentials Committee. As an example, any two complaints regarding record keeping practices or office conditions will trigger a site assessment, regardless of specialty. Any practitioner who receives five or more complaints of any type, and from any source, within a three year period will be subject to review by the Credentials Committee. In addition to the data gathered for the review of individual practitioners, the data collected by the QI Department is presented to the Credential Committee in a semi-annual aggregate report. Further details regarding the quality metrics used in performance monitoring quality can be found in Section 10, Quality Improvement.

Ongoing Monitoring

Ongoing monitoring is the monitoring of practitioners and organizational providers between recredentialing cycles and the assessment of adverse events pertaining to performance. This activity includes, but is not limited to, the monitoring of state license sanctions, Medicare and/or Medicaid sanctions, Medicare Opt Out reports, adverse events including a determination of fraud and/or other criminal charges/convictions.

Notification of Credentialing Committee Decision

After a practitioner has been reviewed and approved for participation by the Credentialing Committee, MVP will:

- Assign a provider number.
- Notify the applicant of the approval decision, within 60 calendar days of the approval date through a "welcome letter".
- Add the applicant's name to the MVP provider directory at the next publishing date.
- Provide the physician/practitioner and office staff orientation to MVP procedures, as appropriate.

Upon a physician/practitioner's recredentialing approval, the administrative staff will continue to list the physician/practitioner in the provider directory as recommended by the Committee and as per the MVP directory listing policy. Upon denial of a new applicant, the MVP administrative staff will:

- Notify the applicant in writing within 60 calendar days of the denial decision by the MVP Chief Medical Officer or his/her designee. The IPA also will be notified in writing, if applicable.
- If the applicant is licensed and practicing in Vermont, the physician/practitioner will have appeal rights as outlined in Vermont Rule 10.203(F)(9) and 10.203(I).
- If the physician applicant applied for participation with a Medicare product, the physician will be permitted to request a review of the decision by presenting information and views on the decision.

Upon termination of an affiliated physician/practitioner, the MVP administrative staff will:

- a. Notify the physician/practitioner in writing of the termination decision by the MVP Chief Medical Officer or his/her designee. The IPA will also be notified in writing, if applicable.
- b. Advise physicians/practitioners of any applicable right to a hearing or review.

Termination Process for Participation with MVP Health Plan, Inc.

In the event that the MVP Credentials Committee proposes to terminate a physician's/practitioner's participation or contract with MVP, the physician/practitioner will be notified in writing of the decision. Such notice will state:

- The MVP Credentials Committee's decision.
- The nature of the basis for the Committee's decision. For physicians participating in an MVP Medicare Advantage plan, the reason would include if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by MVP.
- The practitioner's right to request a hearing or review of the decision before a hearing panel appointed by MVP.
- A time limit of 30 calendar days to request a hearing or review and a description of the manner in which a request may be properly made to MVP.

Upon receipt of the notice of proposed termination, the physician/practitioner has 30 calendar days in which to request a hearing before the hearing panel. Failure to request a hearing or review within the 30 calendar day time period will result in termination of a physician's/practitioner's participation or contract with MVP. If a hearing is requested during the 30 calendar day time period, MVP will notify the physician/practitioner of the scheduled hearing date. The hearing must be held within 30 calendar days of receipt of the request. This time limit may be extended by mutual agreement of MVP and the physician/practitioner. If such an extension is agreed to, the physician/practitioner shall sign a waiver evidencing his or her consent to such extension. The hearing panel shall be comprised of at least three persons appointed by MVP, the majority of whom shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel will render a decision and a copy of such decision will be memorialized in writing and mailed to the health care professional in a timely manner. Decisions will include one of the following: reinstatement; provisional reinstatement with conditions set forth by MVP, or termination. The effective date of the termination shall be not less than 30 days after the receipt by the health care professional of the hearing panel's decision. In no event shall termination be effective earlier than 60 days from the health care professional's receipt of the notice of termination.

Summary Suspension/Termination of Participation

MVP may summarily terminate or suspend a physician's/practitioner's participation or contract with MVP on behalf of the Credentials Committee immediately for the reasons defined below

Summary Suspension:

- Cases or actions that may represent imminent harm to patient care.
- A charge of fraud by a competent state or federal legal authority
- Cases where the actions raise the potential for financial or administrative damage to the plan.
- A preliminary disciplinary action or pending investigation by the New York State Office of Professional Medical Conduct, other state licensing board or other governmental agency that impairs the health care professional's ability to practice.
- Physical or behavioral impairment that may impede or limit the practitioner's ability to provide appropriate medical care.

Summary Termination:

- Cases involving actual or imminent harm to patient care.
- Cases involving a determination of fraud by a competent state or federal legal authority.
- A determination of fraud by the MVP Special Investigation Unit.
- A final disciplinary action that has been taken against the Health Care Professional by a state licensing board or other governmental agency that impairs the health care professional's ability to practice.
- Physician's/Practitioner's license in the state where they see MVP members is expired or showing as not registered.

A practitioner does not have the right to appeal a summary suspension/summary termination. Summary suspension/summary termination of a practitioner's participation or contract with MVP shall be effective immediately upon notice to the practitioner. Practitioners contracted for the Medicare Advantage Plan network have the right to appeal a summary suspension or summary termination.

A practitioner's suspension may not extend beyond 13 months. Practitioners with a suspension extending beyond 13 months will be notified of the pending termination and will be offered the appropriate appeal rights, as per state and federal law.

Reasons MVP May Not Terminate

MVP Health Care may not terminate a contract or practitioner participation status, solely because the practitioner has:

- Advocated on behalf of an enrollee or:
- Filed a complaint against MVP Health Care or:
- Appealed any MVP Health Care decision or:
- Provided information or files a report pursuant to Section 4406-c of the Public Health Law of the State of New York or:
- Requested a hearing or review pursuant to Section 4406-d of the Public Health Law of the State of New York or:
- Discussed treatment options with members or;
- Reported, in good faith, to state or federal authorities any act or practice by MVP Health Care that jeopardizes patient health or welfare.

Reporting Requirements

MVP Health Care shall report to state professional disciplinary agencies and/or the federal National Practitioner Data Bank (NPDB) as per applicable state and/or federal laws.

Review Process for Medicare Advantage Physicians

Physicians denied participation that have applied for participation with a Medicare product are permitted to present information and their views on the decision. The physician must request the review within 30 days of receipt of the denial notification letter. **Physicians who participate in the Medicare Advantage Plan network have the right to appeal a summary suspension or summary termination.**

Reapplication for Participation

- Practitioners who are denied participation must wait one year before they may reapply.
- Practitioners whose participation is involuntarily terminated (except for non-compliance with recredentialing) must wait a minimum of three years or as required by regulatory bodies. If terminated due to a license action, the action must be fully resolved before reapplication will be allowed.
- Practitioners who voluntarily resign their participation due to an unwillingness to meet criteria or due to contractual issues will be required to wait one year before they will be allowed to reapply.
- Practitioners who were suspended and/or terminated due to pending criminal charges that were resolved in the practitioner's favor (charges that were dismissed/dropped or the provider was acquitted of all charges) will not be subject to a waiting period for reapplication.

Practitioner Leave of Absence

Health care practitioners shall notify MVP Health Care prior to taking a leave of absence (LOA) that will last over 90 days. The following guidelines apply to practitioners who will be taking a LOA longer than 90 days:

- LOA may be contingent upon IPA approval, if applicable.
- Practitioners must complete the MVP Health Care Leave of Absence form and return it to their Professional Relations Representative at least 30 days prior to the start of their leave except in urgent or emergent circumstances. The Leave of Absence form can be found at <https://www.mvphealthcare.com/providers/forms/>
- The covering practitioner must participate with MVP Health Care.
- The specialty of the covering practitioner must fall within the MVP accepted covering rules.
- The practitioner's membership will be voluntarily suspended at the beginning of the leave.
- Practitioners returning from a LOA of less than 13 months will be reinstated as a participating practitioner if there has been no change to their specialty, spectrum of services provided, physical or mental health, nor any other substantive change in the practitioner's ability to provide care to MVP members.
- Practitioners must provide proof of current malpractice coverage prior to reinstatement.
- Practitioners LOA may not extend beyond 13 months. Practitioners returning from a LOA of over 13 months must reapply for participation via the credentialing process.
- An "indefinite" LOA shall be regarded as a LOA exceeding 13 months.
- When a LOA extends beyond 13 months, the provider will be notified of pending termination and will be offered appropriate appeal rights as per state and federal regulations.

Facility Credentialing Guidelines

To be compliant with NCQA credentialing guidelines and MVP policy, we are required to credential and then recredential our contracted organizational providers every three years. MVP credentials the following organizational providers:

- Adult Day Care programs
- Ambulatory mental health and alcohol/substance abuse treatment facilities
- Bariatric surgery centers*
- Clinical Laboratories
- Federally Qualified Health Centers (FQHC)
- Free-standing ambulatory surgery centers (ASC)
- Free-standing dialysis centers
- Free-standing radiology centers
- Free-standing rehabilitation center (mental rehab and physical rehab only)
- HIV/AIDS Day Care programs
- Home health/infusion agencies/home health agencies providing Personal Care Assistant Services
- Hospice
- Hospitals
- Hyperbaric Medicine Treatment Centers
- Long-term care facilities
- Portable/Mobile X-ray Suppliers
- Psychiatric hospitals
- Residential alcohol/substance abuse treatment facilities
- Skilled nursing facilities (SNF)
- Transplant programs*
- Urgent Care Centers (UCC)
- Ventricular Assisted Device Facilities (LVAD)*

*Indicates Center of Excellence Program

Criteria for Participating with MVP

To participate with MVP the following are required:

Operating Certificates/Licensure/Certification

A current and active operating certificate or licensure in the state where MVP patients are serviced is required, where applicable.

Participation in Medicare (Title XVIII of the Social Security Act) and Medicaid (Title XIX of the Social Security Act)

If contracted for services to Medicare and/or Medicaid members, documentation of participation in those programs is required, where applicable.

General Liability and Professional Malpractice Insurance

Proof of general liability and professional malpractice insurance coverage is required with minimum coverage amounts of \$1 million per incident and \$3 million aggregate.

Malpractice History

MVP will obtain written confirmation from the applicant for the past 10 years of malpractice settlements (three years at time of recredentialing). Applicants with any history of malpractice cases are required to fully document, in writing, the case specifics. As per New York State Public Health Law, hospitals are not required to disclose information regarding malpractice claims.

Application and Attestation

A completed MVP application containing a signed attestation statement is required for initial credentialing and at recredentialing.

Accreditation

Organizational providers must provide proof that they have been reviewed and are accredited by one of the following:

| Entity | Abbreviation | Facility Type |
|--|---------------------|---|
| The Joint Commission | TJC | Hospitals/SNFs /Home Health/FQHCs/SBHCs |
| The American Osteopathic Association Healthcare Facilities Accreditation Program | HFAP | Hospitals/FQHCs/SBHC. |
| Accreditation Association of Ambulatory HealthCare | AAAHC | ASC |
| American College of Radiologists | ACR | Free Standing Radiology Centers |
| Det Norske Veritas Health Care Inc. | DNV | Hospitals/SNFs/FQHCs/SBHCs |
| | | |
| Community Health Accreditation Program | CHAP | Home Health Care and Hospice |
| Clinical Laboratory Certification Amendment certification | CLIA | Lab |

| | | |
|---|---------|---|
| Designation as a Comprehensive Bariatric Surgery Center by the American College of Surgeons and the American Society for Metabolic and Bariatric Surgeons (ASMBS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) | MSBAQIP | Bariatric Surgery Centers |
| Foundation for the Accreditation of Cellular Therapy (FACT) for bone marrow transplants | FACT | Bone Marrow Transplants |
| Accreditation as a Level 1, 2 or 3 Hyperbaric Treatment Center by the Undersea and Hyperbaric Medical Society no later than July 1, 2014 | UHMS | Hyperbaric Treatment Centers |
| Commission on the Accreditation of Rehabilitation Facilities | CARF | Day Treatment Health Centers (Adult and HIV/AIDS) and rehabilitation facilities |
| The Joint Commission | TJC | Ventricular Assisted Devices |

Non-accredited organizational providers will be considered for participation based on network need as defined by MVP. Non-accredited organizational providers must supply MVP with a copy of their CMS or state review and meet the additional requirements. The organizational provider will need to demonstrate satisfactory completion of an on-site quality assessment using MVP developed assessment criteria.

Site Visit

The organizational provider must meet MVP’s facility site standards. The facility reviews focus on patient safety, access and availability, confidentiality, emergency services, credentialing processes, and quality-improvement processes. The corresponding medical record review is tailored to address the specific needs of each of these facility types. For a copy of the criteria for any of these facilities, contact the Credentialing Department at Credentialing@mvphealthcare.com. At MVP’s option, a CMS or state review may be substituted for an MVP-conducted site review. If MVP is using a state review in lieu of an MVP conducted site visit, MVP must verify that the review was completed within the time limits and meets MVP’s site visit standards. In this instance, organizational provider applicants must provide a copy of the CMS or state review report performed within the previous 36 months and a copy of the organization’s QI Plan and Credentialing Process.

Access Standards

The facility must meet MVP Health Plan's Access Standards for Appointment Availability, as applicable. (See QI policies and procedure on Access Standards).

Special Requirements for Home Health Agencies Providing Personal Care Assistant Services to New York State Medicaid Recipients

Home Health Agencies that provide Personal Care Assistant Services are required to attest that the agency has policies, procedures, programs and protocols to demonstrate compliance with NYS Medicaid Standards for the following:

- a. The level of personal care services provided and title of those providing services;
- b. The criteria for selection of persons providing personal care services;
- c. Compliance with the requirements of the Criminal History Record Check Program (NYCRR Part 402);
- d. That training, approved by the NYS DOH, is provided to each person performing personal care services, other than household functions;
- e. The agency assigns appropriate staff to provide personal care services to a member according to MVP's authorization for the level, amount, frequency and duration of services to be provided;
- f. There is administrative and nursing supervision of all persons providing personal care services;
- g. The agency's administrative supervision assures that personal care services are provided according to the MVP's authorization for the level, amount, frequency and duration of services to be provided;
- h. The administrative supervision includes the following activities:
 - i. Receipt of the initial referrals from MVP, including its authorization for the level, amount, frequency and duration of the personal care services to be provided.
 - ii. Notifying MVP when the agency providing services accepts or rejects a patient.
 - iii. When accepted, the arrangements made for providing personal care services
 - iv. When rejected, the reason for such rejection.
- i. The agency promptly notifies the MVP when the agency is unable to maintain case coverage.
- j. The agency provides nursing supervision to assure member's needs are being met.

MVP Credentialing Committee

The MVP Credentials Committee, which reports to the MVP Quality Improvement Committee, reviews the credentials of organizational providers for affiliation or continued affiliation with MVP.

Change in Information

MVP requires organizational credentialing and recredentialing providers to immediately notify the health plan in writing of any change in information relative to their application or any other information that is being verified as part of the credentialing or recredentialing process.

Non-compliance with Recredentialing

Failure to meet the recredentialing criteria or non-compliance with the recredentialing process may result in termination of participation. Non-compliance is defined as not responding to or returning requests for the recredentialing application and all supplemental information within 45 days from the date of request.

Non-compliance Policy

MVP monitors provider compliance with company policies and procedures. The following categories represent potential organizational provider non-compliance issues that MVP reviews and investigates:

- Violations of MVP contracts
- Accessibility of care issues involving MVP members
- Balance billing of members by MVP providers/physicians
- Utilization Management issues
- Verbal abuse of MVP employees

The MVP Credentialing Department tracks occurrences of non-compliance. Non-compliance information is reviewed during the MVP recredentialing process.

Notification of Credentialing Committee Decision

Following a complete review of the organizational provider's credentials application, the MVP Credentialing Committee will approve or deny the organizational provider.

- Upon approval of a new organizational provider applicant, the MVP administrative staff will notify the applicant of the approval decision and assign a provider number.
- Upon denial of a new organizational provider applicant, the MVP administrative staff will notify the applicant in writing of the decision.
- Upon termination of an affiliated organizational provider, the MVP administrative staff will notify the organizational provider in writing of the decision.

Denial or termination of Organizational Providers will not be subject to appeal.