

## **MHMD NETWORK PARTICIPATION CRITERIA AND POLICIES**

Approved by the MHMD Credentials Committee September 7, 2016

**I. POLICY OBJECTIVES** - These Network Participation Criteria and Policies establish guidelines for granting qualified Network Providers [Doctors of Medicine, Doctors of Osteopathy, Dentists, Podiatrists, and Allied Health Professionals] status as MHMD Provider Members. The objectives are as follows:

- A) To set forth MHMD membership eligibility criteria for Network Providers.
- B) To enable MHMD to evaluate current and applicant Network Providers regarding education and medical training, board certification status, medical staff and health system affiliations, regulatory compliance, professional liability claims coverage and history, and other information determined by the Board of Directors of MHMD to be relevant to ensuring membership of the highest quality.
- C) To develop a balanced network which satisfies a geographic and specialty need of MHMD as determined by the Board.
- D) To structure programs of utilization review, quality assurance and other medical peer review for Network Providers.

**II. NETWORK PARTICIPATION CRITERIA** - Network Provider Applicants and Network Providers will be reviewed and considered for initial membership and membership renewal on a provider-by-provider basis according to the provider's qualifications, evidence of clinical competency, practice history in the community, group affiliation with other providers, network geographic and specialty need. In order to be considered for and to maintain membership in MHMD, Provider Applicants and Network Providers must meet the following minimum requirements as determined by the Board:

**A. MHMD-Participating Facility Affiliation Requirements:** Network Provider Applicants and Network Providers must either:

- 1. Acquire and maintain clinical privileges (privileges to admit, enter orders, perform consultations or procedures, and/or enter documentation into the medical record) at an MHMD-participating facility, OR
- 2. For providers primarily practicing in an ambulatory setting and rarely or never in an inpatient setting, attest to that fact and designate a Network Provider or Network Provider group to provide care to patients of Provider, who are covered under a Network Plan, at an MHMD-participating facility when facility-based care is required and an MHMD-participating facility is in network for the contracted health plan of the patient.

## B. Clinical Competency Requirements

- a. Initial Membership: At the time of initial appointment to membership in MHMD, MHMD Physician Member applicants must either:
- i. be board certified in their practice specialty by the American Board of Medical Specialties, the American Board of Podiatric Surgery, the American Board of Maxillofacial Surgery, or the American Osteopathic Association, or
  - ii. be certified by a non-United States Board and provide documentation of equivalency between the Foreign and American Specialty Boards, or
  - iii. be within the grace period following completion of training as determined by the corresponding specialty board and be otherwise board eligible, or
  - iv. for physician applicants joining MHMD as part of a group already in MHMD or being acquired by Memorial Hermann, be demonstrably engaged in obtaining board certification as described below and become board certified within five years.

MHMD Allied Health Professional applicants must meet these same certification requirements with the certifying agency as approved by the MHMD Board for each professional category (e.g., Physician Assistant, Nurse Practitioner, LPC, etc.).

- b. Maintenance of Membership: MHMD holds its Provider Members accountable to maintaining clinical competency and practicing medicine with a high level of clinical quality, safety and efficiency. As such:
1. Board certified physician members must also meet MHMD Board requirements relating to practice quality, efficiency, access and satisfaction measures. Failure to do so will disqualify the physician from ongoing MHMD membership.
  2. With the exceptions described in paragraph II.C.b.4 below, MHMD Physician Members who were not board certified at the time of initial MHMD membership must achieve board certification within the time period as applicable above. Failure to do so will disqualify the Physician Member from ongoing MHMD membership.
  3. MHMD Physician Members whose prior board certification has lapsed may retain their MHMD membership for a period of time not to exceed two years or two additional recertification opportunities, whichever comes last, provided that they:
    - a. Provide documentation of participation in the corresponding Maintenance of Certification program and of intent to regain board certification at the earliest time available from the Specialty Board, and continue to meet MHMD Board requirements relating to practice quality, efficiency, access and satisfaction measures, or

- b. Have been members of MHMD for at least twenty consecutive years, choose not to remain Board Certified, and demonstrate to the Board's satisfaction competency in their practice specialty and performance in quality, efficiency, satisfaction and access consistent with MHMD's expectations of its board certified members.
  - c. Failure to meet the requirements referenced in 3a and 3b immediately above will disqualify the physician for ongoing MHMD membership.
4. Never-board certified MHMD Physician Members meeting the following previously established "grandfathered" criteria may retain MHMD membership:
- a. Physicians who completed training prior to 1978 and demonstrate to the Board's satisfaction competency in their practice specialty and performance in quality, efficiency, satisfaction and access consistent with MHMD's expectations of its board certified members.
  - b. Physicians who became MHMD members prior to July 1999 and have remained MHMD continuously since then and who demonstrate to the Board's satisfaction competency in their practice specialty and performance in quality, efficiency, satisfaction and access consistent with MHMD's expectations of its board certified members.
  - c. Failure to so demonstrate to the Board's satisfaction competency in their practice specialty and performance in quality, efficiency, satisfaction and access consistent with MHMD's expectations of its board certified members will disqualify the physician for ongoing MHMD membership.
5. MHMD Allied Health Professional members must meet these same certification maintenance requirements with the certifying agency as approved by the MHMD Board for each professional category (e.g., Physician Assistant, Nurse Practitioner, LPC, etc.).

### C. Membership Level Requirements

- a. **Clinical Integration Requirements:** Providers participating in the Memorial Hermann Accountable Care Organization (MHACO) through the MHMD Clinical Integration (CI) program must execute the MHMD Clinical Integration Network Provider Agreement (CI NPA) and thus comply with the participation requirements of the MHMD Clinical Integration (CI) Program as set forth by the Board of Directors, including entering into all CI and MHACO payer contracts including risk-based contracts, compliance with and reporting of quality and claims data, and meeting attendance and educational requirements. Additionally, upon joining MHMD and with each membership renewal, they will sign a statement of intent to comply with the components of the MHMD – Physician Compact.

- i. **Advanced Practice Participants:** Providers participating in MHMD at either the Advanced Primary Care Provider (APCP) or the Advanced Pediatric Provider (APP) level will additionally execute participation addenda to the CI NPA (or a separate NPA) as determined by the MHMD Board of Directors.
    - ii. **Memorial Hermann Physician Partners (MHPP):** Providers participating in MHMD at the Memorial Hermann Physician Partner (MHPP) level will additionally execute participation addenda to the CI NPA (or a separate NPA) as determined by the MHMD Board of Directors.
  - b. **Clinical Integration Affiliates Requirements:** CI Affiliate providers MHMD Network Providers must execute the MHMD Clinical Integration Affiliate Network Provider Agreement (CIa NPA) or a separate NPA and thus comply with the participation requirements of the MHMD CI Affiliates Program as set forth by the Board of Directors, including entering into selected CI payer and MHACO contracts, and meeting attendance and educational requirements. Additionally, upon joining MHMD and with each membership renewal, they will sign a statement of intent to comply with the components of the MHMD – Physician Compact.
  - c. **Messenger Model Requirements:** MHMD Messenger Model (MM) Provider Members must execute the MHMD Messenger Model Network Provider Agreement (MM NPA). Additionally, upon joining MHMD and with each membership renewal, they will sign a statement of intent to comply with the components of the MHMD – Physician Compact. They are not eligible for inclusion in MHMD CI and ACO contracts.
- D. **Professional ethics and standards** - MHMD Network Providers must be able to document to the satisfaction of the Board his/her background, experience, training, competency, physical and mental health, and adherence to the ethics of his/her profession with sufficient adequacy to enable the Board to determine that patients treated by him/her will be given appropriate and necessary health care in accordance with the MHMD objectives of quality, operational and economic efficiency.

Each MHMD Network Provider shall have an absence of professional disciplinary actions and shall strictly abide by the ethics and standards of his/her profession. Network Providers must be licensed to practice medicine, dentistry or podiatry by the applicable Texas Board without sanction, restriction, probation or other limitation. Network Providers must possess an unrestricted current registration with the Drug Enforcement Administration.

Failure to meet these requirements or any adverse action taken against any MHMD Network Provider by any other health care system, HMO, PPO, professional society, state or federal licensing agency or other health care entity will initiate a review by the MHMD Credentials Committee which could result in termination of MHMD membership.

**E. Professional Liability** - Provider Applicants and Network Providers must:

1. Maintain professional liability insurance (\$200,000/\$600,000 minimum for physicians, \$100,000/\$300,000 for Allied Health Practitioners).
2. Have an absence of a history of denial or cancellation of professional liability insurance
3. Have a satisfactory malpractice claims and/or settlement history as determined by the Board
4. Provide requested information on professional liability claims history and experience, including the name of carriers.

**F. Practice Location** - Provider Applicants and Network Providers must document the location of patient accessible practice locations within the Network service area and the names and addresses of other Providers with whom coverage arrangements exist so as to assure that acute care services are available 24 hours per day, seven days per week.

**G. References** - MHMD at its discretion may request a Peer Reference from an active Network Provider who is not a practicing partner of the applicant.

**H. Policy Compliance** - Network Providers must satisfy the Board of their ability and willingness to comply with the components of the MHMD By-laws, the MHMD Network Participation Criteria and Policies, the applicable MHMD Network Participation Agreement, and the Compact between MHMD and its members. Network Providers must work cooperatively and in a supportive manner with patients, physicians, and other healthcare professionals in order to perform the functions, duties and obligations required to optimize provision of care of the highest quality.

**I. Conviction/Indictment** - Provider Applicants and Network Providers may not have been convicted of a misdemeanor involving moral turpitude, and must not have at any time a criminal conviction or indictment. (A “conviction” includes a plea or verdict of guilty or a conviction following a plea of nolo contendere.)

**III. APPLICATION PROCESS** - Upon receipt of a completed application on the prescribed form, the information in the application shall be verified, using National Committee Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), Texas Department of Insurance (TDI) and MHMD processing criteria. Applicants for renewal of membership or for initial membership must also complete and submit a Conflict of Interest Disclosure form.

A. Incomplete Application - MHMD shall notify the Provider Applicant/Network Provider if his/her application is not complete or if verification cannot be obtained and shall have no obligation to review or consider the application until the application and its verification have been completed. The burden of supplying or obtaining Provider Applicant/Network Provider requested information should rest with the Provider Applicant/Network Provider. The Provider Applicant/Network Provider must supply requested information to MHMD within 10 business days of notification. When the Provider Applicant/Network Provider fails to provide the requested

information within said ten (10) business day period, the Provider Applicant/Network Provider will be deemed to have withdrawn his/her initial application or application for membership renewal.

- B. Allied Health Professionals - Provider Applicants/Network Provider who employ Allied Health Professionals such as, Physician Assistants, Advanced Practice Nurses, or Registered Nurse First Assistants, must provide the Allied Health Professionals, name, professional designation and state license number (Requested in the practice information section of the Texas Standardize Credentialing Application) and sign an addendum which states the following: *“If you employ Physician Assistants, Advanced Practice Nurses, or Registered Nurse First Assistants, do you have written policies, which are implemented and enforced and describe the duties of all such providers in accordance with the statutory requirements for licensure and supervision as appropriate?”* Options are “Yes” or “No”.

C. Provider Rights and Notification: Provider Applicants and Network Providers have will be notified of the following:

1. Application Status - Provider Applicants/Network Providers upon request shall be informed of the status of their credentialing and/or re-credentialing application.
2. Right to Review Information – Provider Applicants/Network Providers who have applied or reapplied to MHMD have the right to review information submitted in support of their membership or membership renewal application.
3. Provider Notification of Differing Information -Provider Applicants/Network Providers must be notified when information obtained during the credentialing process differs from self-reported information.

Note: The Provider Applicant/Network Provider may only review information obtained from any outside primary source such as; malpractice insurance carriers, state licensing boards or specialty boards. The Provider Applicant/Network Provider may not review references or recommendations or other information that is peer review protected.

E. **Individual Providers and Group Tax ID Numbers** MHMD is an Independent Physician Association (IPA) whose members are credentialed and approved as individual providers by the MHMD Board. However, once approved by the Board, Network Providers participate in the MHMD contracted plans based on their tax identification numbers. As such, to participate in these plans, each Provider using a group tax ID number must meet the same MHMD membership requirements as all other Network Providers in the same group using the group tax ID number.

E. **Medical Director Review**- The completed application shall then be forwarded to the Credentialing Medical Director for review and recommendation to the MHMD Credentials Committee. The Credentials Committee will review the application and shall make a recommendation to either approve, to defer a decision pending receipt of additional information or forward the application to the Board for additional review. Any recommendation to reject the application shall be accompanied by a statement of the reasons, and forwarded to the Board for further action in accordance with Section VII.

**F. Denial of Application** - Denial of membership may be based on criteria related to the prompt, courteous, quality and operationally and economically efficient delivery of patient care, to professional ability, judgment and conduct, to the geographic and specialty needs of MHMD, the community or the patients served, or other factors as determined by MHMD. Any Provider Applicant/Network Provider who fails to document to the Board's satisfaction compliance with the MHMD membership criteria and qualifications shall have his/her application denied.

1. Any misrepresentation, misstatement or omission in the initial or renewal application or any subsequent information provided for or during membership will constitute grounds for denial of the application or for termination of MHMD membership.
2. Providers shall not be denied membership on the basis of gender, age, race, creed, color, ethnic/national origin, sexual orientation, types of procedures or types of patients the Provider Applicant specializes in or any other basis prohibited by law.
3. MHMD will not discriminate in the selection or retention of Network Providers who serve high-risk populations or specialize in the treatment of costly conditions.
4. The Provider Applicant/Network Provider will be notified via mail within 10 business days of the Board's decision.

**IV. INITIAL MEMBERSHIP** – After successfully completing the initial credentialing process, the Provider Applicant will be offered a membership in MHMD. The Provider Applicant will be notified via mail within 10 business days of the Board's decision and will be provided with a copy of the MHMD Bylaws, the Network Participation Criteria and Policies, the appropriate Network Participation Agreement, and the MHMD-Physician Compact. The Network Participation Agreement (NPA) and the Compact Compliance Statements must be signed and returned to MHMD within twenty-one days after receipt of the NPA in order for the Provider Applicant to be considered a Network Provider. It is the responsibility of the Network Provider to familiarize himself/herself with the contents of the Bylaws, the Network Participation Criteria and Policies and NPA.

**V. MEMBERSHIP RENEWAL** - Prior to completion of the Initial membership, the Network Provider shall be required to seek renewal of his/her membership in MHMD. The membership renewal shall be conducted in alignment with the Memorial Hermann single reappointment date for all its organizations and facilities.

- A. Renewal of membership in MHMD shall be required at intervals not exceeding three years, and must conform to Memorial Hermann staff appointment / reappointment policies.
- B. The Network Provider's failure to renew MHMD membership prior to term expiration will be deemed to be a voluntary relinquishment of MHMD membership and forfeiture of Contracted Plan participation.
- C. Only those Network Providers who provide information regarding or otherwise document compliance with the following shall be eligible for renewal of membership:

1. Executed Network Participation Agreement
2. Attest to current physical and mental health status
3. Provide the name of each hospital, health care facility or practice setting where the Network Provider provides or provided patient services during the preceding membership period
4. Provide the Network Provider's level of staff membership (active, courtesy, provisional, consulting, etc.) and percentage or usage at each hospital and healthcare facility he/she provides patient services
5. Authorize MHMD to obtain requested information from each hospital, healthcare facility, medical society, professional medical organization, professional liability insurance carrier, and/or other individual or entity
6. Disclose any sanctions, reprimands, investigations, complaints, or proceedings, of any kind which have been imposed or instigated by any hospital, health care facility, professional health care organization, professional society or licensing authority
7. Current malpractice liability coverage
8. Provide a complete medical narrative regarding each professional liability insurance claim, litigation, judgment, or settlement since the Network Provider's last credentialing or re-credentialing
9. Demonstrated a satisfactory attitude toward his/her patients, MHMD, Plans, and Plan members, and the staff(s) of the Plan Hospital(s)
10. Demonstrated compliance with all applicable MHMD Bylaws, the MHMD – Physician Compact, the Network Participation Agreement, the Network Participation Criteria and Policies, and all other policies and rules promulgated by the Board

NOTE: Requests for renewal of membership shall be processed in the same manner as initial applications, or as may otherwise be required by the Board. In addition, the Network Provider's patterns of care including utilization, procedures performed in the Plan Hospitals as well as in the office, as demonstrated in the findings of the utilization review, quality assurance and other medical peer review activities, will be reviewed by the Board in connection with the renewal process.

**VI. ACCEPTANCE OF MEMBERSHIP** - In accepting membership each Network Provider shall be required to comply with the MHMD Bylaws, the MHMD-Physician Compact, Network Participation Criteria and Policies and the Network Participation Agreement. It is the responsibility of the Network Provider to familiarize himself/herself with the contents of the Bylaws, and the Network Participation Criteria and Policies and Network Participation Agreement.

- A. Notification - Network Provider agrees to notify the Board within five (5) business days of any occurrence or change which may affect or relate to his/her compliance with the Network Participation Criteria and Policies including but not limited to; denials, revocations, non-renewals, restrictions, suspensions, imposition of probation, sanctions, reprimands, investigations, disciplinary action, fines or penalties,



complaints or proceedings of any kind that have been threatened or imposed, and/or any change, whether voluntary or involuntary, to licensure membership and/or clinical privileges with regards to:

1. Professional medical, dental or podiatric license in Texas or any other state;
2. DEA, DPS, or any other narcotic license or certificate;
3. Hospital, academic institution and/or other healthcare organization staff membership, appointment or privileges;
4. Medicare, Medicaid or other governmental program participation;
5. Membership or fellowship in any professional medical society, medical organization, board organization, or peer review organization; or
6. Participation in any HMO, PPO, or prepaid health plan.

- B. Directories -Network Providers will be listed in Contracted Plan directories according to their board certified primary practice specialty and/or board certified or recognized sub-specialties or “Added Qualifications” and verified training approved by the Board. Where no ABMS recognized specialty board exists, Network Providers practice specialty listings will be consistent with all recognized training programs and the MHMD Contracted Plans.
- C. Provider Cooperation - Each Network Providers agrees to fully cooperate with all re-credentialing activities, and must meet all deadlines for providing requested information. A Network Provider who fails to comply with requests for information within the prescribed time period will receive a notification of noncompliance by certified mail return receipt requested and given thirty (30) calendar days from the Network Provider’s receipt of the notice of non-compliance to provide all outstanding requested information. Where the Network Providers fails to provide the requested information within said thirty (30) day period, the Network Providers will be deemed to have voluntarily relinquished his/her MHMD membership and forfeited Contracted Plan participation.
- D. Membership Fees -Network Providers shall be required to comply with the reapplication fee requirements of the Board. Network Providers shall be notified in writing by certified mail return receipt requested of nonpayment of fees and shall be given ten (10) business days from the Network Provider’s receipt of said notice to pay the fees. Where the Network Provider fails to pay the fee within said ten (10) business days the Network Provider will be deemed to have voluntarily relinquished his/her MHMD membership and forfeited Contracted Plan participation.
- E. Confidentiality of Network Information -Network Providers may from time to time receive proprietary information from MHMD. Network Providers Member agrees that such information shall be kept confidential and unless otherwise required by law, shall not be disclosed to any person except as authorized in writing by MHMD.
- F. Contracted Plan Participation - Availability to MHMD, as well as Plans who contract with MHMD, for a quality group of Network Providers is essential to the business of

MHMD and each Network Provider of MHMD. Therefore, each individual Network Provider agrees to participate in a reasonable number of those Contracted Plans offered to the Network Provider as a condition of continued participation in MHMD.

**VII. RESIGNATION** - A Network Provider may officially resign from MHMD by submitting written notice to the Board. Resignation shall not relieve the resigning Network Provider from the Network Provider's obligation to pay any dues or other charges accrued and unpaid. The Network Provider also agrees to cooperate with MHMD in arranging for the continuing care of any patients who may be affected by the Network Provider's resignation.

**VIII. TERMINATION, SUSPENSION, OR PROBATION OF MEMBERSHIP -**

Termination of membership is solely within the discretion of the Board. Prior to terminating membership, if appropriate, the Board may issue an oral or written warning or reprimand, or place the Network Provider on suspension or probation for a limited period of time.

A. Grounds for Suspension, Probation or Termination - The grounds for suspension, probation or termination of membership apply whether concerns or complaints regarding a Network Provider are raised during the membership period or identified through the renewal process. The following may be grounds for suspension, probation or termination of membership:

1. The loss, restriction, probation, sanction, reprimand, fine or penalty assessed against the reprimand, fine or penalty assessed against the Network Provider's professional medical license, DEA registration, or by any other governmental agency.
2. Reliable information that patients or prospective patients of the Network Provider may face imminent harm under his/her care.
3. Involuntary loss of a Network Provider's membership or clinical privileges at a hospital, healthcare facility, professional health care organization or contracted health plan (excluding termination for medical record non-completion, or for failure to satisfy facility meeting attendance or board certification requirements).
4. Failure to timely notify the Board of any occurrence or change affecting or relating to the Network Participation Criteria and Policies or the Network Participation Agreement.
5. Failure to comply with any of the MHMD Bylaws, Network Participation Criteria and Policies, Network Participation Agreement or breach of any condition or requirement which is necessary for MHMD to promote the delivery of quality and operationally and economically efficient patient care by its members.
6. Failure to cooperate or comply with quality assurance, utilization review, and other medical peer review activities.
7. As otherwise established by the Network Participation Agreement.

**IX. RIGHT OF REVIEW** - Any Provider Applicant or Network Provider whose application for membership or membership renewal to MHMD has been denied or whose Network Participation has been suspended, placed on probation or terminated and who desires to appeal such decision

is entitled to be provided an opportunity for review. This opportunity does not apply to Network Providers who fail to complete the application for membership renewal or re-credentialing.

A. Initial Notice - If the Board has suspended, placed on probation, denied or terminated membership the affected Provider Applicant or Network Provider shall be notified in writing by the Medical Director prior to the suspension, probation or termination of the Network Providers Network Participation Agreement and/or contracted plan participation. The notice shall state the following:

1. The reason for the suspension, probation, denial or termination.
2. The effective date and the length of the suspension or probation.
3. The effective date of termination will be 90 days from the date of the notice; unless the termination should be immediate due to:
  - a. Providers loss of medical licensure
  - b. Conviction of a crime or
  - c. Criteria established by the Network Participation Agreement
4. Except for terminations based on clinical quality concerns, the fact that it is an “administrative decision”, not reportable to the Texas Medical Board or National Practitioner’s Data Bank.
5. That the Provider Applicant or the Network Provider has a right to file a written request for review (an “appeal”) within thirty (30) calendar days following receipt of the notice of suspension, probation, denial or termination either by hand delivery or by certified mail, return receipt requested, at the address specified in the notice of denial or termination. Delivery of the request for review will be deemed effective upon receipt if delivered in person and when postmarked if sent by certified mail, return receipt requested.
6. If the Provider Applicant or Network Provider requests a review, the Provider Applicant or Network Provider must provide at the time such a request is made a detailed written rebuttal for the Appeals Committee to review that supports his or her request for review.
7. That a Provider Applicant or Network Provider who either fails to request a review or fails to submit the reasons that support his or her review within the time and in the manner specified above waives all rights to any review to which he or she might otherwise have been entitled

B. **Review Process** – Upon receipt of a proper written request for review from the affected Provider Applicant or Network Provider within the required time period and in the manner specified above, the Chairman of the Appeals Committee shall schedule a meeting of the Appeals Committee within sixty days of receipt of the appeal to conduct the review.

1. The composition of the Appeals Committee shall be as provided for in the MHMD Bylaws.
2. The review by the Appeals Committee must be conducted within sixty (60) calendar days of the request for appeal.

3. The Appeals Committee may consider and make its decision on the basis of only the written materials before it, or it may, at its discretion, allow the Provider Applicant or Network Provider to make a personal appearance or interview by telephone conference before the Appeals Committee in an informal hearing of the appeal.

4. In the event of such hearing, the Appeals Committee Chair shall send the Provider Applicant or Network Provider written notice including;

- a. The time, place and date of the review hearing;
- b. A list of members serving on the Appeals Committee and
- c. The rules and process to be followed at the review hearing.

#### 5. Review Hearing Procedures

a. If the Any Provider Applicant or Network Provider fails to appear at the hearing or fail to submit any information requested by the Appeals Committee, the appellant shall be deemed to have waived any opportunity for any review, which he or she might otherwise have been entitled.

b. The Provider Applicant or Network Provider may:

1. Make an oral statement; introduce exhibits, present any documentary evidence determined to be relevant by the Chair of the Appeals Committee, and may
2. Rebut any evidence, and submit an additional written statement at the close of the review hearing.
3. The Appeals Committee may establish limitations on the time allowed for the presentation by the Provider Applicant or Network Provider presentation or by MHMD, and on time allowed for any rebuttal or question and answer period.
4. Attendance of legal counsel or other persons on behalf of either the appellant or MHMD during the hearing must be previously approved by the Appeals Committee, in the sole discretion of the Appeals Committee.

c. The review/appeal hearing shall be informal and not be conducted according to 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 reviewed if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. At its discretion, the Appeals Committee may request or permit both sides to file additional written statements.

d. The Appeals Committee may recess and reconvene the review hearing without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or for further consultation.

e. Upon conclusion of the presentation of all evidence, the review hearing shall be adjourned. Then, at a convenient time, the Appeals Committee shall deliberate outside the presence of the parties. Upon conclusion of these deliberations, the review hearing shall be declared closed.

f. After completion of its review, the Appeals Committee shall render a recommendation accompanied by a written report, which shall be delivered to the Board.

- C. Decision of the Board - The Board shall review the recommendation of the Appeals Committee and render a decision, which may affirm, modify, or reverse the recommendation of the Appeals Committee or return the matter to the Appeals Committee with instructions for further action. The Board then shall notify the Provider Applicant or Network Provider of its decision. A notice of the recommendation shall be forwarded to the Provider Applicant or Network Provider within five (5) business days of the Board's decision.
- D. Right to Additional Review - A Provider Applicant or Network Provider is entitled to one additional review of any matter that was the subject of an adverse recommendation. Should the Provider or Provider applicant request a second review, that review will be conducted by an *ad hoc* Appeals Committee appointed by the MHMD Board and composed of individuals not serving on the Appeals Committee that conducted the initial review. The decision of the Board to affirm, modify or reverse a recommendation of the second Appeals Committee is final.
- E. Reapplication – MHMD Provider Members who have been terminated from membership in MHMD may apply for membership in MHMD. Such applications will be processed as initial MHMD membership applications.
- F. Release from Liability - Each Provider Applicant or Network Provider agrees to release and hold harmless from liability all MHMD employees, agents, officers, directors and other representatives for any actions taken pursuant to this policy in connection with the resolution and final decision of any such Adverse Recommendation.
- G. Exhaustion of Remedies - Each Provider Applicant or Network Provider agrees to be bound by all of the terms and conditions of this policy with respect to any Adverse Recommendation (and final decision) that may be made against such the Provider Applicant or Network Provider. Each Provider Applicant or Network Provider agrees to exhaust all available remedies under this policy before taking any further legal action in connection with the resolution of any such Adverse Recommendation (and final decision).

## **X. AMENDMENT OF POLICY**

The Network Participation Criteria and Policies will be reviewed annually or sooner as may be as required to maintain compliance with NCQA, URAQ or TDI other legal, Health plans or accreditation requirements, or and may be amended or repealed in whole or in part by one of the following mechanisms: resolution of the Credentials Committee, recommended to and adopted by the Board; or action by the Board on its own initiative, after notice to the Credentials Committee of its intent, such notice to include a reasonable period of time for response.

A. In the event that there is any inconsistency between any provisions of the Network Participation Criteria and Policies and any provisions of the Network Participation Agreement, the provisions of the Network Participation Agreement shall prevail and control.

B. The Board may at its discretion may make an exception to or waive any requirement, criterion, or provision of the Network Participation Criteria and Policies if it determines that to do so is reasonable and appropriate under the circumstances and consistent with the mission and purpose of MHMD. MHMD will notify the Contracted Health plans of Provider Member exceptions according to each Contracted Health plan's delegation policy.