CAROLINA COMPLETE HEALTH

POLICY AND PROCEDURE

DEPARTMENT: Corporate Credentialing and Provider Data Management	**DOCUMENT NAME:** Practitioner Credentialing & Recredentialing
PAGE: Page 1 of 17	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE:	**REVIEWED/ REVISED:**
PRODUCT TYPE:	**REFERENCE NUMBER:** NC.CRED.01

SCOPE:

Centene Corporate Credentialing ("Credentialing") and the Provider Data Management Department ("PDM") on behalf of Carolina Complete Health, Carolina Complete Health Provider Relations, Network Contracting, and Quality Improvement Departments.

PURPOSE:

The purpose of the credential verification program is to exercise reasonable care and employ consistent standards in the selection and retention of competent providers as participants in Carolina Complete Health's network. The primary objective of the credential verification program is to assure accessibility and availability of services through successfully selecting and retaining participating providers. The credential verification program's goal is to ensure that, through meeting the primary objective of the program, Carolina Complete Health develops and maintains a network of professional practitioners who are qualified to meet the health care needs of Carolina Complete Health's covered beneficiaries in an efficient, compliant, safe, and effective manner.

POLICY:

Centene has established standards for conducting the functions of practitioner selection and retention. These standards include practices for practitioner credentialing, recredentialing, and ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), 42 C.F.R 438.214, and Carolina Complete Health requirements to the extent that those standards do not conflict with other laws of the state. This policy is in alignment with the standards as defined in Attachment M. 6. Uniform Credentialing and Re-credentialing Policy

Carolina Complete Health will submit the Credentialing and Re-credentialing Policy to the Department for review and approval thirty (30) days after the Contract Award. The Policy must be approved by the Department at least sixty (60) days prior to executing contracts with providers.

Carolina Complete Health will utilize the draft Policy submitted as part of the Proposal and Response prior to approval by the Department with notification to the provider that the Policy is subject to amendment based upon Department

review and approval. Approved Provider Credentialing and Recredentialing policies, including all published versions, will be published on the Carolina Complete Care website and include the effective date of each policy.

Network Participation Committee: Carolina Complete Health designates a Provider Network Participation Committee that uses a peer-review process to make recommendations regarding credentialing decisions. This Committee makes Quality Determinations in accordance with Carolina Complete Health's Credentialing and Re- credentialing Policy. The Chief Medical Officer (CMO) or CMO designee shall serve as the chair of the Provider Network Participation Committee. The chair must be a North Carolina licensed physician.

Network Participation: For consideration to participate in the Carolina Complete Health network, all individual practitioners who have an independent relationship with Carolina Complete Health must credential with NC Medicaid/NCHC via NCTracks enrollment process. This includes in state providers, border (i.e., providers who reside within forty (40) miles of the NC state line), and out of state network providers. Carolina Complete Health will make the final quality determination. Carolina Complete Health verifies that all network providers are credentialed before listing those providers in Carolina Complete Health's provider directory, handbooks, or other marketing materials.

Within 45 days after receipt of a completed application and all supporting documents, Carolina Complete Health will assess the application's qualifications and notify the applicant of it's decision. 90% of decisions will be made within 30 days and 100% within 45 days.

In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, Carolina Complete Health must assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting data. Carolina Complete Health uses the National Provider Identifier (NPI) issued by NPPES as the unique provider identifier. For those providers who do not qualify for NPI's, the Atypical Provider ID issued by NC DHHS' NCTracks system will be used.

Exclusion from federal procurement activities is non-compliant with minimum administrative requirements and results in exclusion from payment, except as permitted under 42 CFR 1001.1801 and 1001.1901. Prior to contracting, the exclusion status of all contracted providers is checked against the following lists:

State Exclusion list, U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE). For currently participating practitioners, exclusion results in immediate termination of network participation.

Types of Practitioners: The credentialing/recredentialing processes apply, but are not limited to, the following practitioner types:

- Medical doctors (MD);
- Nurse Practitioners (NP);
- Oral surgeons (DDS/DMD);
- Chiropractors (DC);
- Osteopaths (DO);
- Podiatrists (DPM); and
- Mid-level practitioners (non-physician).

Completion of the credentialing/recredentialing process is not required when Carolina Complete Health does not select or direct its beneficiaries to see a specific practitioner or group of practitioners and for non-participating practitioners. This includes practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Carolina Complete Health beneficairies only as a result of beneficairies being directed to the hospital, inpatient setting, or free-standing facility. These practitioners may include, but are not limited to the following specialties:

- Anesthesiology,
- Emergency Medicine,
- Neonatology,
- Pathology,
- Radiology, and
- Telemedicine.

DEPARTMENT: Corporate Credentialing and Provider Data Management	**DOCUMENT NAME:** Practitioner Credentialing & Recredentialing
PAGE: Page 4 of 17	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE:	**REVIEWED/ REVISED:**
PRODUCT TYPE:	**REFERENCE NUMBER:** NC.CRED.01

Practitioner Rights: All practitioners must credential with NC Medicaid/NCHC via NCTracks enrollment process.The rights of the practitioner to review information collected for the credentialing process will be handled through the state's MMIS vendor and PDC.

Should the practitioner believe any of the credentialing information to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner, he/she has the right to correct any erroneous information submitted by another party. Practitioner has the ability to contact the PDC if they disagree with the information provided that led to Carolina Complete Health's Credentialing Committee deny the practitioner.

New practitioners who are denied participation by the Provider Network Participation Committee have the right to request a reconsideration of the decision within thirty (30) calendar days of the date of receipt of the denial letter.

Notification of these rights may occur via individual correspondence, in the provider manual, and/or on Carolina Complete Health's website.

Recredentialing: During the Provider Credentialing Transition period, practitioners are reviewed against objective quality standards based upon the recredentialing materials provided by the North Carolina Medicaid Department's MMIS no less frequently than every five (5) years. After the Provider Credentialing Transition period, no less frequently than every three (3) years. Payment Suspension at Re-Credentialing: Carolina Complete Health shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements. Carolina Complete Health shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information with fifty (50) days of suspension, the Department will terminate the provider from Medicaid. Carolina Complete Health shall not be liable for interests or penalties for payment suspension at re-credentialing. Carolina Complete Health has addressed payment suspension at

re-credentialing in this Network Provider Credentialing and Re-credentialing Policy.

Binding Nature of Credentialing Decisions: Carolina Complete Health has the right to make the final determination about which practitioners may participate within its network. Practitioners who are denied initial participation may reapply for admission into the network.

Retention of Credentialing Records. All records related to credential verification are maintained in a manner that Carolina Complete Health deems to be adequate and for a period of at least five (5) years from the time the records are no longer considered "active."

PROCEDURES:

Through the uniform credentialing process, the North Carolina Medicaid Department will screen and enroll, and periodically revalidate all Carolina Complete Care network providers as Medicaid providers. 42 C.F.R. § 438.602(b)(1).

Carolina Complete Health may execute network provider contract, pending the outcome of North Carolina Medicaid Department screening, enrollment, and revalidation, of up to one hundred twenty (120) days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the provider, and notify affected Members. 42 C.F.R. § 438.602(b)(2).

Carolina Complete Health shall meet with the North Carolina Medicaid Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process. The Department or a designated vendor will provide to Carolina Complete Health a daily, full file including all North Carolina Medicaid and NC Health Choice enrolled providers, including relevant enrollment and credentialing information. Carolina Complete Health's PDM IT Department shall reconcile provider data with the Department, or designated vendor, at least monthly. Carolina Complete Health is responsible for notifying the Department, or designated vendor, of any discrepancies

(mismatched information) identified in reconciliation in a format defined by the Department.

Providers will credential and recredential with NC Medicaid/NCHC via NCTracks enrollment process. Carolina Complete Health will receive credentialing information from the North Carolina Medicaid Credentialed File via a secure FTP site daily. Quality determinations will be made based solely on the credentialing information provided by the North Carolina Medicaid Department, additional information shall not be required from the provider to be used in the quality determination. During the Provider Credentialing Transition Period, the PHP shall apply the Objective Quality Standards most recently approved by the Department, or designated Department vendor, to contracted providers as the provider is re-enrolled in Medicaid.

I. Application Received

A. Carolina Complete Health contracting secures first-signature contracts. Credentialing applications and associated documents are obtained from the North Carolina Medicaid Department or designated Department vendor via a daily file and submitted to Carolina Complete Health's Provider Data Management Department.

B. PDM assesses existence of sufficient information needed for enrollment as provided by North Carolina Medicaid Department's MMIS:

   i. Completed Provider Data Form or Provider Roster to include, at a minimum the following:

      a. Name Suffix
      b. Gender
      c. After Hours Phone and Fax Number per Location
      d. Hospital Affiliation
      e. HCBS Provider Type
      f. Behavioral Health Provider Type
      g. Telemedicine and/or Psychotic Provider (Y/N)
      h. Telemedicine and/or Psychotic Provider Physical Location (Y/N)
      i. Medicaid Service Location Code

II. Determination and Review of Clean Files

Applicants who meet the participation criteria and are determined to have a "clean file" are approved for Carolina Complete Health participation following review by the Medical Director, the Chief Medical Officer or designee. Clean File review may occur daily when files are ready for review.

A. Carolina Complete Health defines a "clean file" as one that meets the following criteria (the criteria review is based upon the information received via the MMIS/PDC file - no additional items are collected) Several of these items listed below may not be provided in the MMIS/PDC file, and if they are not, the review and determination will be based upon the factors and information available solely in the MMIS/PDC file):

   i. No past or present suspensions or limitations of state licensure within a five (5) year look back period;

   ii. No past or present suspensions or limitations of DEA or state controlled substance registration within a five (5) year look back period;

   iii. No past or present federal or state sanction activity including Medicare/Medicaid sanctions (via review of State Exclusion List, U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE);

      a. At the discretion of the Credentialing Manager or Medical Director, sanctions over the five (5) year look back period may be presented to the Committee if the practitioner has recent sanctions and the older history may provide more information regarding an appropriate decision;

iv. No malpractice claims that resulted in a settlement or a verdict in favor of the plaintiff (claims ruled in favor of the defendant are acceptable for a clean file) in a five (5) year look back period from date of settlement;

a. At the discretion of the Credentialing Manager or Medical Director, malpractice claims over the five (5) year look back period may be presented to the Committee if the practitioner has recent aberrant malpractice claims and the older history may provide more information regarding an appropriate decision.

v. No gaps in relevant (as a health professional) work history of six (6) months or longer for a minimum of five (5) years. If the practitioner has practiced fewer than five (5) years from the date of credentialing, the work history starts at the time of initial licensure;

vi. No involuntary terminations from an HMO or PPO.

B. In cases of recredentialing:

i. Issues, judgments, or settlements previously reviewed do not have to be resubmitted during the current phase of recredentialing; and

ii. Issues, judgments, or settlements since prior credentialing must be considered in the determination of whether a file is considered clean.

C. If a file is determined to be clean, the practitioner is presented to the Medical Director on a summary listing containing, at minimum, practitioner name, NPI and specialty.

i. Information is typically presented via email, but may also be presented in person.

ii. Approvals received via email are from a secure system with a unique electronic identifier with appropriate controls to ensure that only the designated medical director or qualified physician can access and use as an electronic signature.

D. If approved for network participation, a letter of acceptance is mailed to the applicant within five (5) days after Carolina Complete Health's determination.

III. Committee Review of Unclean Files

Credentialing and/or recredentialing application files that do not meet criteria for clean file review are brought to the Provider Network Participation Committee for review. This Committee meets at least monthly. The Provider Network Participation Committee has been delegated the responsibility from Carolina Complete Health's Quality Improvement Committee to review the qualifications of each applicant presented and make a recommendation on approval or rejection determinations.

A. The following grid summarizes file criteria and when Provider Network Participation Committee review is required:

Credentials	Criteria	Committee Review
NPDB Profiles	Any NPDB Reports within five (5) years of the resolution date, per report to the committee decision/date.	Yes
	Example: Committee Date 01/2007 NPDB Report 1 Resolution 1/2009	*Yes*
	NPDB Report 2 Resolution 10/1991	*No*
Restricted License Adverse Activity Disciplinary Limited Supervision	State Licensure documentation within five (5) years of date of any final action/order to the committee decision/date. *Please see the NPDB example for date compliance.*	Yes
Malpractice History	All Open, Pending, Discovery Claims *Committee cannot make a recommendation on these types of issues until a final judicial outcome. The Provider Network Participation*	No [1]

DEPARTMENT: Corporate Credentialing and Provider Data Management	**DOCUMENT NAME:** Practitioner Credentialing & Recredentialing
PAGE: Page 10 of 17	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE:	**REVIEWED/ REVISED:**
PRODUCT TYPE:	**REFERENCE NUMBER:** NC.CRED.01

Credentials	Criteria	Committee Review
	Committee will review the final outcome during the recredentialing or ongoing monitoring process.	
	All Closed or Dismissed Claims	No
	Any Claim(s)s that resulted in a settlement or judgement for the plaintiff	Yes
Federal, State Sanctions, Financial	State, Medicare/Medicare Sanctions, Fines, Any discipline activity within five (5) years. Review dates for determination.	Yes
	Any current Medicare/Medicaid Exclusions File will be administratively declined for participation.	No
Work History Gap	Any gaps over 1year in work history must be documented in writing and reviewed by committee.	Yes
Specialty Issues Board Certification Clinical Education Training Program	Any discrepancies found through the verification process with a final order or judgment within 10 years of the Provider Network Participation Committee decision/date.	Yes
Relinquish privileges, licensure, certification	Any relinquishing of state clinical license or certificates, malpractice insurance coverage, clinical or staff privileges, appointments, board status etc. Also any state, local, or federal agencies.	
	*Under Investigation	Yes
	Not Under Investigation – *Credentialing Manager review to determine committee file review.*	Yes or No
Quality Indicators Recredentialing Only	During recredentialing the practitioner or facility have any unsatisfactory Quality indicators, which can be one or more of the following: quality of care, over/under utilization, inadequate medical records, accessibility issues, and inappropriate volume of beneficiary complaints.	Yes

* It is expected that these findings will be discovered for currently participating practitioners through ongoing sanction monitoring. Practitioners with such findings will be individually reviewed and considered by the Provider Network Participation Committee at the time the findings are identified. These practitioners will be identified (off cycle) when they are presented to the Provider Network Participation Committee.

C. The Provider Network Participation Committee may utilize an exception process should it be necessary to credential certain practitioners given the needs of its membership.

   i. When there are extenuating circumstances that preclude the practitioner from meeting minimum participation criteria, but do not preclude the practitioner from providing quality care and service for Carolina Complete Health's beneficairies, the Medical Director may decide to utilize an exception process to extend an offer of participation.

   ii. A complete discussion of this decision is reflected in the Provider Network Participation Committee meeting minutes.

   iii. If such a need exists, each criterion for selection is examined on an individual basis taking into account the following (information reviewed as attested to and **only if available** in the credentialing/recredentialing materials provided by the North Carolina Medicaid Department's PDC file, which is the MMS vendor and the PDC combined):

      a. Previous sanction activity: the nature of the sanction and remedy.

      b. Additional exceptions are granted and reviewed on an individual basis by the Provider Network Participation Committee.

D. The applicant is sent notice of his/her status in writing within five (5) days after Carolina Complete Health's determination.

IV. Denial of Initial Credentialing/Recredentialing Application

A. The Provider Network Participation Committee may recommend not to extend or continue to extend participation status to a practitioner.

B. The Medical Director will consider the Provider Network Participation Committee's recommendation and has final authority over the determination on the credentialing decision.

C. The Medical Director or his or her designee notifies the practitioner via certified mail of the Credentialing denial decision within five (5) days after Carolina Complete Health's determination.

   i. A letter of denial includes information on the practitioner's right to view and/or correct erroneous information.

   ii. A copy of the letter is retained in the practitioner's closed file and maintained in the Credentialing Department for future reference.

   iii. If the practitioner's current participation status is being suspended, restricted or terminated based on issue of quality of care or service, Carolina Complete Health offers and informs the practitioner of the appeal process in accordance with the associated policies, NC.CRED.07 - Practitioner Disciplinary Action and Reporting, and NC.CRED.08 - Practitioner Appeal Hearing Process. Practitioners denied during the initial credentialing process may request reconsideration as detailed in item VI.

D. In order to support compliance with specific Carolina Complete Health requirements, Credentialing notifies Carolina Complete Health's Compliance of the Credentialing denials as soon as reasonably possible after the final determination is made.

V. Practitioner Requests for Status of Credentialing/ Recredentialing

A. Practitioner contacts North Carolina Department of Medicaid's MMIS vendor to request status.

B. Upon receiving such request, the North Carolina Department of Medicaid's MMIS vendor provides practitioner with the information.

VI. New Practitioner Requests Reconsideration

A. A practitioner who is denied participation by the Provider Network Participation Committee requests a reconsideration of the decision.

i. If the request is received within thirty (30) calendar days of the date of receipt of the denial letter and includes additional supporting documentation in favor of the applicant's consideration for network participation, reconsideration will occur.

ii. The request is presented to the Provider Network Participation Committee at the next regularly scheduled meeting but in no case later than thirty (30) days after Carolina Complete Health's receipt of a completed application and all supporting documents. The Provider Network Participation Committee may recommend:

a. Support of the original denial recommendation by the Provider Network Participation Committee and closure of the file; OR

b. Support of the applicant's ability to meet Carolina Complete Health's minimum participation criteria and approval of the applicant for inclusion in Carolina Complete Health's practitioner network.

c. The Medical Director will consider the Provider Network Participation Committee's recommendation and has final authority over the determination on the credentialing decision.

iii. The Medical Director, or his or her designee, notifies the applicant in writing within five (5) days after Carolina Complete Health's determination.

VII. Participation Upon Completion of Credentialing.

Once credentialing is complete, PDM performs a quality check of the information in the Provider Data Management system to ensure demographic information is in alignment with the documentation received from the Department of Medicaid's MMIS vendor and makes the provider "par" (i.e. participating) in the Provider Data Management system. Once made par, the record is fed to both the online directory, the call center system, and the eligibility system for member cards and enrollment. When a practitioner joins a practice that is under contract as participating in Carolina Complete Health's network, the effective date of the practitioner's participation in Carolina Complete Health's network is the date Carolina Complete Health approves the practitioner's credentialing. Timelines for loading credentialed practitioners into the system(s): newly credentialed provider attached to a new contract within ten (10) business days; Newly credentialed provider attached to an existing contract within five (5) business days; Changes for a recredentialed provider attached to an existing contract within five (5) business days after completing recredentialing.

I. Network Data File and PHP Network File

Carolina Complete Health PDM IT Department shall provide the Department with Network data files quarterly and anytime there is significant change that impacts Network adequacy and the ability to provide services. The Network data file will be in excel format and will be submitted electronically using the NCMP_Interim Document Submission Process_20190204_v1.0 The standardized detailed file layout must include the following data elements:a) Provider names (first, middle, last);b) Group affiliation(s) (i.e., organization or facility name(s), if applicable);c) Street address(as) of service location(s);d) County(ies) of service location(s);e) Telephone number(s) at each location;f) Website URL(s);g) Provider specialty; The standardized detailed file layout must include the following data elements: Provider NPI or API;i) NPI type (individual or organization/facility providers); Taxonomy(ies); Whether provider is accepting new Members and the conditions if applicable; Identification as an IHCP; Identification as an Essential Provider; Provider's linguistic capabilities, i.e., languages (including American Sign

Language) offered by provider or a skilled medical interpreter at provider's office; Whether provider has completed cultural competency training; and Office accessibility, i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment. Carolina Complete Health shall accurately and timely load into the claim adjudication and payment systems new provider contracts, provider demographic information, changes in provider contract terms, changes in provider demographic information, updated prior authorization requirements, and changes to the Provider Directory. Unless otherwise written in the contract, Carolina Complete Health shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a Member and billed to the health plan by the provider: Newly credentialed provider attached to a new contract within ten (10) business days after completing credentialing; Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing; Newly credentialed provider attached to an existing contract within five (5) business days after completing credentialing. d. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five (5) business days after completing re-credentialing;e. Change in existing contract terms within ten (10) business days of the effective date after the change; andf. Changes in provider service location or demographic data or other information related to Member's access to services must be updated no later than thirty (30) calendar days after receipt of updated provider information.iii. Payment should be made on the next payment cycle following the requirement outlined above.iv. In no case shall a provider be used as a PCP or loaded into the provider directory during a timeframe in which the provider cannot receive payment on Carolina Complete Health's current payment cycle. Carolina Complete Health will, at a frequency defined by the Department, create a full Network data file including data (as defined in the Contract) on all contracted providers in their network. The final file format will be in Excel and will be submitted electronically using the NCMP_Interim Document Submission Process_20190204_v1.0.

DEPARTMENT: Corporate Credentialing and Provider Data Management	**DOCUMENT NAME:** Practitioner Credentialing & Recredentialing
PAGE: Page 16 of 17	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE:	**REVIEWED/ REVISED:**
PRODUCT TYPE:	**REFERENCE NUMBER:** NC.CRED.01

The Department produces a daily Medicaid Credentialed Provider file, which is received via secured data exchange (sftp) from the PDC (Provider Data Contractor) in Text format. This file includes all active and terminated Medicaid Providers. Carolina Complete Health is responsible for maintaining the correct provider identification number for the claims and encounter data and service date.

Carolina Complete Health shall develop a PHP Network File in accordance with Section D. 2 Provider Network Management and integrate provider directory information into the Enrollment Broker's Consolidated Provider Directory to support Carolina Complete Health choice counseling and selection. The PHP Network File is submitted daily via secured data exchange (sftp) to the Enrollment Broker and to the State (NCTracks).

Carolina Complete Health shall develop a Provider Directory in accordance with Section D. 2 Provider Network Management and integrate provider directory information into the Enrollment Broker's Consolidated Provider Directory to support Carolina Complete Health choice counseling and selection.

REFERENCES:
NCQA Health Plan CR Standards and Guidelines – Current Year *NC.CRED.07 – Practitioner Disciplinary Action and Reporting* *NC.CRED.08 – Practitioner Appeal Hearing Process* *R §§ 1001.1801, 1001.1901* *Template Credentialing Letters*
ATTACHMENTS:
DEFINITIONS:

REVISION LOG

REVISIONS	**DATE**

This Policy and Procedure has been officially developed and formally approved by Carolina Complete Health to demonstrate compliance with all applicable federal and North Carolina law and related regulatory guidance.

CAROLINA COMPLETE HEALTH

POLICY AND PROCEDURE

DEPARTMENT: Corporate Credentialing and Provider Data Management	**DOCUMENT NAME:** Practitioner Credentialing & Recredentialing
PAGE: Page 17 of 17	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE:	**REVIEWED/ REVISED:**
PRODUCT TYPE:	**REFERENCE NUMBER:** NC.CRED.01

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.