CREDENTIALING POLICIES AND PLAN FOR
West Texas Integrated Healthcare Network, a Texas non-profit corporation, d/b/a Midland Quality Alliance

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CREDENTIALING

INTRODUCTION

West Texas Integrated Healthcare Network d/b/a Midland Quality Alliance, a Texas non-profit corporation certified as a Texas Occupations Code §162.001 non-profit health organization by the Texas Medical Board ("**MQA**"), has been formed with the mission of achieving through clinical integration high quality, cost effective care for the patients that MQA serves. MQA's vision is to be the preferred alliance of physicians, hospitals, and other health care providers offering exceptional quality and value. MQA is committed to improving continuously the quality of patient care and serving the community in an efficient and cost effective manner. Members of the CIN network, including Participating Health Professionals, will be expected to deliver care in a clinically-integrated fashion. Among CIN's purposes is to contract with Payers on behalf of, among others, its participating Health Professionals, to provide health care services to the Enrollees of Payer Plans. CIN is responsible for recruiting, contracting, and credentialing the participating Health Professionals who will provide services to the Enrollees of those Payer Plans.

CIN intends to accept delegation of credentialing from Payers, and accordingly, has adopted these Credentialing Policies and Plan ("**Plan**") in order to provide written standards and guidance for the credentialing of Health Professionals who wish to participate in CIN's network ("**Participating Health Professionals**") in accordance with National Committee for Quality Assurance ("**NCQA**") Standards. The NCQA Standards require, among other things, CIN to request information from the National Practitioner Data Bank ("**NPDB**"), and if required by law, CIN shall report to the NPDB an action which is taken against a Participating Health Professional for quality or cost of care reasons which action affects the continuing status of the Health Professional as a Participating Health Professional. CIN also intends to comply with applicable law in its application and interpretation of this Plan. In conducting credentialing activities under this Plan, CIN shall not unlawfully discriminate against a Participating Health Professional or those who wish to become Participating Health Professionals on the basis of race, national origin, age, sex, religion, sexual orientation, or the types of procedures or types of patients served.

The defined terms used in this Plan are either defined in this document or have the meanings set forth in the CIN Application and Participation Agreement. In the event of a conflict between this Plan and the CIN Application and Participation Agreement, the CIN Application and Participation Agreement shall control.

GOVERNANCE STRUCTURE

The CIN Board of Managers ("**Board**") has the ultimate decision making authority on matters of credentialing policy. The Board has charged the Credentialing Committee of CIN ("**Committee**") with the development of policies and procedures in the form of this Plan that are consistent with Board policy, compliant with the NCQA Standards and Guidelines for Certification in Credentialing, responsive to the needs of Enrollees of the Payer Plans served by Participating Health Professionals, and maintain confidentiality in accordance with applicable law. This Plan will be used in credentialing Participating Health Professionals for CIN.

PURPOSE

The purpose of the Plan is to assure a systematic approach to the selection, evaluation, monitoring, remedial action, and termination of Participating Health Professionals and those who wish to become Participating Health Professionals.

The Plan will allow CIN to evaluate the qualifications of Health Professionals who seek to become Participating Health Professionals and the continued qualifications and patient care rendered by Participating Health Professionals. This includes, without limitation, standards and procedures to:

- Screen applicant Health Professionals to determine if they meet the credentialing requirements defined in this Plan, and if they meet such requirements, recommend to the Board that they be accepted as a Participating Health Professional.

- Obtain and maintain relevant information about the qualifications and performance of Participating Health Professionals in an appropriate and privileged manner.

- Establish procedures for remedial action.

- Provide a hearing process for Participating Health Professionals in cases where an action has been taken against a Participating Health Professional for quality or cost of care reasons which action affects the continuing status of the Health Professional as a Participating Health Professional.

MEMBERSHIP AND STANDARDS COMMITTEE

The Committee is a standing committee of the Board. The purposes, membership, and rules of the Committee include but are not limited to the following:

Purposes

The purposes of the Committee are, among other things, to:

a. Review applications from Health Professionals to determine whether such applicant qualifies to become a Participating Health Professional based on the criteria set forth in this Plan.

b. Ensure that credentialing decisions do not unlawfully discriminate against applicants on the basis of race, national origin, age, sex, religion, sexual orientation, or the types of procedures or types of patients served. This will be accomplished via an annual review of CIN and the sub-delegate procedures that have been used for any and all practitioners who have been credentialed and recredentialed. This includes practitioners who did not meet the qualifications of CIN. A random generated sample of Files will be audited to ensure that no discriminatory processes have taken place during any type of credentialing.

c. recredentialling, and/or sanctions monitoring process throughout the previous year.

d. Receive reviews of the quality and cost of care provided by Participating Health Professionals to Enrollees of Payer Plans conducted by the CIN Best Care/Clinical Integration Committee.

e. Recommend to the Board remedial action to be taken with respect to Participating Health Professionals.

f. Provide an opportunity for a hearing for Participating Health Professionals in cases in which an action has been taken against a Participating Health Professional for quality or cost of care reasons which action affects the continuing status of the Health Professional as a Participating Health Professional, including, without limitation, situations in which the Participating Health Professional has:

i. Failed to demonstrate quality of care consistent with CIN standards; or

ii. Failed to satisfy patient satisfaction guidelines or utilization management/quality improvement criteria in a manner that is serious enough to warrant Board action.

g. Advise the Board on credentialing policy issues and necessary revisions to this Plan.

Committee Membership

Only voting members of the Committee who are Participating Health Professionals will act on matters involving Health Professionals. The Committee shall be heterogeneous and include primary and specialty care representation. CIN shall require those participating in the credentialing process to sign an affirmative statement to maintain confidentiality and make credentialing decisions in a nondiscriminatory manner. From time to time, Committee members may be appointed as appropriate to carry out Committee functions. Such appointment of Committee members and the engagement of other persons to assist the Committee and the Board will be done by the Committee.

Committee Rules

The Committee will operate in accordance with the Company Agreement of CIN and its Charter as approved by the Board. To the extent not covered by the Company Agreement or the Committee's Charter, the Committee will establish operating rules for its functioning, including rules for the conduct of its meetings. Among other things:

a. A majority of the voting members of the Committee is required for a quorum.

b. Any formal action of the Committee must be voted on and passed by a majority of the quorum of the Committee.

c. Confidential minutes of Committee meetings shall be taken.

d. The Committee shall ensure that the completed application of every applicant for Participating Health Professional status be reviewed by the Committee or any person or entity who has been designated or delegated to do so, and action shall be taken within 180 days of receipt of the completed application.

e. Any changes in the Plan must be approved by the Board.

g. Each Committee member is eligible for indemnification by CIN for his/her actions taken in good faith and without malice as a member of the Committee.

i. Meetings shall occur monthly or otherwise as established by the Chair or the Board.

Chair of Membership and Standards Committee

The Chair of the Committee will be a Participating Health Professional who is a physician. The Chair of the Committee will bear direct responsibility for overseeing and monitoring the CIN Credentialing Program. This responsibility shall include participation in Committee meetings and approving correspondence or notification letters to applicants or Participating Health Professionals. The Chair of the Committee will have those additional responsibilities, duties and obligations consummate with membership on the Committee.

REVIEW AND USE OF CRITERIA

CIN, through the Committee in coordination with the CIN Best Care/Clinical Integration Committee, shall evaluate the cost and quality of clinical services provided by Participating Health Professionals. The Committee shall evaluate the qualifications of Participating Health Professionals, including without limitation each Participating Health Professional's, as the case may be, professional behavior, educational background and experience. CIN, through the Committee and in coordination with the CIN Best Care/Clinical Integration Committee, shall also evaluate the merits of complaints relating to Participating Health Professionals and make determinations or recommendations regarding those complaints in keeping with this Plan.

Review of Participating Health Professionals shall be based on objective facts and explicit requirements applied in good faith, without discrimination. Requirements shall be used in conjunction with the judgment and experience of the Committee and others involved in the review process. The Committee may recommend that the Board waive any credentialing requirements when believed to be in the best interest of CIN or patient care, except criteria regarding the Participating Health Professional being appropriately licensed and receipt of a completed CIN Application and Participation Agreement and a Texas Standardized Credentialing Application ("**TSCA**"). The Board makes the final decision on participation status for Health Professionals, unless that decision has been designated or delegated to other persons or entities in a manner keeping with NCQA Standards and Guidelines.

CIN intends to qualify as a "health care entity" as defined in the federal Health Care Quality Improvement Act of 1986, as amended ("**HCQIA**"). Accordingly, CIN will be entitled to access the NPDB. CIN will also be required to report to the NPDB, in the event of an adverse action (as defined in the HCQIA), through the applicable state licensing boards in accordance with the HCQIA, its implementing regulations and the NPDB *Guidebook*. For purposes of certification of the legitimacy of information reported to or requested from the NPDB, the president of CIN shall identify an "**Entity Representative**."

BINDING POLICIES AND PLAN

Each applicant and each Participating Health Professional must agree to be bound by all of the terms and conditions of this Plan.

RELEASE FROM LIABILITY

Each applicant and Participating Health Professional shall agree to release and hold harmless from liability any Board or committee, member, employee, agent, officer, director, staff member, attorney, investigator, assistant, intervenor and any other person or entity who participates with, serves or assists CIN, the Board or the Committee in any capacity with respect to review of requirements for participation, and for any actions taken pursuant to this Plan.

CONFIDENTIALITY

Confidential and Privileged Communications; Immunities

All proceedings and records, and all communications, whether written or oral, made by or to the Board, the Committee, any hearing committee, as well as any other committee of CIN when acting as a professional review body and/or a medical committee under Texas law shall be confidential and privileged. Accordingly, each person who is involved in the credentialing process, professional review action activities and/or a medical committee shall maintain such proceedings, records and communications in strict confidence. Information obtained in the credentialing process shall be kept confidential and shall not be disclosed, except as necessary to conduct the credentialing process or as otherwise required by law. The credentialing files shall be stored in a secure environment. All activities taken by any person or organization on behalf of CIN in connection with a review action, including with the decision making process leading to an action affecting status as a Participating Health Professional and any hearing requested under the terms of this Plan, shall be subject to and have all protections accorded by the HCQIA, the Texas Occupations Code, the Texas Health and Safety Code, and/or other applicable federal or state law. Each person participating in a review action contemplated by this Plan, shall be informed of the confidential and privileged nature of these activities and the proceedings, records and communications made as a part thereof, and the nature of the immunities from liability in connection with those activities as provided for by law.

Confidentiality and Security of Information

In furtherance of the confidential and privileged nature of the proceedings, records and communications, all information submitted to, collected by or prepared by any party for the purpose of: (i) evaluating, monitoring or improving the quality and efficiency of patient care services delivered by any Participating Health Professional; (ii) determining that any services are professionally indicated or performed in compliance with the applicable standard of care; or (iii) otherwise related to any of the review action activities, may not be disclosed to any person or entity other than in conformance with the approval of the President of CIN and a written waiver executed by the Chair of the Board, or as otherwise provided by law.

Midland Quality Alliance utilizes security controls to protect practitioner information from unauthorized modification by taking the following approach:

a. Limiting physical access to the credentialing information, to protect the accuracy of information gathered from primary sources and NCQA- approved sources through only designated personnel as approved by the MQA administrator
b. Preventing unauthorized access, changes to and release of credentialing information through secured databases and portals.
c. Password-protecting electronic systems, including but not limited to user requirements such as
    1. Use strong passwords that contain at least 8 characters and contains three of the four following elements: upper-case letters; Lower-case letters; Numbers and special Characters or punctuation
    2. Avoid writing down passwords.
    3. Use different passwords for different accounts.
    4. Changing passwords periodically, at least every 120 days
    5. Withdrawing passwords after significant events (i.e. change of personnel or potential malware issues), including alerting appropriate staff who oversee computer security routinely
    6. Disable or remove passwords of employees who leave the organization.
d. Electronic systems

1. Prohibits the use of multi-user or "generic" accounts to access confidential files via application software
2. Separate user accounts and passwords will be required for system level \ administrative access and application \user level access
3. Employees will initially be assigned default passwords by the MQA administrator. After the initial assignment, each employee is required to change his/her password
4. Each employee is responsible for any database activity that is identified with his/her user ID/password.

e. All Board of Directors and Credentialing Staff will sign a Confidentiality and Non-Disclosure Statement on an annual basis

If Midland Quality Alliance contracts with an external entity to outsource storage of credentialing information, the contract describes how the contracted entity ensures the security of the stored information. Midland Quality Alliance will review any contracts that are outsourced on at least an annual basis.

PLAN REVIEW AND AMENDMENT

This Plan shall be reviewed annually by the Committee, to ensure conformance with applicable law and regulations, and applicable standards, policies and the purpose of this Plan. Revisions will be prepared for and adopted by the Committee and the Board. In addition, the Board, on the recommendation of the Committee or on its own initiative, may revise this Plan at any time or adopt an interim policy or plan.

PARTICIPATION SEPARATE FROM EMPLOYMENT/STAFF MEMBERSHIP

Initial and continuing eligibility for and status as a Participating Health Professional is different from and separate from a person's employment by CIN and status as a member of the medical staff of any hospital or other facility. Although decisions made under this Plan may affect a Participating Health Professional's continuing status with CIN, a hospital or other facility, just as a decision by such an entity may affect status as a Participating Health Professional, each status will be governed separately by the standards and rules applicable thereto.

PRIMARY SOURCE VERIFICATION

Primary Source Verification (PSV), is received by utilizing electronic sources (including the approved internet sources), email, and facsimile. All verifications will be dated at the time of verification and then stored in the electronic database. Verifications obtained are reviewed by the Credentialing Specialist and tracked in the database. A third review is completed by administrator or designee prior to Board approval.

Modifications made to the credentialing information are audited on a monthly basis. Database reports will provide user details on when the modifications were made, the changes made and reasons for modifications.

DELEGATED CREDENTIALING

DELEGATED CREDENTIALING FROM MANAGED CARE ORGANIZATIONS

It is the intent of CIN to seek the delegation to CIN of the process of credentialing and recredentialing by Payers, which would otherwise be responsible for that activity. When a delegation of the credentialing responsibility is acceptable to the Payer, the Committee will review the Payer's provider application and credentialing requirements, policies and procedures for variances with CIN's application and credentialing requirements, policies and procedures. If there are variances, the Committee will work with the Payer to

resolve those differences between the requirements of the Payer and CIN. The Committee will present its recommendations to the Board for a decision if any variances are to be adopted for that Payer.

If the Payer approves of the delegation, after approval is also received from the Board, an agreement evidencing the delegation shall be signed. In the agreement of delegation CIN will agree to allow the Payer and NCQA access to credentialing files and Committee minutes (or a written summary of such minutes) as required or permitted by NCQA standards and applicable law. The Committee and the Payer's authorized representatives will meet periodically to foster cooperation and an efficient credentialing process and to allow the Payer to monitor the performance of CIN in credentialing. The Payer may re-assume the right to credential new Participating Health Professionals and to terminate or suspend individual Participating Health Professionals for the Payer's Payer Plan(s) on reasonable prior notice to CIN. The agreement will also obligate the Payer to provide CIN (through its Best Care/Clinical Integration Committee) with provider-specific utilization review and any other quality measurement data that is relevant to the recredentialing process.

If necessary, as part of the delegated credentialing process, applicants for Participating Health Professional status and Participating Health Professionals up for recredentialing will sign a "Delegated Credentialing Release" that allows CIN to provide information obtained during credentialing that is required by the Payer. This is in addition to the CIN form of release which must be signed by applicants for initial and reapplicants for Participating Health Professional status.

DELEGATED CREDENTIALING TO HEALTH PROFESSIONAL ENTITIES

It is the intent of CIN to delegate to entities comprised of Health Professionals the process of credentialing and recredentialing by CIN, which would otherwise be responsible for that activity. The Committee will review such entities' provider application and credentialing criteria, policies and procedures for variances with CIN's application and credentialing criteria, policies and procedures. If there are variances, the Committee will work with such entities to resolve those differences between the criteria of such entities and CIN.

An agreement evidencing the delegation shall be signed. In the agreement of delegation such entities will agree to allow CIN, the Payer, the Texas Department of Insurance ("**TDI**") and NCQA access to credentialing files and credentials committee minutes (or a written summary of such minutes) as required or permitted by NCQA standards and applicable law. The Committee and such entities' authorized representatives will meet periodically to foster cooperation and an efficient credentialing process and to allow CIN to monitor the performance of such entities in credentialing, and such entities shall provide semi-annual reports to the Committee regarding the delegated credentialing functions. CIN may re-assume the right to credential new applicants and Participating Health Professionals and to terminate or suspend individual Participating Health Professionals for specific Payer Plan(s) on reasonable prior notice to the applicable entity. The agreement will also obligate CIN to provide the particular entity with provider-specific utilization review and any other quality measurement data that is relevant to the recredentialing process.

If necessary, as part of the delegated credentialing process, applicants for Participating Health Professional status and Participating Health Professionals up for recredentialing will sign a "Delegated Credentialing Release" that allows such entities to provide information obtained during credentialing that is required by CIN. This is in addition to any entity-specific form of release the applicant or Participating Health Professional up for recredentialing must sign.

The Committee shall retain the final authority regarding any credentialing and recredentialing decisions and may approve, suspend, and terminate any Health Professionals as part of the credentialing or recredentialing processes, even if such functions have been delegated by the Committee.

DESIGNATED CREDENTIALING

CIN, in its sole discretion may designate the Chair of the Committee or other equally qualified Participating Health Professional as the individual with authority to determine whether a clean credentialing file meets all applicable criteria and to make the subsequent credentialing approval decision. Criteria for clean files are as follows:

- Meets all credentialing requirements outlined in policy
- No current challenge or a previously successful challenge to licensure or registration
- No involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization
- No history of malpractice claims or settlements
- No gaps in training or practice over ninety days other than maternity or military leave
- No discrepancies between information provided by the applicant or references and the verified information
- No adverse National Practitioner Data Bank reports
- No other issues that raise questions about the qualifications, competency, professionalism or appropriateness of the applicant as determined by the Chair of the Committee or other equally qualified Participating Health Professional

In the event of such designation, subsequent credentialing approval by the Board is not required. If an equally qualified Participating Health Professional, as opposed to the Chair of the Committee, is designated to perform the above described functions, he/she shall be responsible for oversight of the credentialing function of CIN. Any qualifying events including any disciplinary action or sanctions that occurred or are open during the initial or reappointment timeframe will need to be reviewed by the Board of Directors.

DELEGATING CREDENTIALING DUTIES TO OTHER ENTITIES

The primary source verification and credentials file development process may be delegated by contract to a credentials verification organization ("**CVO**") that meets NCQA Standards. The contract must contain the requirements of an NCQA compliant delegation agreement, including but not limited to provisions which address specific responsibilities, reporting, performance monitoring, consequences of failure to perform, and the handling and use of Protected Health Information. Once a contract is executed, an agent for the Committee will perform an on-site review of the CVO's verification and file development processes and audit the credentialing and re-credentialing files of the CVO against NCQA Standards at least annually or more often as may be required by applicable law and regulation and NCQA Standards and Guidelines. The arrangement between CIN and the CVO shall provide that if an audit of the CVO results in findings indicating discrepancies with the proper process in any respect, CIN may terminate the delegation to the CVO. The Committee will also periodically (but at least annually) monitor and evaluate the delegated primary source verification process and credentialing policies and procedures of the CVO and the Committee will periodically (but at least semiannually) review and evaluate regular reports provided by the CVO against NCQA Standards.

The CVO will use a CIN approved application, credentialing requirements, policies and procedures to ensure compliance with Board policy and NCQA standards. Unless using an NCQA certified CVO, the CIN staff or agent will perform a pre-assessment evaluation of the CVO prior to entering into a contractual relationship. The Committee, in the sole discretion of the Board may perform the actual credentialing and recredentialing functions and final decision/approval based on the information compiled and verified by the CVO, or the Board in its discretion may delegate the actual credentialing functions. In the event of delegated credentialing decision making, the Board will nonetheless retain the right to approve, suspend,

and terminate individual Participating Health Professionals. CIN, applicable Payers and NCQA will have access to the contract for services as well as the credentialing files, if any, of the CVO.

CREDENTIALING OF PROVIDERS

APPLICATION AND REAPPLICATION FOR PARTICIPATING PROVIDER STATUS AND CREDENTIALING REQUIREMENTS

The following professionals ("**Provider**") must apply for and be approved for Participating Provider status:

- Medical Doctor
- Doctor of Osteopathic Medicine
- Podiatrist
- Dentist/Medical Dentists
- Surgeons
- Chiropractor
- Psychiatrist
- Doctoral and/or Master's-level psychologists
- Master's level clinical social worker and nurse specialists/practitioners
- Advanced Practice Providers including, but not limited to: nurse practitioners, physician assistant, certified nurse specialist
- Allied Health Professionals including, but not limited to: licensed surgical assistants, medical assistant, dental assistant, registered dietitian
- Other medical practitioners

A Provider who has submitted a MQA Application and Participation Agreement and a TSCA (collectively, "**Application**") to be considered for Participating Provider status is referred to in this Section as an "**Applicant**," and a Participating Provider who has submitted a TSCA for re-credentialing is referred to in this Section as a "**Re-applicant**." Participating Provider status may be granted or continued only after:

(i) a completed Application/TSCA is timely received;
(ii) the Application/TSCA (with accompanying and obtained information) is reviewed;
(iii) it is determined that the Applicant/Re-applicant satisfies the credentialing requirements of MQA;
(iv) approval is given granting Participating Provider status to such Provider.

The Applicant/Reapplicant will be notified of the Credentialing Committee's decision to join the network within (15) days. All decisions, approved, tabled or denied, will be documented in the Applicant /Reapplicant's file and organization's electronic database. Applicants who did not meet criteria will be deactivated from the organization's electronic database. The provider may not provide care to members until participating status has been granted by the Board of Directors.

In order to obtain information about an Applicant/Reapplicant to determine if the credentialing requirements are satisfied, CIN will utilize the TSCA. Information on the TSCA, together with other information gathered about the Applicant/Reapplicant, must clearly demonstrate that he/she satisfies the credentialing requirements in order to be granted Participating Provider status. On recredentialing, a Participating Provider must, among other things, continue to satisfy the credentialing requirements. Participating Providers with breaks in service of 30 days or more must be recredentialed.

Applicants/Reapplicants shall be notified of the right, upon request, to review information obtained to evaluate their Application/TSCA, except that Applicants/Reapplicants shall not have the right to review

references or recommendations or other information, if any, that is confidential and privileged under the law.

The credentialing requirements for a Participating Provider are as follows:

Credentialing Requirements

APPLICATION	Receipt of a fully completed and attested Application.
LICENSE TO PRACTICE	A current, unrestricted license to practice medicine, podiatry, dental surgery or dental medicine, APP/AHP as the case may be, in Texas.
EDUCATION/EXPERIENCE	Clear documentation of acceptable clinical background, successful completion of education, sound clinical experience, quality training, and ability to perform the essential functions required for the provision of Covered Medical Services to enrollees, adherence to professional ethics and ability to work well with others.
PRACTICE LOCATION	Active practice in a practice location in a geographic area consistent with the marketing needs and enrollment of CIN as reasonably determined by the Board.
DEA REGISTRATIONS	Current DEA controlled substances registrations, unless, in the opinion of the Board, those registrations are not essential to the delivery of Covered Medical Services by the Provider.
DISCIPLINARY ACTIONS	No current or prior disciplinary actions against the Provider's license in any jurisdiction which resulted in probation, restriction, forfeiture or other loss of such license. Additionally, the absence of any sanctions against or debarment or exclusion of the Provider by Medicare or Medicaid authorities, or any action by a hospital or other health care facility that probated, suspended, restricted or revoked the Provider's medical staff membership or clinical privileges.
FELONY CONVICTIONS	Clear documentation of past history of any prior felony convictions.
ILLEGAL DRUG USE	No current, illegal drug use by the Provider.
MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES	Current medical staff membership and clinical privileges at a hospital or other health care facility approved by the Board or coverage arrangements with designated Providers of like specialty, except in instances in which CIN has determined that medical staff membership and clinical privileges are not essential to the delivery of Covered Medical Services to CIN Enrollees. Record of adherence to hospital and

	medical staff bylaws and rules and regulations, utilization review programs, record completion requirements and quality improvement programs as applicable.
24 HOUR COVERAGE	Agreement/ability to provide 24 hour coverage to CIN Enrollees, either personally or through practice coverage arrangements with other Providers of like specialty.
MALPRACTICE HISTORY	Professional malpractice history acceptable to CIN.
MALPRACTICE COVERAGE	Proof of professional malpractice insurance coverage in the minimum amounts and terms established by CIN for Providers. Unless waived by action of the Board in a specific situation, the minimum acceptable level of coverage shall be $200,000 per occurrence and $600,000 in the aggregate.
BOARD CERTIFICATION	Unless otherwise determined by the Board: MD/DO: Board certification by a specialty board which is either a recognized member of the American Board of Medical Specialties, American Osteopathic Association or Royal College of Physicians and Surgeons of Canada. DPM: Board Certification by the American Board of Podiatric Surgery or the American Board of Podiatric Medicine. DDS/DMD: Board certification by the American Board of Oral and Maxillofacial Surgery. APP: American Association of Nurse Anesthetists, American Academy of Nurse Practitioners, American Nurse Credentialing Center, National Commission on Certified Physician Assistants. Unless waived by the Board, an Applicant who is not board certified upon initial application must be in the process to attain board certification at the time of application and must attain board certification up to five (5) years from the date such Provider becomes a Participating Provider.
SATISFACTION OF NEED	Based on evidence such as experience, patient demographics of present and anticipated CIN Enrollees, the economics of the Provider's practice and quality considerations related to the Utilization Management/Quality Improvement Plan of CIN, satisfaction of current network adequacy, economic, quality and accessibility guidelines of CIN.

CURRICULUM VITAE	Submission of a current CV, with dates.
WORK HISTORY	Record of continuous work history for the past ten years, with explanation for gaps of greater than 90 days.
INITIAL OFFICE REVIEW	Office reviews will be conducted prior to final credentialing of at least all primary care physicians (e.g., family practice, pediatrics and internal medicine) and obstetrics/gynecology.

Continuing Credentialing Requirements for Participating Providers

Eligibility for continued participation by a Participating Provider in CIN will be determined at least every three (3) years. A Participating Provider must submit an Application and continue to meet all of the credentialing requirements. In addition to those requirements, additional data will be considered by the Membership and Standards Committee and the Board in determining the Provider's continued status as a Participating Provider. These data may include, but are not limited to:

- Participation Criteria as developed by the Board from time to time
- Quality Improvement Activities
- Enrollee Satisfaction Surveys
- Enrollee Complaints
- Readmission Rate/1000 Enrollees*
- Out of Network Referrals

(* To the extent that a hospital admission was made by the Provider jointly with another Provider, these requirements will be considered taking into consideration both Provider's decisions.)

Payer Criteria

Although CIN will seek to have Payers accept Participating Providers without having to satisfy further credentialing requirements, Payers may nonetheless impose additional or other criteria for participation in one or more of the panels serving that Payer's Enrollees. In that event, the Committee will work with the Payer and the Participating Providers identified by the Payer or CIN for the particular panel to obtain additional information that may be needed to make a determination of whether the additional or other criteria are met. It may also be the case that a Payer does not impose additional or other criteria, but will not waive one or more of the requirements of CIN, such as board certification, and a Participating Providers may be excluded from participation on a panel because of that fact.

CREDENTIALING POLICIES AND PROCEDURES

The following outline summarizes the credentialing process.

Participating Provider Credentialing Procedure

Once a signed and completed Application has been submitted, the credentialing review process will begin. An incomplete TSCA must be completed within forty-five (45) days of submission, or it will be returned to the Applicant/Reapplicant and the credentialing process will end. The Applicant/Reapplicant has the burden to submit all required information. Submission of false information on the Application may result in the immediate withdrawal of the Application without further processing or consideration, and may thereafter disqualify the Applicant/Reapplicant from CIN membership or reapplication in the future. Submission of false information includes the failure to submit material true information or submission of untrue information. All Applicants/Reapplicants will be notified of their credentialing review decisions within sixty (60) days from the date that a completed TSCA is submitted.

Participating Provider Right to Review Information

An Applicant/Reapplicant has a right to review the information from outside primary sources submitted in support of the Applicant/Reapplicant's application, primary source verification being the process by which credentialing information is verified from the organization that originally conferred or issued the credentialing element to the Provider. The Applicant/Reapplicant will be notified of these rights to review information.

At least sixty (60) days prior to the end of the one hundred eighty (180) day credentialing process period, CIN shall notify the Applicant/Reapplicant of any substantial variance between the information contained in the Application and obtained through primary source verification. Examples of substantial variance include but are not limited to actions on the Applicant/Reapplicant's license to practice medicine in Texas, inconsistencies in the Applicant/Reapplicant's malpractice history, suspension or termination of medical staff membership or clinical privileges or inaccurate board certification or eligibility status.

The Applicant/Reapplicant shall be notified in writing of the specific variances and of the Applicant/ Reapplicant's right to correct erroneous information submitted by another party. The Applicant/Reapplicant may not correct peer review information. CIN shall not be required to reveal the source of the information from other sources.

The Applicant/Reapplicant shall have thirty (30) days to correct any erroneous information. Any corrections must be submitted in writing to CIN along with all supporting documentation necessary to verify the accuracy of the corrected information.

CIN shall include documentation in the Applicant/Reapplicant's file of the notification sent to the Applicant/Reapplicant, and any corrections submitted by the Applicant/Reapplicant.

The Applicant/Reapplicant can request and will be informed as to the status of the credentialing/recredentialing application by having the CIN provide that information in writing.

Upon request the CIN can disclose in writing to the Applicant/Reapplicant information relative to their application status such as:

- In process – meaning the Credentialing Specialist is performing PSV (Primary Source Verification)
- Committee Review – meaning the Credentials Committee is reviewing the Applicant/Reapplication information to make a decision.

Current Licensure Maintenance

Current licensure documentation shall be maintained to meet NCQA, TDI and Payer delegation standards.

Malpractice History Assessment

A complete malpractice history for the previous five (5) years including cases (lawsuits and claims) pending, settled, arbitrated, litigated, mediated and dismissed will be reviewed and considered to assist in the decision to grant or continue Participating Provider status. CIN has not established a specific number of cases or defined a payment amount limit which will automatically disqualify an Applicant/Reapplicant. CIN recognizes that malpractice history may vary among Providers because of many factors. Malpractice case history will be reviewed and considered on an individual-by-individual basis. Factors that may be considered in determining whether a malpractice history is acceptable include, without limitation:

a. Number of cases;
b. Time periods over which cases filed;
c. Nature of the claims made in the cases;
d. Disposition of the cases (including payment amounts and degree of responsibility assessed);
e. Whether insurance coverage has ever been denied;
f. Specialty;
g. Any mitigating factors determined reasonable and appropriate (such as complexity of procedures performed on a certain patient population); and
h. Action taken by other peer review committees related to the incident that is the basis for a case.

The following procedure will be implemented for malpractice cases that have been filed, settled or have had an award in favor of a plaintiff after Participating Provider status has been granted.

RESPONSIBILITY	ACTION
PARTICIPATING PROVIDER	Reports case information
CIN STAFF	Discovers case information if not previously reported.
CIN STAFF	Sends Participating Provider a "Professional Liability Claims" information form for completion.
COMMITTEE, DESIGNATED PERSON OR DELEGATED ENTITY	Determines if immediate remedial action is needed or if the Participating Provider needs to be reviewed by the Committee. May refer the matter to the Best Care/Clinical Integration Committee for input before referral to the Board.
COMMITTEE, DESIGNATED PERSON OR DELEGATED ENTITY	Determines whether the case(s), in light of prior malpractice history, present issues requiring immediate remedial action or recommendation for review and action by the Board.
COMMITTEE, DESIGNATED PERSON OR DELEGATED ENTITY	Notifies Participating Provider in writing within thirty (30) days of decision.

Unrestricted Licensure

For purposes of this Plan, a Provider's license is considered restricted when any action taken with respect to such Provider's license by the applicable licensing board encumbers the ability of the Provider to diagnose, manage the treatment of, and/or treat patients.

Provider Practicing Without Board Certification

Participating Providers are to be board certified or be in the process of obtaining board certification in the specialty for which the Provider requests Participating Provider status. Unless waived by the Board, if not board certified at the time of initial application, the Participating Provider must become board certified within three (3) years from his/her initial date of participation. If board certification is not obtained timely, the Participating Provider may request a waiver of the certification requirement. Unless otherwise determined by the Board, a Provider who has been awarded board certification, but who received such status by reason of a "grandfather clause" exception to the normal requirement of completion of a training program in the particular specialty, will not be considered to meet the board certification requirement. Exceptions to the requirement of board certification may be recommended by the Committee and granted by the Board. The consideration of a waiver will be based on the facts of each particular case, and may take into account the following factors:

a. The need for a Provider in a particular specialty and/or in a geographic area in order to address the needs of present and anticipated Enrollees.

b. An explanation by the Provider on why the Provider has not taken the necessary steps to become board certified or what steps the Provider has taken and why they have not resulted in board certification.

c. How long the Provider has been in practice in the community and the nature of that practice (including whether the Provider practices or has practiced as a part of a group).

d. The professional reputation of the Provider in the community, insofar as the Committee is able to reasonably determine that reputation.

e. If the Provider provides call for Participating Providers.

f. The continuing medical education completed by the Provider over the past five (5) years.

g. The hospitals and other health care facilities at which the Provider has medical staff membership, the nature of the clinical privileges awarded and the length of time the Provider has held such membership and privileges.

h. Whether the Provider satisfies the other credentialing requirements, particularly malpractice history.

If the waiver is not granted the Participating Provider status will be denied or terminated. In such an event the Participating Provider will not be entitled to a hearing.

Notwithstanding the foregoing or anything else contained in this Plan, and regardless of the reason for the Provider's lack of board certification, providers approved for participation in CIN who lack board certification in their primary specialty in which they practice shall complete twenty-four (24) formal Category I hours of continuing medical education (CME) in their primary specialty in which they practice each year. Evidence of completion of such CME shall be due at recredentialing and failure to meet such requirement or to timely submit evidence of meeting such requirement shall be grounds for immediate removal from CIN without hearing or appeal.

Ongoing Monitoring

Data will be collected for inpatient and outpatient care provided to Enrollees and sorted by Participating Provider. Data will be analyzed within the local peer group so that care provided by Participating Providers in the same market area will be compared and local norms established. Data will be analyzed in accordance with delineation of medical staff membership and clinical privileges and adjusted for severity and age, so that an unusual number of Enrollees with complex health problems do not skew the data (i.e., adverse selection impact).

The applicable data will be provided to the Participating Provider and will be evaluated by the Best Care/Clinical Integration Committee, with recommendations on review actions, including recredentialing, to be made to the Committee and to the Board. Failure to meet these standards over a reasonable period of time, as determined by the Board in each case, may result in loss of Participating Provider status.

Auditing Credentialing Processes

Refer to the Confidentiality of Protected Information Policy which outlines the auditing processes for credentialing practices relative to modifications and deletions within the electronic database.

ACTION REVIEW POLICY FOR PARTICIPATING PROVIDERS

CIN recognizes that in certain situations, including when required by law, a Participating Provider should have the opportunity for a hearing before a body of his/her peers before an action taken or proposed to be taken that would adversely affect his/her status as a Participating Provider becomes final. This Section of the Plan contains the provisions that govern such a situation. Additionally, CIN will follow Midland Health Medical Staff Code of Conduct for Medical Staff and Practitioners for actions against practitioners who's conduct adversely affect the delivery of quality and cost-efficiency of care provided.

Process for Review Action

Typically, review of negative performance of Participating Providers with respect to the delivery of quality and cost-effective care will follow the following process:

a. Participating Providers will be required as part of the CIN Participation Criteria to review their data a certain specific number of times per year.

b. A Participating Provider whose performance fails to meet the standards established by CIN from time to time will initially be provided with a notice and a reasonable period within which to meet such performance standards. ("**First Cure Period**").

c. Failure by the Participating Provider to meet the applicable standards within the First Cure Period will result in individual counseling by a CIN medical director and the provision of a second cure period within which to meet the applicable standards ("**Second Cure Period**").

d. Failure to meet the applicable standards within the Second Cure Period may, unless otherwise determined by the Board, result in exclusion from CIN reward distributions and a final cure period will be provided within which to meet the applicable standards ("**Final Cure Period**").

e. Failure to meet the applicable standards within the Final Cure Period may result in loss of Participating Provider status.

Right to Hearing

a. Grounds for a Hearing

When a Participating Provider receives notice that he/she has failed to meet CIN standards with respect to the delivery of quality and cost-effective care during the Final Cure Period, the Participating Provider is entitled to request a hearing before loss of status as a Participating Provider. A decision by the Board related to: (i) a Provider's application for Participating Provider status or (ii) a Provider's status as a Participating Provider for reasons other than the delivery of quality and cost-effective care, including without limitation, failure to meet other Participation Criteria established by the Board from time to time shall not entitle a Provider to a hearing. However, if, in the opinion of legal counsel for CIN, an appeal or other form of review must be provided to a Provider under Texas or federal law in a specific situation, an appeal or review will be made available and conducted as required by such law (or by regulation or rule implementing such law).

b. Request for a Hearing

A Participating Provider shall have thirty (30) days following receipt of notice from the Committee of pending termination of Participating Provider status to make a written request for a hearing. The request shall be delivered to the Director of Performance Management either in person, by commercial courier service, or by certified mail return receipt requested directed to the principal office of CIN. Delivery shall be effective upon receipt if delivered in person or by courier and on the second day following the date of deposit if sent by certified mail, return receipt requested.

c. Waiver by Failure to Request a Hearing

A Participating Provider who fails to request a hearing within the time and in the manner specified waives any right to a hearing and any review to which he/she might otherwise have been entitled.

Hearing Prerequisites

a. Notice of Time and Place for Hearing

Upon receipt of a timely request for a hearing, the Director of Performance Management will notify the Board and the Committee of the request. The Committee shall, within a reasonable time, appoint a Hearing Panel of Participating Providers and establish a mutually convenient time, place and date of the hearing. The Committee shall send the Participating Provider notice of the time, place, and date of the hearing; a list of persons serving on the Hearing Committee; a summary of the Participating Provider's rights in the hearing; and a list of currently known witnesses, if any, expected to testify at the hearing on behalf of the Committee. The notice sent to the Participating Provider shall require the Participating Provider to submit to the Hearing Panel, within thirty (30) days after the date of the notice of hearing date, a list of currently known witnesses, if any, expected to testify at the hearing on behalf of the Participating Provider; a

statement of any objections to any member of the Hearing Panel based on direct economic competition with the Participating Provider; and a statement of facts of the basis for any such objection. The Committee may replace members of the Hearing Panel as it deems appropriate. Unless extended by the Hearing Panel, the date of the hearing shall not be more than sixty (60) days from the date of receipt of the Participating Provider's request for a hearing.

b. Appointment and Composition of Hearing Panel

When a Participating Provider timely and properly requests a hearing, the Committee shall, in its sole discretion, appoint the members of a Hearing Panel to conduct the hearing. No member of the Hearing Panel may be in direct economic competition with the Participating Provider involved, nor may any member actively have participated in the consideration of the matters leading up to the action being reviewed. No member of the Committee may be a member of a Hearing Panel. The Hearing Panel shall be composed of at least three (3) Participating Providers. The majority of the Hearing Panel will be peers of the affected provider in the same or similar specialty as the Participating Provider who requested the hearing.

Hearing Procedure

a. Personal Presence

The personal presence of the Participating Provider who requested the hearing is required. A Participating Provider who fails without good cause to appear and proceed at the hearing shall have waived his/her rights to a hearing and the matter shall be deemed closed and the action taken final.

b. Hearing Officer

The Hearing Panel shall appoint a hearing officer to preside at the hearing. The hearing officer will be an independent third party, who may be a Provider, who is competent to preside at the hearing. The hearing officer shall:

i. act to maintain decorum;

ii. assure that all participants in the hearing have a reasonable opportunity to present relevant oral and written evidence;

iii. determine the order of or procedure for presenting evidence and argument;

iv. have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence; and

v. Establish a process for supplementation of witness designations and exchange of exhibits prior to the hearing.

If the hearing officer determines that either side in the hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as is warranted by the circumstances. Since the hearing officer is not a member of the Hearing Committee, he/she shall not vote on the decision but may participate in the deliberations if requested by the Hearing Committee.

c. Representation

Either party may consult with legal counsel and be accompanied by legal counsel or other advisor at the hearing. However, the role of legal counsel shall be limited to a consultative or advisory role. For example, legal counsel for either party shall not present the case or examine witnesses. The Participating Provider may be assisted in the presentation of his/her case by another Provider. The Committee's presentation will be made by a Provider member of the Committee. If the Participating Provider elects not to be accompanied by legal counsel at the hearing, the Committee representative shall not be accompanied by legal counsel.

d. Rights of Parties

During the hearing each party shall have the following rights:

i. to call and examine witnesses;

ii. to introduce exhibits and present any evidence determined to be relevant by the hearing officer;

iii. to cross-examine any witness on any matter relevant to the issues;

iv. to impeach any witness;

v. to rebut any evidence; and

vi. to submit a written statement at the close of the hearing.

If the Participating Provider who requested the hearing does not testify in his/her own behalf, he/she may nonetheless be called and examined as if under cross-examination.

e. Record of the Hearing

A record shall be made of the hearing proceedings. The Hearing Panel shall select the method to be used for making the record, such as electronic tape recording or court reporter. The cost of the court reporter, if any, shall be borne by CIN, but the cost of the transcript, if any, shall be borne by the party requesting it.

f. Burden of Proof and Basis of Decision

At the hearing the Committee shall proceed first with the evidence; however, the Committee shall not have any burden of proof regarding the action or proposed recommendation. At the conclusion of the Committee's presentation the Participating Provider shall proceed with his/her presentation.

The burden of proof shall rest solely on the Participating Provider to prove by a standard of "clear and convincing" evidence (as routinely defined in law) that the adverse action or recommendation was either (1) arbitrary or capricious, or (2) not supported by substantial evidence. Arbitrary and capricious means the absence of any rational connection between the known facts and the recommendation made or adverse action taken. Not supported by substantial evidence means that no reasonable person could conclude that there was sufficient support for the recommendation or action based on the facts.

The Hearing Panel shall recommend in favor of the Committee's recommendation or action unless the Participating Provider has carried the burden of proof as to each one of the Participating Provider's contentions.

g. Procedure and Evidence

The hearing need not be conducted strictly according to the judicial rules of evidence and procedure. Regardless of the admissibility of the evidence in a court of law, any relevant evidence, including hearsay, shall be admitted if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The Hearing Panel may question the witnesses and call additional witnesses if it deems such action appropriate. At its discretion, the Hearing Panel may request or permit both sides to file written statements within a specified time period following the close of the hearing.

h. Recess and Adjournment

The Hearing Committee may recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. Then, at a convenient time, the Hearing Committee shall deliberate outside the presence of the parties. Upon conclusion of these deliberations, the hearing shall be declared finally closed.

i. Decision of the Hearing Committee

Within thirty (30) days after the conclusion of the oral and written evidence, the Hearing Panel shall render a decision, which shall be accompanied by a written report and delivered to the Committee. A copy of the decision and report shall be forwarded promptly to the Participating Provider by the Director of Performance Management. The Hearing Committee's decision must be a recommendation to affirm, to reverse or to modify the recommendation of the Committee. The report shall contain a concise statement of the decision and the reasons in support of the decision. The report to the Committee shall also contain the exhibits presented at the hearing and any written statements of the parties submitted to the Hearing Panel.

j. Decision of the Board

Within thirty (30) days of receiving it, the Committee shall review the Hearing Panel's report and decision, and within ten (10) days deliver its recommendation to the Board. The recommendation of the Committee will be accompanied by the materials delivered to the Committee by the Hearing Panel. At its next regularly scheduled meeting or, in its sole discretion, at a special called meeting, the Board shall consider the decision of the Hearing Panel and the recommendation of the Committee and render a decision which may affirm, modify, remand with instructions or reverse the recommendation of the Committee. The Board then shall notify the Participating Provider in writing within ten (10) days of its decision. The decision of the Board is final.

k. Right to One Hearing; Reapplication

No Participating Provider shall be entitled to more than one hearing on any matter that is the subject of a hearing. Following termination of a Provider's status as a Participating Provider with CIN, the Provider shall not be permitted to re-apply for participation for a period of one (1) year.

Extension of Time Periods

It is the intent of the Committee and the Board that there be adherence to the time periods set forth with regard to the hearing procedure. However, on occasion there may be reasons to extend a time period in order to address an unusual need or problem of a party. If the Participating Provider feels he/she needs to

have a time period extended, he/she must make a written request for extension to the Committee. The request is to be directed to the Director of Performance Management. It must be made as soon as possible when the situation arises that is the cause for the request. The written request must set forth in detail the reasons behind the requested extension and, in particular, how the time period originally set would now place the Participating Provider in a significant hardship. The Committee (or its Chair if there is insufficient time to meet or poll all members of the Committee) will consider the request as soon as possible, taking into account the expressed hardships to the Participating Provider and any significant hardships that may be anticipated to a party from granting of the extension, and notify the Participating Provider of its decision in writing. The Committee and the Hearing Panel may also seek an extension under the same standards. A request for an extension of time from the Committee or Hearing Panel will be considered and ruled upon by the Board. The Board may extend any time period applicable to it on its own motion when it believes the extension is appropriate to the facts.

Reporting Adverse Actions Under the HCQIA

The HCQIA may require CIN to report certain actions taken with respect to Applicants/Reapplicants to the applicable licensing board for a further report to the NPDB. Loss of Participating Provider status under this Plan may or may not constitute an adverse action reportable under the HCQIA. Whenever an action taken is reportable under the HCQIA or other federal state laws, rules or regulations, or by virtue of a Payer contract the Entity Representative, with the assistance of legal counsel, will prepare the appropriate forms and be responsible for ensuring compliance with the requirements of the HCQIA.

REMEDIAL ACTION

Criteria for Initiation

Any person, whether outside of CIN or connected with CIN, may provide information to the officers, members of the Board, the Best Care/Clinical Integration Committee or the Committee about the conduct, performance, or competence of a Participating Provider. When information indicates a Participating Provider may have exhibited acts, demeanor, or conduct reasonably likely to: (a) be detrimental to patient safety or to the delivery of quality patient care to any Enrollee; (b) be unethical; (c) be contrary to the rules or regulations of CIN or Participation Criteria applicable to Participating Providers; (d) be below applicable professional standards; (e) fail to satisfy any of the credentialing requirements for Participating Providers; or (f) indicate impairment from the use of alcohol or drugs, the Board or the Committee may request an investigation or action against such Participating Provider.

Initiation

A request for an investigation must be in writing, submitted to the Committee, and supported by reference to specific activities, conduct, or other facts alleged. When circumstances require, such request may be made orally, provided that it is confirmed in writing as soon as possible thereafter. If the Committee initiates the request, it shall make an appropriate written record of the reasons.

Investigation

The Committee shall evaluate the request for investigation to determine if an investigation is warranted or may direct one or more of its members to conduct an initial review of such request on its behalf. If further action on the request is deemed warranted, the Committee shall direct that an investigation be undertaken. The Committee may conduct the investigation itself, or may appoint an *ad hoc* committee of at least three (3) Participating Providers, and other person(s) as it determines in its sole discretion to be necessary. The Committee in its discretion may appoint Participating Providers who are not members of the Committee as

temporary members of the Committee along with any other person(s) as it determines in its sole discretion may be necessary. If the investigation is delegated to an *ad hoc* committee, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Committee as soon as possible. The report may include recommendations for appropriate remedial action. The Participating Provider who is the subject of the investigation shall be notified by the Committee or its designee that an investigation is being conducted and the nature of the investigation and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate, which may (but it is not required) include an informal meeting with the Participating Provider under investigation. The body investigating the matter may, but is not obligated to, conduct interviews with persons involved. In no event shall such investigation be considered a "hearing" as that term is used in this Plan, nor shall the procedural rules with respect to a hearing under this Plan apply. Despite the status of any investigation, at all times the Committee and the Board shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

Committee Action

As soon as possible after the conclusion of the investigation, the Committee shall make its recommendations, which may include, without limitation:

a. determining no remedial action be taken and, if the Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Participating Provider's file;

b. deferring action for a reasonable time where circumstances warrant;

c. issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude other appropriate committees or the Board from issuing informal written or oral warnings outside of this mechanism for remedial action. In the event such letters are issued, the affected Participating Provider may make a written response which shall be placed in the Participating Provider's file;

d. recommending the imposition of terms of probation or special limitation upon continued status as a Participating Provider, including, without limitation, requirements for mandatory consultation or monitoring;

e. recommending suspension, probation or revocation of Participating Provider status; and

f. taking other actions deemed appropriate under the circumstances.

Subsequent Action

If remedial action is recommended by the Committee, that recommendation shall be transmitted to the Board. So long as the recommendation is supported by substantial evidence as defined in this Plan, the recommendation of the Committee shall be adopted by the Board as final action, unless the Participating Provider is entitled to and requests a hearing, in which case the final decision shall be determined as set forth in this Plan.

Initiation by Board

If the Committee fails to investigate or take remedial action, the Board may initiate investigation or remedial action in accordance with this Plan. If the Committee fails to take action in response to the Board's direction, the Board may initiate remedial action on its own in the place of the Committee, and this remedial action shall comply with the process set forth in this Plan.

Mental or Physical Impairment

Whenever a Participating Provider's actions, demeanor, or conduct, or information provided by any person, indicates that a Participating Provider's current mental or physical status, including suspected impairment from alcohol or drugs, is detrimental to patient safety or to the delivery of quality patient care to Enrollees, such Participating Provider may be asked at any time by the Committee or the Board to provide evidence of current health status through a physical or mental examination. Such physical or mental examination shall be performed at the expense of CIN, shall be provided by a practitioner selected by the Board and may include blood and/or urine drug testing for those individuals suspected of impairment from alcohol or drugs. Pending the results of any physical or mental examination or if the results of such physical or mental examination indicate impairment, any action may be taken as may be warranted by the circumstances, and in keeping with this Plan.

Automatic Suspension or Limitation

In the following instances, the Provider's status as a Participating Provider may be suspended or limited as described below:

a. Licensure

i. Revocation and Suspension: Whenever a Participating Provider's license or other legal credential authorizing and necessary to practice in Texas is revoked or suspended, Participating Provider status shall be automatically terminated as of the date such action becomes effective. In such instance there shall be no right to a hearing under this Plan.

ii. Restriction: Whenever a Participating Provider's license or other credentials authorizing and necessary to practice in Texas is limited or restricted by the applicable licensing or certifying authority, such Participating Provider's status as a Participating Provider shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term. . In such instance there shall be no right to a hearing under this Plan.

iii. Probation: Whenever a Participating Provider is placed on probation by the applicable licensing or certifying authority, status as a Participating Provider shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term. In such instance there shall be no right to a hearing under this Plan.

Whenever a Participating Provider becomes aware of an action taken against him/her as specified in paragraphs (i), (ii), and (iii) above, he/she is required to notify CIN of such facts in accordance with the terms of the CIN Application and Participation Agreement. The Committee shall commence a review of the facts involved within fourteen (14) days of receipt of notice.

b. Professional Liability Insurance

Failure to maintain required professional liability insurance shall be grounds for automatic suspension of a Provider's Participating Provider status. If within fourteen (14) days after written notice of the failure, the Participating Provider does not provide evidence of required professional liability insurance coverage, the Provider's status as Participating Provider shall be automatically terminated. In such instance there shall be no right to a hearing under this Plan.

ONGOING MONITORING OF SANCTIONS AND COMPLAINTS

The Committee will monitor and investigate any Medicare/Medicaid sanctions, Medicare Opt-Out list, state sanctions, or limitations on licensure, Enrollee or Payer complaints, identified adverse events, and failure to meet applicable standards related to quality and cost-effectiveness of care rendered, and take appropriate action. CIN staff will review the information monthly, prior to the Committee meeting.

CONTRACTS WITH ORGANIZATIONAL PROVIDERS

In the event that the CIN contracts with any other hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, or behavioral health providers (including, without limitation, behavioral healthcare facilities providing mental health or substance abuse services in inpatient settings, residential settings, and ambulatory settings) (collectively, "**Institutional Providers**") to which CIN members are directed for services, then the Committee shall assess and confirm prior to the contract being entered into and at least once every thirty-six (36) months thereafter that (a) such Institutional Provider is in good standing with state and federal regulatory bodies, and (b) such Institutional Provider has been reviewed and approved by an accrediting body. In the event that the Institutional Provider is not accredited, then a duly authorized representative of the Committee shall conduct an onsite quality assessment of such Institutional Provider prior to the contract being entered into and at least once every thirty-six (36) months thereafter.