CAROLINA COMPLETE HEALTH

POLICY AND PROCEDURE

DEPARTMENT: Corporate Credentialing and Provider Data Management	**DOCUMENT NAME:** Practitioner Credentialing & Recredentialing
PAGE: Page 1 of 9	**REPLACES DOCUMENT:**
APPROVED DATE:	**RETIRED:**
EFFECTIVE DATE:	**REVIEWED/ REVISED: 2/20/2020**
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 rely on the enrollment/credentialing of GDIT, as indicated on the Medicaid Provider Enrollment File (vs the Medicaid Credentialed Provider File), to replace individual Plan Quality Determinations during the transition period. Verification that all network providers are credentialed by review of the Medicaid Provider Enrollment File will occur before listing those providers in Carolina Complete Health's provider directory, handbooks, or other marketing materials.

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. 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.

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.

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.

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).

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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.

Carolina Complete Health will rely on the enrollment/credentialing of GDIT, as indicated on the Medicaid Provider Enrollment File (vs the Medicaid Credentialed Provider File), to replace individual Plan Quality Determinations during the transition period.

Caroline Complete Health will:

a. ingest the Medicaid Provider Enrollment File (extended version) and when a Medicaid/NCHC enrolled provider is active in the Medicaid program you may contract with them using our enrollment effective date
b. update procedures to reflect this change and resubmit to the Department for approval

I. Participation Upon Completion of Credentialing.

Upon ingestion of the Medicaid Provider Enrollment File (extended version) and when a Medicaid/NCHC enrolled provider is active in the Medicaid

program, and upon receipt from the Contracting team notification that the provider has been contracted, 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 using the Medicaid/NCHC's enrollment effective date. 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 Medicaid/NCHC's enrollment effective date. 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.

II. Network Data Files and Reporting

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 Department will prescribe the standardized file format. 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. The Department produces a daily provider file that 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 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. Carolina Complete Health will, at a frequency defined by the Department, create a full provider file including data (as defined in the Contract) on all contracted providers in their network. Carolina Complete Health will deliver the file based on the Enrollment Brokers defined technical process.iii. The final file format will be determined by the Enrolment Broker; however, it is anticipated to be an industry standard format (XML, CSV, HL7, JSON, etc.).iv. The transport will also be determined; however, it is also anticipated to be an industry standard method (SFTP, etc.).

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**
Updated policy to align with the following guidance from the NC State Department of Medicaid: The Plans will rely on the enrollment/credentialing of GDIT, as indicated on the Medicaid Provider Enrollment File (vs the Medicaid Credentialed Provider File), to replace individual Plan Quality Determinations during the transition period. The plans will:	**2/2020**

a. ingest the Medicaid Provider Enrollment File (extended version) and when a Medicaid/NCHC enrolled provider is active in the Medicaid program you may contract with them using our enrollment effective date b. update procedures to reflect this change and resubmit to the Department for approval	

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.

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.