Organizational Provider Credentialing Criteria for Participation and Termination

I. Statement of Purpose

Asuris Northwest Health (referred to hereinafter as "the Company") is firmly committed to developing organizational provider networks that meet our established level of standards and are consistent with the delivery of high quality, cost-effective health care. The Company has established criteria for the evaluation, appointment and reappointment of organizational providers to its network panels. Based upon the application of these criteria and the need for additional organizational providers within the network, the Company reserves the right to accept or deny a request for participation or terminate participation.

All organizational providers requesting participation with the Company, and its subsidiaries must complete an application for participation which has been designed to provide the Company with information necessary to perform a comprehensive review of the organizational provider's credentials. Once an organizational provider's application is deemed complete, the Company will commence a review of the organizational provider's credentials using a variety of national and state data sources. The Company requires all organizational providers to meet the criteria prior to contracting and remain in compliance with the criteria at all times.

The Company will provide notice of material change(s) in criteria 90 days in advance of the effective date of the change(s). The Company reserves the right to exercise discretion in applying *any* criteria and to exclude organizational providers who do not meet the criteria. To remain eligible for participation, organizational providers must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by the Company.

II. Organizational Providers

- Ambulance
- Ambulatory Surgery Center
- Applied Behavioral Analysis (ABA) Agency
- Behavioral Health Agency-Crisis Services
- Behavioral Health Facility-Mental Health Services
- Behavioral Health Facility-Substance Use Disorders
- Birthing Center
- Diabetes Prevention Program
- Durable Medical/Home Medical Equipment
- Home Health Agency
- Home Infusion Therapy
- Hospice
- Hospital
- Independent Diagnostic Testing Facility
- Kidney Dialysis Center
- Clinical Laboratory
- Mass Immunization Provider
- Orthotics/Prosthetics
- Radiology and Medical Imaging Center (Free Standing or Mobile)
- Residential Treatment Facility
- Skilled Nursing Facility
- Sleep Disorder Center
- Substance Abuse, Alcohol and Drug Treatment Facility

III. Criteria for all Organizational Providers

To be eligible for participation, organizational providers must meet and maintain the following criteria adopted by the Company:

1. The organizational provider, where applicable by state requirements, must have a current, valid unrestricted permanent state license or certificate as an organizational provider recognized by the Company (see Section II).
2. The organizational provider must submit a complete, signed and dated application, and all required documentation. Recredentialing is conducted every three (3) years, at a minimum.
3. At the time of initial application, the organizational provider must not have any of the following sanctions imposed by Medicare, Medicaid, accrediting agencies or other state and federal agencies:
   a) stop placement status; or
   b) denial of payment status; or
   c) temporary management status; or
   d) pending state charges, actions; or
   e) excluded or expelled status; or
   f) loss of accreditation, licensure, or certification status.
4. The Company may review and consider the organizational provider's history in making its decision relating to participation and continued participation on our networks, including, but not limited to, the following:
   a) a suspended or revoked license, certification, or registration; or
   b) actions taken by any state or governmental professional body; or
   c) sanctions of any nature taken against the organizational provider by any government program, including, but not limited to, Medicare and Medicaid; or
   d) denial, limitation, suspension, or termination of participation by any health care institution or plan; or
   e) loss of accreditation; or
   f) prior history with the Company.
5. The organizational provider's State license(s) and certification(s) must be currently free of any restrictions, limitations, conditions, or sanctions (formal or informal).
6. Organizational providers must meet the following requirements:
   a) **Ambulance**: State license and Medicare certified
   b) **Ambulatory Surgery Center**: State license (if applicable), Medicare certified, or Accreditation designation for the covered level of service being provided
   c) **Applied Behavioral Analysis (ABA) Agency**: State certification
   d) **Behavioral Health Agency-Crisis Services:** State License and/or Certification and Certified as a Mobile Crisis Response Service
   e) **Behavioral Health Facility-Mental Health Services:** State license and/or Certification (if applicable) or Accreditation designation for the covered level of service being provided
   f) **Behavioral Health Facility-Substance Use Disorders:** State license and/or Certification (if applicable) or Accreditation designation for the covered level of service being provided
   g) **Birthing Center**: State license and Accreditation designation for the covered level of service being provided
   h) **Diabetes Prevention Program:** Centers for Disease Control and Diabetes Prevention Recognition Program and Medicare enrolled
   i) **Durable Medical/Home Medical Equipment**: Medicare enrolled and Accreditation designation for the covered level of service being provided
   j) **Home Health Agency**: State License and either Medicare certified, or Accreditation with Medicare deemed status for the covered level of service being provided
      i. CMS quality of patient care rating below 2 out of 5 stars require review and approval from the Regence Medical Director and/or Credentialing Committee
   k) **Home Infusion Therapy**: State license (if applicable), Medicare certified, or Accreditation designation for the covered level of service being provided

l) **Hospice**: State license (if applicable) and either Medicare certified, or Accreditation with Medicare deemed status for the covered level of service being provided
m) **Hospital**: State License and either Medicare certified, or Accreditation with Medicare deemed status for the covered level of service being provided
n) **Independent Diagnostic Testing Facility**: Medicare enrolled
o) **Kidney Dialysis Center**: State license (if applicable) and Medicare certified
p) **Clinical Laboratory**: Medicare certified, and Clinical Laboratory Improvement Amendments (CLIA) certified
q) **Mass Immunization Provider**: Medicare enrolled
r) **Orthotics/Prosthetics**: Medicare enrolled and Accreditation designation for the covered level of service being provided
s) **Radiology and Medical Imaging Center (Free Standing or Mobile):** Medicare certified and Accreditation designation for the covered level of service being provided
t) **Residential Treatment Facility**: State license and/or Certification (if applicable), or Accreditation designation for the covered level of service being provided
u) **Skilled Nursing Facility**: State license and either Medicare certified, or Accreditation with Medicare deemed status for the covered level of service being provided
    i. CMS Special Focus Facility (SFF) designation; or
    ii. Nursing Home Compare ratings below 2 out of 5 stars require review and approval from the Regence Medical Director and/or Credentialing Committee
v) **Sleep Disorder Center**: Medicare certified and Accreditation designation for the covered level of service being provided
w) **Substance Abuse, Alcohol and Drug Treatment Facility**: State license and/or Certification (if applicable), or Accreditation designation for the covered level of service being provided

7. The organizational provider's accreditation must be from an accrediting organization that has Medicare deeming authority or from an accrediting organization recognized by the Company. Accreditation designation must be for the covered level of service being provided.
8. Non-accredited Ambulatory Surgery Centers, Behavioral Health Agencies-Crisis Services, Behavioral Health Facilities, Home Health Agencies, Hospitals, Residential Treatment Facilities, Skilled Nursing Facilities and Substance Abuse, Alcohol and Drug Treatment Facilities must meet one of the following:
    a) Current passing quality review from CMS that is no more than three years old; or
    b) Current passing state quality review survey that is no more than three years old; or
    c) Current onsite quality assessment completed by the Company.
9. The organizational provider's professional liability insurance and general liability must be through a commercial carrier or statutory authority, and at a minimum, in the amounts specified below:
    a) Hospital: $2 million per occurrence and $5 million aggregate.
    b) All other organizational providers: $1 million per occurrence and $3 million aggregate.
10. The organizational provider must not have what the Company determines to be a pattern of questionable or inadequate treatment, or a pattern of substandard care or mismanagement.
11. The organizational provider must not have made any material misrepresentation or omission to the Company concerning licensure, registration, certification, disciplinary history, or any other material matter covered in the application or credentialing materials.
12. The Company has the right to terminate the organizational provider for any reason, including, but not limited to, those stated in the contract between the Company and the organizational provider, or for any pattern of demonstrated unwillingness to abide by the terms and conditions of the contract.
13. When applicable, the credentialing and recredentialing process incorporates available information from utilization management, case management, quality management, external audit, member complaints, medical record reviews and site visits. The organizational provider must comply with these quality improvement activities. This information will be utilized as a component in determining the organizational provider's acceptability for participation and continued participation.
14. The organizational provider location(s) must meet the Company's site visit standards and requirements.

15. The Company may determine, in its sole discretion that an organizational provider is not eligible to apply for network participation if the organizational provider is owned by a practitioner or is owned in whole or in part by a practitioner, who has been removed from network participation by the Company, who is currently in the Provider Contract Termination Appeal Process, or who is under investigation by the Company. The Company also may determine, in its sole discretion that an organizational provider cannot continue network participation if the organizational provider is owned by a practitioner or is owned in whole or in part by a practitioner, who has been removed from network participation by the Company. 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.
16. Organizational providers must comply with the Company's requirement for recredentialing.
    a) Organizational providers that fail to respond to recredentialing requests or do not complete the recredentialing process in a timely manner will be temporarily removed from all provider directories.
17. Organizational providers that have been removed from network participation due to medical records audits or non-compliance with recredentialing requirements are not eligible to reapply for participation on any network for one (1) year from the end of network participation date.
18. Organizational providers that have been removed from network participation due to external audits findings are not eligible to reapply for participation on any network.
19. Organizational providers that have been removed from network participation for any reason other than for those set forth in criteria III. 17 and 18 above, are not eligible to reapply for participation on any network for two (2) years from the end of the network participation date.
20. Organizational providers that have been denied initial network participation are not eligible to reapply for participation on any network for one (1) year from the date of the final denial letter.
21. Organizational providers who have been removed from network participation or denied initial network participation more than once are not eligible to reapply for participation on any network.
22. Organizational providers who have been denied initial network participation do not have the right to submit an appeal.
23. Organizational providers that have been sent a termination notice will be temporarily removed from all provider directories.
24. The Company has the right to deny or terminate the organizational provider if the Company determines, in good faith and in its sole discretion, that the organizational provider poses a threat or risk of harm to Members.
25. The organizational provider, person(s) with ownership or controlled interest in the organizational provider and managing employees of the organizational provider must not have been:
    a) excluded, expelled, or suspended from any federally funded programs, including, but not limited to, the Medicare or Medicaid programs; or
    b) convicted of a felony or pled guilty to a felony for a health-care related crime, including, but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispending of a controlled substance; or
    c) precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
26. The organizational provider must not have personal or business activities or relationships that could create a potential or actual conflict of interest when rendering services to the Company's members. The Company may review and consider any such actual or potential conflict of interest in making its decision relating to the organizational provider's participation or continued participating on our networks.
27. If organizational provider renders services to the Company's Medicare Advantage or Medicaid members, the organizational provider must meet the compliance requirements set forth in the organizational provider's agreement with the Company.