



**Molina Healthcare of California  
Provider/Practitioner Manual**

**Credentialing**

	<b>Pages</b>
<b>Facility Site Review</b>	<b>1-6</b>
<b>Credentialing and Recredentialing</b>	<b>7-28</b>

## **FACILITY SITE REVIEW**

The facility site review (FSR) is a comprehensive evaluation of the facility, administration and medical records to ensure conformance to the California Department of Health Care Services (DHCS) and regulatory agency standards. The review and certification of Primary Care Practitioner (PCP) sites are required for all health plans participating in the Medi-Cal managed care program (Title 22, CCR, Section 56230). The California statute requires that all PCP sites or facilities rendering services to Medi-Cal eligible patients must be certified and compliant with all applicable DHCS standards. Furthermore, facility site reviews are required as part of the credentialing process, according to the provision of Title 22, CCR, Section 53856.

A PCP is defined as a General Practitioner, an Internist, a Family Practitioner, Obstetrician/Gynecologist (OB/GYN) who meets the requirements for PCP, or a Pediatrician who, by contract, agrees to accept responsibility for primary medical care services.

### **Facility Site Review Process**

Effective July 1, 2002 the State of California's Health and Human Services Agency mandated that all County Organized Health Systems (COHS), Geographic Managed Care (GMC) Plans, Primary Care Case Management (PCCM) Plans, and Two-Plan Model Plans use the Full Scope Site Review and Medical Record Review Evaluation Tool. This is found in Medi-Cal Managed Care Division (MMCD) Policy Letter 02-002 and includes, but is not limited to, any relevant superseding policy letters.

In efforts to avoid duplication and overlapping of FSR reviews, the Medi-Cal managed care health plans within the county have established systems and procedures for the coordination and consolidation of site audits for mutually shared PCP sites and facilities. One (1) site review conducted by a participating collaborative Medi-Cal managed care health plan will be accepted by other Medi-Cal managed care health plans. This will establish **ONE** (1) certified FSR and MRR that the participating PCP site will need to pass and be eligible with all the Medi-Cal Health Plans in a given county.

Standardized DHCS Facility Site Review Tool is comprised of three (3) components:

- Attachment A: Facility Site Review Tool
- Attachment B: Medical Record Review Tool
- Attachment C: Physical Accessibility Review Survey

### **Initial Full Scope Review:**

All primary care sites serving Medi-Cal managed care members must undergo an initial site review with attainment of a minimum passing score of 80% on the site review and medical record review. The initial site review is the first onsite inspection of a site that has not previously had a full scope survey, or a PCP site that is returning to the Medi-Cal managed care program and has not had a full scope survey within the past three (3) years with a passing score. The initial full scope site review survey can be waived by a managed care health plan for a pre-

contracted physician site if the physician has a documented proof of current full scope survey, conducted by another Medi-Cal managed care health plan within the past three (3) years. Molina Healthcare follows the same procedures as for an initial site visit when a PCP relocates or opens a new site.

### **Subsequent Periodic Full Scope Site Review:**

After the initial full scope survey, the maximum time period before conducting the subsequent full scope site survey is three (3) years. Managed care health plans may review sites more frequently per local collaborative decision or when determined necessary, based on monitoring, evaluation or corrective actions plan (CAP) follow-up issues.

### **Medical Record Review:**

The on-site practitioner/provider medical record review is a comprehensive evaluation of the medical records. Molina will provide information, suggestions and recommendations to assist practitioners/providers in achieving the standards. All PCPs must complete and pass the medical record review at each practice location. Medical Record Reviews are conducted in conjunction with the Facility Site Review, prior to participating in Molina provider network and at least every three (3) years thereafter. Ten (10) medical records are reviewed for each physician. Sites where documentation of patient care by multiple PCPs occurs in the same medical record will be reviewed as a “shared” medical record system. Shared medical records are those that are not identifiable as “separate” records belonging to any specific PCP. A minimum of ten (10) records will be reviewed if two (2) to three (3) PCPs share records, twenty (20) records will be reviewed for four (4) to six (6) PCPs, and thirty (30) records will be reviewed for seven (7) or more PCPs.

### **Physical Accessibility Review Survey (PARS):**

In accordance to the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD) policy letter 11-013, managed care health plans are required to assess the level of physical accessibility of provider sites, including all primary care physicians, specialists and ancillary providers that serve a high volume of Seniors and Persons with Disabilities (SPD). The PARS tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). PARS consists of 86 criteria, which include 29 designated critical access elements. Based on the outcome of the PARS review, each site is designated as having either Basic Access or Limited Access, along with the six specific accessibility indicator designations for parking, exterior building, interior building, restrooms, examination rooms, and medical equipment. Unlike the Facility Site Review and Medical Records Review, **PARS is a survey and no corrective action is required.**

## Scoring

All Primary Care Physicians must maintain an Exempted or Conditional pass on site review and medical record review to participate in Molina provider network. The evaluation scores are based on standardized scoring mechanism established by DHCS.

## Compliance & Corrective Action Plan (CAP)

- **Facility Site Review Score Threshold**

Exempted: A performance score of 90% or above without deficiencies in Critical Elements, Pharmaceutical or Infection Control sections of the review tool. A Corrective Action Plan is not required.

Conditional: A performance score of 80% - 90% or 90% and above with deficiencies in Critical Elements, Pharmaceutical or Infection Control sections of the review tool. A Corrective Action Plan is required.

Not Pass: Below 80% performance score.

- **Medical Record Review Score Threshold**

Exempted: A performance score of 90% to 100%. Any section score of less than 80% will require a Corrective Action Plan for the entire medical records reviewed, regardless of the total score.

Conditional: A performance score of 80% to 89%. A Corrective Action Plan is required.

Not Pass: Below 80% performance score

## Physicians with an Exempted Pass Score

- All reviewed sites that score 90% to 100% on the facility site review survey without deficiencies in Critical Elements, Pharmaceutical or Infection Control sections of the review tool do not need to submit a CAP.
- All reviewed sites that score 90% to 100% and greater than 80% on each section scores of the medical record review survey do not need to submit a CAP. Any section score of less than 80% in the medical record review survey requires submission of completed CAP, regardless of the aggregated MRR score.

## Physicians with a Conditional Pass Score

- A score of 80% to 89% or 90% and above with deficiencies in Critical Element, Pharmaceutical or Infection Control sections of the review tool must complete and submit a CAP.
  - A. *Critical Element CAP must be completed and submitted within ten (10) business days from the date of the review*
  - B. CAP must be completed and submitted within forty-five (45) calendar days from the date of the review.

- A score of 80% to 89% of the medical record review survey must complete and submit a CAP. The CAP must be submitted within forty-five (45) calendar days from the date of the review.

### **Physicians with a Not Pass Score**

- A score of 79% or below will not have new members assigned until appropriate and necessary CAP is completed and all deficiencies are corrected and verified. The CAP must be completed, submitted timely, fully accepted, and verified or a follow-up visit must be conducted for a focused review with a passing score.
- In compliance to the Department of Health Care Services, Medi-Cal Managed Care Division Policy Letter 02-02, physicians and sites with Not Pass scores must be notified to all Medi-Cal Managed Care Health Plans in the county.

### **CAP Timeline Extension**

- No timeline extensions are allowed for Critical Element CAP completion.
- A physician may request a definitive, time-specific extension period that does not exceed ninety (90) calendar days from the date of the review. The request shall be submitted through a formal written explanation of the reason(s) for the extension and submitting the completed portions of the CAP within the forty-five (45) calendar day timeframe.
- No extension beyond ninety (90) calendar days from the date of the review can be granted by the health plan. Any extension beyond ninety (90) calendar days requires an approval from the Department of Health Care Services.

**NOTE: AN EXTENSION FOR CAP COMPLETION BEYOND NINETY (90) DAYS REQUIRES THAT THE SITE VISIT BE RESURVEYED WITHIN TWELVE (12) MONTHS OF THE INITIAL SURVEY.**

### **CAP Completion**

Physicians or their designees can complete the CAP:

- Review and correct the identified deficiencies in Column Two (2) and Column Three (3) of the CAP form.
- Review and implement the recommended corrective actions in Column Four (4) of the CAP form and provide appropriate attachments or documents that address the deficiencies.
- Enter the date of completion or implementation of the corrective action in Column Five (5) of the CAP form.
- Document specific comments on implemented activities to address and satisfy the corrective action(s) and document a responsible designee's initials in Column Six (6) of the CAP form.
- Document the signature and the title of the physician or the designee who is responsible for completing the CAP in Column Seven (7) of the CAP form.

- Upon implementation, completion and documentation of the entire corrective action items identified on the CAP form, submit the completed CAP form.

### **CAP Submission**

- The physician, at his/her discretion, may involve any or all IPAs/Medical Groups or management companies with which the physician is contracted to assist in completion of the CAP.
- The CAP must be submitted directly to the Site Reviewer of the health plan.

### **Identification of Deficiencies Subsequent to an Initial Site Visit**

- Any Molina Healthcare Director or Manager shall refer concerns regarding member safety and/or quality of care issues to appropriate Department(s) for necessary follow-up activities.
- Member complaints related to physical office site(s) are referred to appropriate Molina Department(s) for subsequent investigation that may include performing an unannounced onsite facility review and follow-up of any identified corrective actions.

### **Department of Health Care Services (DHCS) Review of Molina Healthcare's Performance of Facility Site Reviews**

Review Process: An oversight audit of Molina Healthcare and contracted physicians and facilities will be conducted by the DHCS.

- These visits may be conducted with or without prior notification from the DHCS.
- If a prior notification is given, the sites selected by the DHCS for oversight reviews will be contacted to arrange a visit schedule by either the DHCS auditor or Molina Healthcare.
- Molina Healthcare will provide any necessary assistance required by the DHCS in conducting facility oversight evaluations.

### **REQUIREMENTS & GUIDELINES FOR FACILITY SITE**

Complete and comprehensive requirements, standards, and guidelines are found in *Facility Site Review Tool* and *Facility Site Review Guideline*. Please visit Molina web site at [www.molinahealthcare.com](http://www.molinahealthcare.com) to review these documents.

### **REQUIREMENTS & GUIDELINES FOR MEDICAL RECORD DOCUMENTATION (APPLIES TO BOTH ADULTS AND CHILDREN)**

Complete and comprehensive requirements, standards, and guidelines are found in *Medical Record Review Tool* and *Medical Record Review Guideline*. Please visit Molina web site at [www.molinahealthcare.com](http://www.molinahealthcare.com) to review these documents.

### **Information Available to Providers on Molina Web site**

In efforts to assist our providers, there are many resources and topics that are relevant to Facility Site Review and Medical Records Review processes and guidelines. Please visit Molina web site to access these materials and information:

- Facility Site Review Tool and Guidelines
- Medical Record Review Tool and Guidelines
- Interim Review of Critical Elements at 18 months
- FSR Attachment C: Physical Accessibility Review Survey (PARS)
- Frequently used facility forms and log sheets
- Frequently used Medical Record forms and documentations
- Preventive Health Guidelines
- Staying Healthy Assessment forms
- Clinical Practice Guidelines

# Credentialing and Recredentialing

The purpose of the Credentialing Program is to strive to assure that the Molina Healthcare network consists of quality practitioners/providers who meet clearly defined criteria and standards. It is the objective of Molina Healthcare to provide superior health care to the community.

The decision to accept or deny a credentialing applicant is based upon primary and secondary source verifications, recommendation of peer practitioners/providers and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and federal requirements and accreditation guidelines. In accordance with those standards, Molina Healthcare Members will not be referred and/or assigned to you until the credentialing process has been completed.

## **A. Criteria for Participation in the Molina Network**

Molina has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the Molina network. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Molina network.

Molina reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. To remain eligible for participation practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Molina.

Practitioners should adhere strictly to the ethics of the profession, have demonstrated a temperament and ability to work cooperatively with others free of evidence of a disruptive personality, and be willing to participate in the provision of cost effective and quality services in the managed care environment, including but not limited to the discharge of Molina responsibilities.

Practitioners must meet the following criteria to be eligible to participate in the Molina network. If the practitioner fails to provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

1. Practitioner must practice, or plan to practice within 90 calendar days, within the area served by Molina.
2. Practitioner must have a current, valid license to practice in their specialty in every state in which they will provide care for Molina members.
3. Practitioner must have current professional malpractice liability coverage with limits that meet Molina criteria specifically outlined in Addendum B of this policy.
4. If applicable to the specialty, practitioner must have a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and Controlled Substance Certification or Registration.



5. Dentists, Oral Surgeons, Physicians (MDs, DOs) and Podiatrists will only be credentialed in an area of practice in which they have adequate training as outlined below. Therefore, they must confine their practice to their credentialed area of practice when providing service to Molina members. Adequate training must be demonstrated by one of the following:
6. Current Board Certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association in the credentialed area of practice, the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedic and Primary Medicine (ABOPM), or the American Board of Oral and Maxillofacial Surgery
7. Successful completion of a residency or fellowship program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians in Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).
8. Practitioners who are not Board Certified as described in section 5a above and have not completed an accredited Residency program are only eligible to be considered for participation as a General Practitioner in the Molina network. To be eligible as a General Practitioner, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.
9. At the time of initial application, the practitioner must not have any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body.<sup>1</sup>
10. Practitioner must not be currently excluded, expelled or suspended from any state or federally funded program including but not limited to the Medicare or Medicaid programs.
11. Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including but not limited to healthcare fraud, patient abuse and the unlawful manufacture distribution or dispensing of a controlled substance.
12. Practitioners not able to practice independently according to state law (e.g. NP's, Midwives, PA-C's) must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with Molina.
13. Physicians, Primary Care Practitioners, Midwives, Oral Surgeons and Podiatrists must have admitting privileges in their specialty with Molina contracted hospitals or have a plan for hospital admission by using a Hospital Inpatient Team or having an arrangement with a credentialed Molina participating practitioner that has the ability to admit Molina patients to a Molina contracted hospital. Practitioners practicing exclusively on a consultative basis are not required to have admitting hospital privileges.
14. Licensed midwives who perform deliveries outside of an acute care hospital must have a formal arrangement in place with an OB/Gyn contracted and credentialed with Molina Healthcare. This arrangement must include 24-hour coverage and inpatient care for Molina members in the event of emergent situations. Family Practitioners providing

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<sup>1</sup> If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

obstetric care may provide the back-up in rural areas that do not have an OB/Gyn. This back-up physician must be located within 30 minutes from the midwives practice.

15. If applicable to the specialty, practitioner must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day.
16. Molina may determine, in its sole discretion, that a practitioner is not eligible to apply for network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina, who is currently in the Fair Hearing Process, or who is under investigation by Molina. Molina also may determine, in its sole discretion that a practitioner cannot continue network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by Molina. For purposes of this criteria, a company is "owned" by a practitioner when the practitioner has a majority financial interest in the company, through shares or other means.
17. Practitioner's denied or terminated by the Credentialing Committee are not eligible to reapply until one year after the date of denial or termination by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation as outlined above.

## **B. Burden of Proof**

The practitioner shall have the burden of producing adequate information to prove he/she meets all criteria for initial participation and continued participation in the Molina network. This includes but is not limited to proper evaluation of their experience, background, training, demonstrated ability and ability to perform as a practitioner without limitation, including physical and mental health status as allowed by law, and the burden of resolving any doubts about these or any other qualifications to participate in the Molina network. If the practitioner fails to provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

## **C. Practitioner termination and reinstatement**

If a practitioner's contract is terminated and later it is determined to reinstate the practitioner, the practitioner must be initially credentialed prior to reinstatement if there is a break in service more than 30 calendar days. The credentialing factors that are no longer within the credentialing time limits and those that will not be effective at the time of the Credentialing Committee's review must be re-verified. The Credentialing Committee or medical director, as appropriate, must review all credentials and make a final determination prior to the practitioner's reentry into the network.

If a practitioner is given administrative termination for reasons beyond Molina's control (e.g., the practitioner failed to provide complete credentialing information), and is then reinstated within 30 calendar days, Molina may recredential the practitioner as long as there is clear documentation that the practitioner was terminated for reasons beyond Molina's control and was recredentialled

and reinstated within 30 calendar days of termination. Molina must initially credential the practitioner if reinstatement is more than 30 calendar days after termination.

If Molina is unable to recredential a practitioner within 36-months because the practitioner is on active military assignment, maternity leave or sabbatical; but the contract between Molina and the practitioner remains in place, Molina will recredential the practitioner upon his or her return. Molina will document the reason for the delay in the practitioner's file. At a minimum, Molina will verify that a practitioner who returns has a valid license to practice before he or she can resume seeing patients. Within 60 calendar days of notice when the practitioner resumes practice, Molina will complete the recredentialing cycle. If either party terminates the contract and there is a break in service of more than 30 calendar days, Molina will initially credential the practitioner before the practitioner rejoins the network.

#### **D. Practitioners terminating with a delegate and contracting with Molina directly**

Practitioners credentialed by a delegate who terminate their contract with the delegate and want to contract with Molina directly must be credentialed by Molina within six-months of the practitioner's termination with the delegate. If the practitioner has a break in service more than 30 calendar days, the practitioner must be initially credentialed prior to reinstatement.

#### **E. Credentialing Application**

At the time of initial credentialing and recredentialing, the practitioner must complete a credentialing application designed to provide Molina with information necessary to perform a comprehensive review of the practitioner's credentials. The application must be completed in its entirety. The practitioner must attest that their application is complete and correct within 180 calendar days of the credentialing decision. The application must be completed in typewritten text, in pen or electronically through applications such as the Counsel for Affordable Quality Healthcare (CAQH) Universal Credentialing Data Source. Pencils or erasable ink will not be an acceptable writing instrument for completing credentialing applications. Molina may use another organization's application as long as it meets all the factors outlined in this policy. Molina will accept faxed, digital, electronic, scanned or photocopied signatures. A signature stamp is not acceptable on the attestation. The attestation must include:

- Reason for any inability to perform the essential functions of the position, with or without accommodation
- Lack of present illegal drug use
- History of loss of license and felony convictions
- History of loss or limitation of privileges or disciplinary action
- Current malpractice insurance coverage and
- The correctness and completeness of the application

#### **Inability to perform essential functions and illegal drug use**

An inquiry regarding illegal drug use and inability to perform essential functions may vary. Practitioners may use language other than "drug" to attest they are not presently using illegal substances. Molina may accept more general or extensive language to query practitioners about impairments; language does not have to refer exclusively to the present, or only to illegal substances.

### History of actions against applicant

An application must contain the following information.

- History of loss of license
- History of felony convictions
- History of all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which a practitioner has had privileges

### Current malpractice coverage

The application form must include specific questions regarding the dates and amount of a practitioner's current malpractice insurance. Molina may obtain a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application.

For practitioners with federal tort coverage, the application need not contain the current amount of malpractice insurance coverage. Practitioner files that include a copy of the federal tort letter or an attestation from the practitioner of federal tort coverage are acceptable.

### Correctness and completeness of the application

Practitioners must attest that their application is complete and correct when they apply for credentialing and recredentialing. If a copy of an application from an entity external to Molina is used, it must include an attestation to the correctness and completeness of the application. Molina does not consider the associated attestation elements as present if the practitioner did not attest to the application within the required time frame of 180 days. If state regulations require Molina to use a credentialing application that does not contain an attestation, Molina must attach an addendum to the application for attestation.

### Meeting Application time limits

If the practitioner attestation exceeds 180 days before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete, but does not need to complete another application. It is preferred to send a copy of the completed application with the new attestation form when requesting the practitioner to update the attestation.

## **F. The Process for Making Credentialing Decisions**

All practitioners requesting initial participation with Molina must complete a credentialing application. To be eligible to submit an application, practitioners must meet all the criteria outlined above in the section titled "Criteria for Participation in the Molina Network". Practitioners may not provide care to Molina members until the final decision is rendered by the Credentialing Committee or the Molina Medical Director.

Molina recredentials its practitioners at least every thirty-six (36) months. Approximately six months prior to the recredentialing due date, a request will be sent to the practitioner requesting completion of a recredentialing application.

During the initial and recredentialing application process, the practitioner must:

- Submit a completed application within the requested timeframe
- Attest to the application within the last 180 calendar days

- Provide Molina adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina network.

Once the application is received, Molina will complete all the verifications as outlined in the attached Practitioner Criteria and Primary Source Verification Table. In order for the application to be deemed complete, the practitioner must produce adequate information to prove he/she meets all criteria for initial participation or continued participation in the Molina network. All fields within the application must be completed, all required attachments must be included, detailed explanations must be provided to all affirmative answers on the attestation questions and any additional information requested by Molina must be provided.

If the practitioner does not provide the information necessary to complete the application process in the time period requested, the application will be deemed incomplete and Molina will discontinue processing of the application. This will result in an administrative denial or termination from the Molina network. Practitioners who fail to provide proof of meeting criteria or fail to provide a complete credentialing application do not have the right to submit an appeal.

At the completion of the application and primary source verification process, each credentialing file is quality reviewed to ensure completeness. During this quality review process each credentialing file is assigned a level based on established guidelines. Credentialing files assigned a level 1 are considered clean credentialing files and the Medical Director(s) responsible for credentialing has the authority to review and approve them. Credentialing files assigned a level 2 are reviewed by the Molina Credentialing Committee.

At each Credentialing Committee meeting, practitioner credentials files assigned a Level 2 are reviewed by the Credentialing Committee. All of the issues are presented to all the Credentialing Committee members and then open discussion of the issues commences. After the discussion, the Credentialing Committee votes for a final decision. The Credentialing Committee can approve, deny, terminate, approve on watch status, place on corrective action or defer their decision pending additional information.

## **G. Process for Delegating Credentialing and Recredentialing**

Molina will delegate credentialing and recredentialing activities to Independent Practice Associations (IPA) and Provider Groups that meet Molina's requirements for delegation. Molina's Delegation Oversight Committee (DOC) must approve all delegation and subdelegation arrangements, and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet Molina's requirements. Molina's Credentialing Committee retains the right to approve new providers and provider sites and terminate practitioners, providers and sites of care based on requirements in Molina Credentialing Policy.

To be delegated for credentialing, IPAs and Provider Groups must:

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass Molina's credentialing delegation pre-assessment, which is based on NCQA credentialing standards and requirements for the Medicaid and Medicare programs, with a score of at least 90%.

- Correct deficiencies within mutually agreed upon time frames when issues of non-compliance are identified by Molina at pre-assessment
- Agree to Molina's contract terms and conditions for credentialing delegates
- Submit timely and complete reports to Molina as described in policy and procedure
- Comply with all applicable federal and state laws
- If the IPA or Provider Group subdelegates primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all ten areas of accreditation.

## **H. Non-Discriminatory Credentialing and Recredentialing**

Molina does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g. abortions) or patients (e.g. Medicaid or Medicare) in which the practitioner specializes. This does not preclude Molina from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.

## **I. Notification of Discrepancies in Credentialing Information**

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license, malpractice claims history or board certification decisions. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law. Please also refer to the section below titled Practitioners Right to Correct Erroneous Information.

## **J. Notification of Credentialing Decisions**

A letter is sent to every practitioner with notification of the Credentialing Committee or Medical Director decision regarding their participation in the Molina network. This notification is sent within two weeks of the decision. Copies of the letters are filed in the practitioner's credentials files. Under no circumstance will notifications letters be sent to the practitioners later than 60 calendar days from the decision.

## **K. Confidentiality**

All practitioner information obtained during the credentialing process is private and confidential except where otherwise specified by law or at the discretion of the Credentialing Committee or the Molina Board. This policy includes both voting and non-voting members of the Credentialing Committee, invited guests of the Credentialing Committee and Molina Credentialing staff who is involved in the data collection and file preparation for the credentialing and recredentialing process.

Information, documents and/or evidence created, collected, maintained or otherwise arising out of matters that are under review, or have been reviewed pursuant to these policies, will be kept

confidential by all participants except as required by law or at the discretion of the Credentialing Committee or the Molina Board, in order to encourage candor and careful assessment necessary to effect peer review and quality assurance.

All members (voting and non-voting) and guests of the Credentialing Committee, or any other committee performing any peer review functions or other individuals who participate in peer review functions will sign a Statement of Confidentiality annually. Members and guests of the Credentialing Committee will not discuss, share or use any information for any purpose other than peer review at Molina.

The Director in charge of Credentialing grants access to electronic credentials files only as necessary to complete credentialing work or as required by law. Access to these documents are restricted to authorized staff, Credentialing Committee members, peer reviewers and reporting bodies as authorized by the Credentialing Committee or the Governing Board of Molina. Each person is given a unique user ID and password. It is the strict policy of Molina that employees keep their passwords confidential and never share their passwords with anyone. All Credentialing employees are prompted to change their passwords into the system every three-months.

Minutes, reports and files of Credentialing Committee meetings are stored in secure electronic folders or in locked cabinets in the Credentialing Department and will be protected from discovery under all applicable laws.

Copies of minutes and any other related Credentialing Committee meeting materials will not be allowed to be removed from meetings of peer review committees and Credentialing staff will shred extra sets of information from such meetings. Electronic data and/or information are password protected and Molina Staff is instructed not to divulge passwords to their co-workers.

#### **L. Practitioners Rights to Review their Credentialing File**

Practitioners have the right to review their credentials file at any time. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

The practitioner must notify the Credentialing Department and request an appointed time to review their file and allow up to seven calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the practitioner are documents which the practitioner sent to Molina (e.g., the application, the license and a copy of the DEA certificate). Practitioners may not copy documents that include pieces of information that are confidential in nature, such as the practitioner credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, State Licensing Board), and verification of hospital privileges letters.

#### **M. Practitioners Right to Correct Erroneous Information**

Practitioners have the right to correct erroneous information in their credentials file. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

Molina will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner. Examples include but are not limited to actions on a license or malpractice claims history. Molina is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

The notification sent to the practitioner will detail the information in question and will include instructions to the practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from Molina.
- In their response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The practitioner's response must be sent to Molina Healthcare, Inc. Attention Kari Horseman, CPCS, Credentialing Director at PO Box 2470 Spokane WA 99210

Upon receipt of notification from the practitioner, Molina will document receipt of the information in the practitioners credentials file. Molina will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioners credentials file. The practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with practitioners' notification, the Credentialing Department will notify the practitioner. The practitioner may then provide proof of correction by the primary source body to Molina's Credentialing Department. The Credentialing Department will re-verify primary source information if such documentation is provided.

If the practitioner does not respond within 10 calendar days, their application processing will be discontinued and network participation will be denied.

#### **N. Practitioners Right to be Informed of Application Status**

Practitioners have a right, upon request, to be informed of the status of their application. Practitioners applying for initial participation are sent a letter when their application is received by Molina and are notified of their right to be informed of the status of their application in this letter.

The practitioner can request to be informed of the status of their application by telephone, email or mail. Molina will respond to the request within two working days. Molina may share with the practitioner where the application is in the credentialing process to include any missing information or information not yet verified. Molina does not share with or allow a practitioner to review references or recommendations, or other information that is peer-review protected.



## **O. Credentialing Committee**

Molina designates a Credentialing Committee to make recommendations regarding credentialing decisions using a peer review process. Molina works with the Credentialing Committee to strive to assure that network practitioners are competent and qualified to provide continuous quality care to Molina members. A practitioner may not provide care to Molina members until the final decision from the Credentialing Committee or in situations of “clean files” the final decision from the Molina Medical Director.

The Credentialing Committee is responsible for reviewing and evaluating the qualifications of applicant practitioners and for approving or denying applicants for participation. In addition, the Credentialing Committee reviews Credentialing Policies and Procedures annually and recommends revisions, additions and/or deletions to the policies and procedures. Composed of network practitioners, the committee is responsible for performing peer review of medical information when requested by the Medical Director, and recommending actions based on peer review findings, if needed. The committees report to the Quality Improvement Committee (QIC).

Each Credentialing Committee member shall be immune, to the fullest extent provided by law, from liability to an applicant or practitioner for damages or other relief for any action taken or statements or recommendations made within the scope of the committee duties exercised.

### **Committee Composition**

The Medical Director chairs the Credentialing Committee and appoints all Credentialing Committee members. Each member is required to meet all of Molina's credentialing criteria. Credentialing Committee members must be current representatives of Molina's practitioner network. The Credentialing Committee representation includes at least five practitioners, one practitioner from each of the following specialties:

- Family Practice or Internal Medicine or General Practice
- Pediatrics
- OB/GYN
- Specialist

Additionally, surgical specialists and Internal Medicine specialists may participate on the committee as appropriate. Other ad hoc practitioners may be invited to participate when representation of their discipline is needed. Ad hoc committees representing a specific profession (e.g., Behavioral Health Practitioner, Nurse Practitioners, Chiropractors) may be appointed by the chairs to screen applicants from their respective profession and make credentialing recommendations to the Credentialing Committee.

### **Committee Members Roles and Responsibilities**

- Committee members participate in and support the functions of the Credentialing Committee by attending meetings, providing input and feedback and overall guidance of the Credentialing Program.

- Review/approve credentialing program policy and related policies established by Molina on an annual basis, or more often as deemed necessary.
- Review and consider each applicant's information based on criteria and compliance requirements. The Credentialing Committee votes to make final decisions regarding credentialing determinations and disciplinary actions.
- Conduct ongoing monitoring of those practitioners approved to be monitored on a "watch status"
- Access clinical peer input when discussing standards of care for a particular type of practitioner when there is no committee member of that specialty.
- Ensure credentialing activities are conducted in accordance with Molina's Credentialing Program.
- Review quality improvement findings as part of the recredentialing and the ongoing monitoring process.

**P. Excluded Practitioners**

Excluded practitioner means an individual practitioner, or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been: convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Molina Healthcare and its subcontractors may not subcontract with an Excluded Practitioner/Person. Molina Healthcare and its subcontractors shall terminate subcontracts immediately when Molina Healthcare and its subcontractors become aware of such excluded practitioner/person or when Molina Healthcare and its subcontractors receive notice. Molina Healthcare and its subcontractors certify that neither it nor its member/practitioner is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Molina Healthcare and its subcontractors are unable to certify any of the statements in this certification, Molina Healthcare and its subcontractors shall attach a written explanation to this Agreement.

**Q. Practitioners/Providers opting out of Medicare**

If a practitioner/provider opts out of Medicare, that practitioner/provider may not accept Federal reimbursement for a period of two (2) years. Practitioners/Providers who are currently opted out of Medicare are not eligible to contract with Molina Healthcare for the Medicare line of business.

**R. Ongoing Monitoring of Sanctions**

Molina monitors practitioner sanctions between recredentialing cycles for all practitioner types and takes appropriate action against practitioners when occurrences of poor quality is identified.

### Medicare and Medicaid sanctions

The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program releases a report every month of individuals and entities that have been excluded from Medicare and Medicaid programs. Within 30 calendar days of its release, Molina reviews the report and if a Molina network provider is found with a sanction, the practitioner's contract is terminated effective the same date the sanction was implemented.

### Sanctions or limitations on licensure

Molina monitors for sanctions or limitations against licensure between credentialing cycles for all network practitioners. All practitioners with identified sanctions or limitations on license in the ongoing monitoring process will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialed process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialed file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

### Continuous Query (Proactive Disclosure Service)

Molina registers all network practitioners with the NPDB/HIPDB Continuous Query program. Molina receives instant notification of all new NPDB and HIPDB reports against the enrolled providers. When a new report is received between recredentialed cycles, the practitioner will be immediately placed into the full credentialing process and will be recredentialed early. The practitioner must provide all necessary information to complete the recredentialed process within the requested time-frames or the practitioner will be administratively terminated from the network. The complete recredentialed file will be reviewed at the next scheduled Credentialing Committee meeting for a determination.

### Medicare Opt-Out

Practitioner's participating in Medicare must not be listed on the Medicare Opt-Out report. Molina reviews the quarterly opt out reports released from the appropriate Medicare financial intermediary showing all of the practitioners who have chosen to Opt-Out of Medicare. These reports are reviewed within 30 calendar days of their release. If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. These provider contracts will be immediately terminated for the Molina Medicare line of business.

## **S. Range of Actions, Notification to Authorities and Practitioner Appeal Rights**

Molina uses established criteria in the review of practitioners' performance. All adverse actions taken by the Credentialing Committee are conducted in compliance with the Fair Hearing Plan and the Healthcare Quality Improvement Act of 1986.

### Range of actions available

The Molina Credentialing Committee can take one of the following actions against practitioners who fail to meet credentialing standards or who fail to meet performance expectations pertaining to quality of patient care:

- Monitor on a Watch Status
- Require formal corrective action
- Denial of network participation
- Termination from network participation
- In cases where the Medical Director determines the circumstances pose an immediate risk to patients, a practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

This applies to all practitioners who are contracted by Molina. These actions do not apply to applicants who do not meet basic conditions of participation and are ineligible for participation. The purpose of this policy is to provide a mechanism for implementation of monitoring on watch status, requiring formal corrective action, suspension or termination of Molina practitioners.

If at any point a practitioner fails to meet the minimum standards and criteria for credentialing or fails to meet performance expectations with regard to quality of patient care the Credentialing Committee may act to implement one of these actions. Termination may be taken after reasonable effort has been made to obtain all the facts of the matter and the practitioner may be given the opportunity to appeal this decision.

### Criteria for Denial or Termination Decisions by the Credentialing Committee

The criteria used by the Credentialing Committee to make a decision to deny or terminate a practitioner from the Molina network include, but are not limited to, the following:

1. The practitioner's professional license in any state has ever had any informal or formal disciplinary orders, decisions, agreements, disciplinary actions or other actions including but not limited to, restrictions, probations, limitations, conditions suspensions and revocations.
2. Practitioner has ever surrendered, voluntarily or involuntarily, his or her professional license in any State while under investigation by the State or due to findings by the State resulting from the practitioner's acts, omissions or conduct.
3. Practitioner has any pending statement of charges, notice of proposed disciplinary actions, notice of agency action or the equivalent from any state or governmental professional disciplinary body which based on the judgment of the Credentialing Committee establishes an immediate potential risk to the quality of care or service delivered by the practitioner to Molina members.
4. Practitioner has ever had any restrictions, probations, limitations, conditions, suspensions or revocations on their federal Drug Enforcement Agency (DEA) certificate or Controlled Substance Certification or Registration.
5. Practitioner has a condition, restriction or limitation on their license, certification or registration related to an alcohol, chemical dependency, or health condition or if other evidence indicates that the practitioner has an alcohol, chemical dependency problem or health condition and there is no clear evidence and documentation demonstrating that the practitioner has complied with all such conditions, limitations,

- or restrictions and is receiving treatment adequate to ensure that the alcohol, chemical dependency problem or health condition will not affect the quality of the practitioner's practice.
6. Practitioner has ever had sanctions of any nature taken by any governmental program or professional body including but not limited to, Medicare, Medicaid, Federal Employee Program or any other State or Federal program or agency
  7. Practitioner has ever had any denials, limitations, suspensions or terminations of participation of privileges by any health care institution, plan, facility or clinic.
  8. Practitioner's history of medical malpractice claims or professional liability claims or settlements reflect what constitutes a pattern of questionable or inadequate treatment or contain what constitutes any gross or flagrant incident or incidents of malpractice.
  9. Practitioner has a criminal history, including, but not limited to, any criminal charges, criminal investigations, convictions, no-contest pleas and guilty pleas.
  10. Practitioner has ever had involvement in acts of dishonesty, fraud, deceit or misrepresentation that relate to or impact or could relate to or impact the practitioner's professional conduct or the health, safety or welfare of Molina members
  11. Practitioner has ever engaged in acts which Molina, in its sole discretion, deems inappropriate.
  12. Practitioner has a pattern of member complaints or grievances in which there appears to be a concern regarding the quality of service provided to Molina members.
  13. Practitioner has not complied with Molina's quality assurance program.
  14. Practitioner is found to have rendered a pattern of substandard care or is responsible for any gross or flagrant incident of substandard care.
  15. Practitioner has displayed inappropriate patterns of referral, which deviate substantially from reasonably expected patterns of referral.
  16. Practitioner makes any material misstatements in or omissions from their credentialing application and attachments.
  17. Practitioner has ever rendered services outside the scope of their license.
  18. Practitioner has a physical or mental health condition that may impair their ability to practice with the full scope of licensure and qualifications, or might pose a risk of harm on patients.
  19. Practitioner's failure to comply with the Molina Medical Record Review Guidelines.
  20. Practitioner's failure to comply with the Molina Site Review or Medical Record Keeping Practice Review Guidelines.

#### Monitoring on a Committee Watch Status

Molina uses the credentialing category "watch status" for practitioners whose initial or continued participation is approved by the Credentialing Committee with follow-up to occur. The Credentialing Committee may approve a practitioner to be monitored on watch status when there are unresolved issues or when the Credentialing Committee determines that the practitioner needs to be monitored for any reason.

When a practitioner is approved on watch status, the Credentialing Department conducts the follow-up according to the Credentialing Committee direction. Any unusual findings are reported immediately to the Molina Medical Director to determine if immediate action is necessary. Every unusual finding is reviewed in detail at the next Credentialing Committee meeting for review and determination.

### Corrective Action

In cases where altering the conditions of participation is based on issues related to quality of care and/or service, Molina may work with the practitioner to establish a formal corrective action plan to improve performance, prior to, or in lieu of suspending or terminating his or her participation status.

A corrective action plan is a written improvement plan, which may include, but is not limited to the following:

- Identifying the performance issues that do not meet expectations
- What actions/processes will be implemented for correction
- Who is responsible for the corrective action
- What improvement/resolution is expected
- How improvements will be assessed
- Scheduled follow-up, monitoring (compliance review, normally not to exceed six months)

Practitioners subject to corrective action will be notified within ten (10) calendar days, via a certified letter from the Medical Director. Such notification will outline:

- The reason for the corrective action
- The corrective action plan

If the corrective actions are resolved, the practitioner's performance may or may not be monitored, as deemed appropriate. If the corrective action(s) are not adequately resolved within the designated time, depending on the circumstances of the case, the Credentialing Committee may recommend that the practitioner continue on an improvement plan, or recommend suspension or termination. All recommendations for termination that result from a lack of appropriate practitioner response to corrective action will be brought to the Credentialing Committee for review and decision.

### Summary Suspension

In cases where the Medical Director becomes aware of circumstances that pose an immediate risk to patients, a meeting will be held immediately with Molina Legal Counsel, the Medical Director and the Director of Credentialing. After discussing the facts, the practitioner may be summarily suspended from participation in the network, without prior notice, pending review and investigation of information relevant to the case.

Such summary suspension shall become effective immediately upon imposition, and the Medical Director shall promptly notify the practitioner of the suspension, via a certified letter. Notification will include the following:

- The action being taken
- Effective date of the action
- The reason(s) for the action and/or information being investigated
- Information (if any) required from the practitioner
- The estimated timeline for determining whether or not to reinstate or terminate the practitioner

- Details regarding the practitioners right to request a fair hearing within 30 calendar days (see Fair Hearing Plan policy) and their right to be represented by an attorney or another person of their choice

Upon initiation of the suspension, the Medical Director and credentialing staff will commence investigation of the issues. Findings of the investigation will be presented to the Credentialing Committee. The Credentialing Committee has the authority to implement corrective action, place conditions on the practitioner's continued participation, discontinue the suspension or terminate the practitioner.

### Termination

After review of appropriate information, the Credentialing Committee may determine that the practitioner does not meet performance expectations pertaining to quality of care, services or established performance/professional standards. The Credentialing Committee may then vote to terminate the practitioner. The effective date of the termination is determined by the contractual agreement between Molina and the affected practitioner.

Within ten (10) calendar days of the Committee's decision, the practitioner is sent written notice of termination, via a certified letter from the Medical Director, which includes the following:

- Effective date of termination
- Reason for termination
- Obligations of the practitioner regarding further care of Molina patients/members
- If applicable, details regarding the practitioners right to request a fair hearing within 30 calendar days (see Fair Hearing Plan policy) and their right to be represented by an attorney or another person of their choice

### Notification to Authorities

Molina will make reports to appropriate authorities as specified in the Fair Hearing Plan Policy when the Credentialing Committee takes or recommends certain Adverse Actions for a Practitioner based upon Unprofessional Conduct including:

- Revocation, termination of, or expulsion from Molina Provider status.
- Summary Suspension in effect or imposed for more than thirty (30) calendar days.
- Any other final action by Molina that by its nature is reportable to the State Licensing Board, the NPDB, and/or HIPDB.

If a Fair Hearing is offered, a certified letter is sent to the practitioner describing the adverse action taken, the reason for the action and notifying the practitioner of their right to a Fair Hearing. A copy of the Fair Hearing Plan Policy is included with the letter. The practitioner is given 30 calendar days to request a Fair Hearing. The practitioner is notified of their right to be represented by an attorney or another person of their choice.

If the practitioner requests a Fair Hearing, the Molina Fair Hearing Plan Policy is followed. A hearing officer is appointed and a panel of individuals appointed by Molina to review the appeal.

Once the hearing is completed, a written notification of the appeal decision will be sent to the practitioner which will contain the specific reason for the decision.

Within 15 calendar days of the effective date of the action, the Manager responsible for credentialing reports the action to the following authorities:

- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)

#### **T. Fair Hearing Plan Policy**

Under State and Federal law, certain procedural rights shall be granted to a provider in the event that peer review recommendations and actions require a report be made to the State Licensing Board, the National Practitioner Data Bank (“NPDB”), and/or the Healthcare Integrity and Protection Data Bank (“HIPDB”).

Molina Healthcare, Inc., and its affiliates (“Molina”), will maintain and communicate the process providing procedural rights to Providers when a final action by Molina will result in a report to the State Licensing Board, NPDB, and/or HIPDB.

##### **A. Definitions**

1. Adverse Action shall mean an action that entitles a Provider to a hearing, as set forth in Section B (l)-(3) below.
2. Chief Medical Officer shall mean the Chief Medical Officer for the respective Molina affiliate state plan wherein the Provider is contracted.
3. Days shall mean calendar days. In computing any period of time prescribed or allowed by this Policy, the day of the act or event from which the designated period of time begins shall not be included.
4. Medical Director shall mean the Medical Director for the respective Molina affiliate state plan wherein the Provider is contracted.
5. Molina Plan shall mean the respective Molina affiliate state plan wherein the Provider is contracted.
6. Notice shall mean written notification sent by certified mail, return receipt requested, or personal delivery.
7. Peer Review Committee or Credentialing Committee shall mean a Molina Plan committee or the designee of such a committee.
8. Plan President shall mean the Plan President for the respective Molina affiliate state plan wherein the Provider is contracted.
9. Provider shall mean physicians, dentists, and other health care practitioners as defined by 42 USC 11151 and Social Security Act § 1861(u).



10. State shall mean the licensing board in the state in which the provider practices.
11. State Licensing Board shall mean the state agency responsible for the licensure of Provider.
12. Unprofessional Conduct refers to a basis for corrective action or termination involving an aspect of a Provider's competence or professional conduct which is reasonably likely to be detrimental to patient safety or the delivery of quality care. Unprofessional conduct does not refer to instances where a Provider violates a material term of the Provider's contract with a Molina Plan.

B. Grounds for a Hearing

Grounds for a hearing exist whenever the Peer Review Committee or Credentialing Committee takes or recommends any of the following Adverse Actions for a Provider based upon Unprofessional Conduct:

1. Revocation, termination of, or expulsion from Molina Provider status when such revocation, termination, or expulsion is reportable to the State Licensing Board, NPDB, and/or HIPDB.
2. Suspension, reduction, limitation, or revocation of authority to provide care to Molina members.
3. Any other final action by Molina that by its nature is reportable to the State Licensing Board, NPDB, and/or HIPDB.

C. Notice of Action

If the Peer Review Committee and/or Credentialing Committee have recommended an Adverse Action, the Committee shall give written notice to the Provider by certified mail with return receipt requested. The notice shall:

1. State the reasons for the action;

2. State any Credentialing Policy provisions that have been violated;
3. Advise the Provider that he/she has the right to request a hearing on the proposed Adverse Action;
4. Advise the Provider that any request for hearing must be made in writing within thirty (30) days following receipt of the Notice of Action, and must be sent to the respective Molina Plan Medical Director by certified mail, return receipt requested, or personal delivery;
5. Advise the Provider that he/she has the right to be represented by an attorney or another person of their choice.
6. Advise the Provider that the request for a hearing **must** be accompanied by a check in the amount of \$1,000.00 as a deposit for the administrative expenses of the hearing and specify that this amount will be refunded if the Adverse Action is overturned;
7. State that the proposed action or recommendation, if adopted, must be reported pursuant to State and Federal law; and
8. Provide a summary of the Provider's hearing rights or attach a copy of this Policy.

D. Request for a Hearing - Waiver

If the Provider does not request a hearing in writing to the Chief Medical Officer within thirty (30) days following receipt of the Notice of Action, the Provider shall be deemed to have accepted the action or recommendation of the Peer Review Committee and/or Credentialing Committee, and such action or recommendation shall be submitted to the Chief Medical Officer for final decision. In the event that a timely written Request for Hearing is received, a Hearing Officer and/or hearing panel shall be appointed as set forth below and the Peer Review Committee and/or Credentialing Committee shall provide the Provider with a Notice of Hearing and Statement of Charges consistent with this Policy.

A Provider who fails to request a hearing within the time and in the manner specified above waives his or her right to any hearing to which he or she might otherwise have been entitled. If the Provider waives his or her right to any hearing by failing to request a hearing within the time and in the manner specified above, the recommendation of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action shall be forwarded to the Chief Medical Officer for final approval. In the event of a submittal to the Chief Medical Officer upon the Provider's waiver as set forth herein, the Peer Review Committee and/or Credentialing Committee may submit to the Chief Medical Officer additional information relevant to its recommended Adverse Action to be considered by the Chief Medical Officer in accepting or rejecting the recommended Adverse Action.

E. Appointment of a Hearing Committee

1. Composition of Hearing Committee

The Chief Medical Officer/Plan President shall select the individuals to serve on the Hearing Committee. The Hearing Committee shall consist of individuals who are not in direct economic competition with the subject Provider; who shall gain no direct financial benefit from the outcome of the hearing; and, who shall have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. General knowledge of the matter involved shall not preclude a physician from serving as a member of the panel.

The panel shall consist of three or more Providers and shall include, whenever feasible, at least one individual practicing the same specialty as the affected Provider. In the event Providers are not available to sit as Hearing Committee members, physicians from the community may be substituted by the Medical Director.

2. Scope of Authority

The Hearing Committee shall have the authority to interpret and apply this Policy insofar as it relates to its powers and duties.

3. Responsibilities

The Hearing Committee shall:

- a. Evaluate evidence and testimony presented.
- b. Issue a decision accepting, rejecting, or modifying the decision of the Peer Review Committee and/or Credentialing Committee.
- c. Maintain the privacy of the hearing unless the law provides to the contrary.

4. Vacancies

In the event of a vacancy in a hearing panel after a hearing has commenced, the remaining panel members may continue with the hearing and determination of the controversy, unless the parties agree otherwise.

5. Disclosure and Challenge Procedures

Any person appointed to the Hearing Committee shall disclose to the Chief Medical Officer/Plan President any circumstance likely to affect impartiality, including any bias or a financial or personal interest in the result of the hearing or any past or present relationship with the parties or their representatives.

The Hearing Officer may remove any person appointed to the Hearing Committee if the Hearing Officer believes that the person is unable to render an impartial decision.

F. Hearing Officer

1. Selection

The Chief Medical Officer and/or Plan President shall appoint a Hearing Officer, who may be an attorney. The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

2. Scope of Authority

The Hearing Officer shall have the sole discretion and authority to:

- a. Exclude any witness, other than a party or other essential person.
- b. Determine the attendance of any person other than the parties and their counsel and representatives.
- c. For good cause shown to postpone any hearing upon the request of a party or upon a Hearing Committee's own initiative, and shall also grant such postponement when all of the parties agree thereto.

3. Responsibilities

The Hearing Officer shall:

- a. Guide the hearing process, including endeavoring to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner;
- b. Ensure that proper decorum is maintained;
- c. Be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing;
- d. Issue rulings pertaining to matters of law, procedure and the admissibility of evidence;
- e. Issue rulings on any objections or evidentiary matters;
- f. Discretion to limit the amount of time;
- g. Assure that each witness is sworn in by the court reporter;

- h. May ask questions of the witnesses (but must remain neutral/impartial);
- i. May meet in private with the panel members to discuss the conduct of the hearing;
- j. Remind all witnesses at the conclusion of their testimony of the confidentiality of the hearing;
- k. Participate in the deliberations of the Hearing Committee as a legal advisor, but shall not be entitled to vote; and
- l. Prepare the written report.

G. Time and Place of Hearing

Upon receipt of a Request for Hearing, the Chief Medical Officer and/or Plan President shall schedule and arrange for a hearing. The Chief Medical Officer and/or Plan President shall give notice to the affected Provider of the time, place and date of the hearing, as set forth below. The date of commencement of the hearing shall be not less than thirty (30) days from the date of the Notice of the Hearing, and not more than sixty (60) days from the date of receipt of the Request for Hearing. Notwithstanding the above timeframes, the parties may agree to extensions, or the Hearing Officer may grant an extension on a showing of good cause. If more than one meeting is required for a hearing, the Hearing Officer shall set the date, time, and location for additional meetings.

H. Notice of Hearing

The Notice of Hearing shall contain and provide the affected Provider with the following:

1. The date, time and location of the hearing.
2. The name of the Hearing Officer.
3. The names of the Hearing Committee Members.
4. A concise statement of the affected Provider's alleged acts or omissions giving rise to the Adverse Action or recommendation, and any other reasons or subject matter forming the basis for the Adverse Action or recommendation which is the subject of the hearing.
5. The names of witnesses, so far as they are then reasonably known or anticipated, who are expected to testify on behalf of the Peer Review Committee and/or Credentialing Committee, provided the list may be updated as necessary and appropriate, but not later than ten (10) days prior to the commencement of the hearing.

6. A list of all documentary evidence forming the bases of the charges reasonably necessary to enable the Provider to prepare a defense, including all documentary evidence which was considered by the Peer Review Committee and/or Credentialing Committee in recommending the Adverse Action.

Except with regard to the disclosure of witnesses, as set forth above, the Notice of Hearing may be amended from time to time, but not later than the close of the case at the conclusion of the hearing by the Hearing Committee. Such amendments may delete, modify, clarify or add to the acts, omissions, or reasons specified in the original Notice of Hearing.

I. Pre-Hearing Procedures

1. The Provider shall have the following pre-hearing rights:
  - a. To inspect and copy, at the Provider's expense, documents upon which the charges are based which the Peer Review Committee and/or Credentialing Committee have in its possession or under its control; and
  - b. To receive, at least thirty (30) days prior to the hearing, a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the Provider to prepare a defense, including all evidence that was considered by the Peer Review Committee and/or Credentialing Committee in recommending Adverse Action.
2. The Hearing Committee shall have the following pre-hearing right:

To inspect and copy, at Molina's expense, any documents or other evidence relevant to the charges which the Provider has in his or her possession or control as soon as practicable after receiving the hearing request.
3. The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards required to protect the peer review process, privileges and ensure justice. In so doing, the Hearing Officer shall consider:
  - a. Whether the information sought may be introduced to support or defend the charges;
  - b. The exculpatory or inculpatory nature of the information sought, if any;
  - c. The burden attendant upon the party in possession of the information sought if access is granted; and
  - d. Any previous requests for access to information submitted or resisted by the parties.

4. The Provider shall be entitled to a reasonable opportunity to question and object to or challenge the impartiality of members of the Hearing Committee and the Hearing Officer. Challenges to the impartiality of any Hearing Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.
5. It shall be the duty of the Provider, the Peer Review Committee and/or Credentialing Committee to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
6. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance or limitation of the evidence or the testimony if deemed appropriate by the Hearing Officer.
7. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable physicians or patients, other than the Provider under review, or to information, interviews, reports, statements, findings and conclusions resulting from studies or other data prepared specifically to be submitted for review purposes made privileged by operation of State.

J. Conduct of Hearing

1. Rights of the Parties

Within reasonable limitations, and as long as these rights are exercised in an efficient and expeditious manner, both sides at the hearing may:

- a. Call and examine witnesses for relevant testimony.
- b. Introduce relevant exhibits or other documents.
- c. Cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues.
- d. Otherwise rebut evidence.
- e. Have a record made of the proceedings.
- f. Submit a written statement at the close of the hearing.
- g. Receive the written recommendation of the Hearing Officer or Hearing Committee, including a statement of the basis for the recommendations, upon completion of the hearing.

The Provider may be called by the Peer Review Committee and/or Credentialing Committee and examined as if under cross-examination.

2. Course of the Hearing

- a. Each party may make an oral opening statement.
- b. The Peer Review Committee and/or Credentialing Committee shall call any witnesses and present relevant documentary evidence to support its recommendation.
- c. The affected Provider may then call any witnesses and present relevant documentary evidence supporting his/her defense.
- d. The Hearing Committee or Officer has the discretion to vary the course of the hearing, but shall afford a full and equal opportunity to all parties for the presentation of material and relevant evidence and for the calling of witnesses.
- e. The Hearing Committee shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the entire Hearing Committee and all of the parties, except when agreed to by the parties, or determined by the Hearing Officer.

3. Use of Exhibits

- a. Exhibits, when offered by either party, may be received into evidence by the Hearing Committee as ruled upon by the Hearing Officer.
- b. A description of the exhibits in the order received shall be made a part of the record.

4. Witnesses

- a. Witnesses for each party shall submit to questions or other examination.
- b. The Hearing Officer shall have the power to sequester witnesses (exclude any witness, other than a party or other essential person, during the testimony of any other witness). The names and addresses of all witnesses and a description of their testimony in the order received shall be made a part of the record.
- c. The Hearing Committee may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the Hearing Committee deems it is entitled to after consideration of any objection made to its admission.



- d. The party producing such witnesses shall pay the expenses of their witnesses.

5. Rules for Hearing:

a. Attendance at Hearings

Only those persons having a direct interest in the hearing are entitled to attend the hearing. This means that the hearing will be closed except for the parties and their representatives. The only exception is when good cause is shown satisfactory to the Hearing Officer that it is necessary in the interest and fairness of the hearing to have others present.

b. Communication with Hearing Committee

There shall be no direct communication between the parties and the Hearing Committee other than at the hearing, unless the parties and the Hearing Committee agree otherwise. Any other oral or written communication from the parties to the Hearing Committee shall be directed to the Hearing Officer for transmittal to the Hearing Committee.

c. Interpreter

Any party wishing to utilize an interpreter shall make all arrangements directly with the interpreter and shall assume the costs of the services.

K. Close of the Hearing

At the conclusion of the hearing, the Hearing Officer shall dismiss all parties and participate in the deliberations of the Hearing Committee. The Hearing Committee shall render its final decision by a majority vote, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached to the Hearing Officer.

Within thirty (30) days of the conclusion of the deliberations, the Hearing Officer shall issue a written report including the following:

1. A summary of facts and circumstances giving rise to the hearing.
2. A description of the hearing, including:
  - a. The panel members' names and specialties;
  - b. The Hearing officer's name;
  - c. The date of the hearing;
  - d. The charges at issue; and
  - e. An overview of witnesses heard and evidence.

3. The findings and recommendations of the Hearing Committee.
4. Any dissenting opinions desired to be expressed by the hearing panel members.

Final adjournment of the Hearing Committee shall occur when the Hearing Officer has mailed or otherwise delivered the written report.

L. Burden of Proof

In all hearings it shall be incumbent on the Peer Review Committee and/or Credentialing Committee taking or recommending an Adverse Action to come forward initially with evidence in support of its action or decision. Thereafter, the Provider who requested the hearing shall come forward with evidence in his/her support.

The burden of proof during a hearing shall be as follows:

The Peer Review Committee or Credentialing Committee taking or recommending the Adverse Action shall bear the burden of persuading the Hearing Committee that its action or recommendation is reasonable and warranted. The term "reasonable and warranted" means within the range of alternatives reasonably available to the Peer Review Committee and/or Credentialing Committee taking or recommending Adverse Action under the circumstances and not necessarily that the action or recommendation is the only measure or the best measure that could have been taken or formulated.

M. Provider Failure to Appear or Proceed

Failure, without good cause, of the Provider to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

N. Record of the Hearing/Oath

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings, if deemed appropriate by the Hearing Officer. The cost of attendance of the reporter shall be borne by Molina, but the cost of the transcript, if any, shall be borne by the party requesting it. The Hearing Officer shall be required to order that all oral evidence be taken by oath administered by a person lawfully authorized to administer such oath.

O. Representation

Each party shall be entitled to representation by an attorney at law, or other representative at the hearing, at their own expense, to represent their interests, present their case, offer materials in support thereof, examine witnesses, and/or respond to appropriate questions.

P. Postponements

The Hearing Officer, for good cause shown, may postpone any hearing upon the request of a party or the Hearing Committee.

Q. Notification of Finding

The Hearing Office shall serve a copy of the written report outlining the basis of the Hearing Committee's decision to the Medical Director, the Peer Review Committee and/or Credentialing Committee imposing the Adverse Action, and the affected Provider.

R. Final Decision

Upon receipt of the Hearing Committee's decision, the Chief Medical Officer/Plan President shall either adopt or reject the Hearing Committee's decision. The Chief Medical Officer/Plan President's action constitutes the final decision.

S. Reporting

In the event the Chief Medical Officer/Plan President adopts the proposed decision of the Peer Review Committee and/or Credentialing Committee taking or recommending the Adverse Action, Molina will submit a report to the State Licensing Board, NPDB, and/or HIPDB, as required. Reports shall be made in accordance with the Credentialing Program Policy.

T. Exhaustion of Internal Remedies

If any of the above Adverse Actions are taken or recommended, the Provider must exhaust the remedies afforded by this Policy before resorting to legal action.