

Medicaid Managed Care
Proposed Concept Paper

Centralized Credentialing and Provider Enrollment

North Carolina Department of
Health and Human Services

March 20, 2018

Contents

I. Introduction.....	3
II. Background.....	3
III. Provider Enrollment and Centralized Credentialing	5
Provider Enrollment	5
Centralized Credentialing.....	5
Guidelines for PHP Quality Determinations.....	7
PHP Provider Network Quality Committee.....	7
Quality Determination Timeframes for PHPs and the CVO	7
Notification and Provider Appeals	7
Recredentialing	8
Accredited Credentialing.....	8
Addressing Additional Data Needs During the Transition Period.....	9
Indian Health Care Providers Enrollment and Credentialing.....	10
IV. Oversight and Monitoring	10
Appendix A: Glossary	11
Appendix B: Federal Requirements – Provider Screening, Enrollment, Credentialing.....	12
Fee-for-Service Medicaid (42 CFR Part 455).....	12
Medicaid Managed Care (42 CFR 438.602, 214)	12
Appendix C: Gaps between North Carolina’s Current Medicaid Provider Enrollment Process and the NCQA Standards for Practitioners	13
Appendix D: Gaps between North Carolina’s Current Medicaid Provider Enrollment Process and Common MCO Information Standards for Facilities	15

This document is part of a series of concept papers that the Department of Health and Human Services scheduled for release from late 2017 through early 2018 to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a predominantly managed care model. This technical paper is written primarily for providers and health plans that will participate directly in Medicaid managed care, but anyone may respond and provide feedback to the Department, including beneficiaries, advocates or other interested parties. Some topics mentioned in this document may be covered in more detail in other concept papers in the series. For more information on the Department’s proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released concept papers available at ncdhhs.gov/nc-medicaid-transformation.

Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.

I. Introduction

North Carolina's health care providers deliver high-quality care to Medicaid beneficiaries. As the Department of Health and Human Services (the Department) transitions from a predominantly fee-for-service system¹ to managed care, the Department seeks to maintain strong provider participation in Medicaid while minimizing providers' administrative burden. One component of this vision is a centralized credentialing process, which will build on the current provider enrollment rules, and include uniform policies and a single electronic application. The Department's vision includes the use of a credentials verification organization (CVO) that will be responsible for credentialing and recredentialing Medicaid providers enrolled or seeking to enroll with North Carolina Medicaid or NC Health Choice. According to North Carolina state law, prepaid health plans (PHPs) must include all willing providers in their networks, except when a PHP is unable to negotiate rates or when there are quality concerns. The centralized credentialing process will provide a PHP with the information necessary to make a quality determination about contracting with a provider eligible to participate in North Carolina's Medicaid managed care program.

Per federal regulation, any provider seeking to participate in a Medicaid fee-for-service (FFS) program or a Medicaid managed care program must complete a provider screening and enrollment process, and credentialing is a central component of that process. States often have a centralized Medicaid provider enrollment process, but then allow each of their plans to have a separate process to credential and contract with providers. Separate plan processes can create redundancies and lead to higher administrative costs for plans and providers. Recently, Medicaid programs have started moving toward procuring a single centralized credentialing process to facilitate administrative simplification to avert inconsistencies and the need for a provider to be credentialed or recredentialed multiple times by different plans.

II. Background

Historically in other states, a typical frustration for providers moving to Medicaid managed care is the administrative burden of submitting similar (but sometimes different) information to multiple plans to become credentialed with each one. The Department will avoid this situation by developing a centralized credentialing process, including a standardized provider enrollment application and qualification verification process. A new federal requirement² mandates that all providers who participate in a Medicaid managed care program also must be enrolled as a Medicaid provider. For North Carolina, this offers a significant opportunity to build on the current Department infrastructure to support enrollment of providers into its existing fee-for-service program.

To ease provider administrative burden, the Department will implement a centralized credentialing and recredentialing process with the following features:

- The Department will procure, through a competitive bid process, a third-party, independent, primary contractor that will act as a CVO to coordinate necessary activities to support provider enrollment and verification.

¹ The Department currently has a managed care delivery system for behavioral health and intellectual and developmental disabilities services through the local management entities/managed care organizations (LME/MCOs). "Fee-for-service," as used in this concept paper, refers to only physical health services.

² 42 CFR 438.602, effective for contracts starting on or after January 1, 2018.

- Providers will use a single, electronic application to become a Medicaid-enrolled provider, with the application permitting providers to submit information once for enrollment in both the Medicaid FFS and managed care programs.³
- The CVO will be required to be certified by a nationally recognized accrediting organization.⁴
- The CVO will collect and verify provider enrollment information and share the information with PHPs.
- PHPs will be required to accept verified information from the CVO and will not be permitted to require additional credentialing information from a provider.
- PHPs will review the information and make a quality determination consistent with each PHP's approved quality review policy to decide whether to contract with the provider.
- Providers will be required to be recredentialed every three years.

Traditionally in Medicaid managed care, physicians and other health care practitioners who wanted to bill a Medicaid managed care organizations (MCO) and receive reimbursement for services as an in-network provider would undergo a process of credentialing in which the MCO verifies the provider's education, training, experience and competency. Each provider was expected to submit a credentialing application to every MCO. The MCOs would then decide if the provider met their internal qualifications as a provider of services to the MCOs' customers. After approval, the MCO would issue a participating provider contract that allowed the provider of services to bill the MCO and receive payment as an in-network provider of services. Under this traditional model, providers seeking to enroll with multiple MCOs were required to submit information to be credentialed or recredentialed to each individual MCO. This process often resulted in multiple submissions on different timeframes by providers, making it administratively burdensome.

In contrast, the Department proposes to use a centralized credentialing process that will build on the current Medicaid FFS provider enrollment process, and will allow providers to submit an application and credentialing materials once using a single, electronic application. For contracted providers, this streamlined process will eliminate the need to submit credentialing and recredentialed materials to multiple PHPs. For non-contracted providers, the new process will facilitate provider enrollment and provide confidence that payment is provided only to providers who have been verified to participate in the Medicaid program.

Centralized credentialing will not apply to the process for LME/MCOs as they exist today. If Behavioral Health and I/DD tailored plans are developed as described in the Department's *Behavioral Health and I/DD Tailored Plan* concept paper⁵ released November 2017, the Department will provide additional information on credentialing and enrollment for tailored plans.

³ Although all providers must be enrolled in Medicaid FFS to contract with a PHP, pursuant to 42 CFR 438.602(b), a provider who contracts with a PHP is not required to also render services to FFS beneficiaries.

⁴ The selected nationally-recognized accrediting organization will align with the accrediting organization picked for PHP accreditation as contemplated in the Department's quality program design and strategy. The selected organization will be named during the PHP procurement process.

⁵ https://files.nc.gov/ncdhhs/documents/files/BH-IDD-TailoredPlan_ConceptPaper_20181109.pdf?CkZhWxchGeNGBa2wXQsrSwWPrgi41aVP

III. Provider Enrollment and Centralized Credentialing

Provider Enrollment

The 2016 Medicaid Managed Care final rule and 21st Century Cures Act require all North Carolina Medicaid providers to be screened and enrolled by the Department. A provider must be enrolled as a Medicaid or NC Health Choice provider to be paid for services provided to a Medicaid beneficiary, and to contract with a PHP to be part of the PHP's provider network. Currently, that enrollment process includes credentialing, endorsement and licensure verification, which are used to ensure that all providers meet professional requirements and are in good standing. The enrollment process confirms a provider's compliance with the professional requirements found in state and federal laws, such as 42 CFR 455 Subparts B and E. (Refer to Appendix B for a description of the current federal requirements for provider screening, enrollment and credentialing). The current enrollment application is completed online through the NCTracks provider portal.⁶

Under managed care, providers will be enrolled in Medicaid in a process similar to the current enrollment process. The provider will access a standard enrollment application online, submit credentialing information and be notified when the enrollment application is approved. However, providers may be required to submit different or more data to be enrolled and credentialed under the managed care centralized credentialing process. This additional information is necessary because the current Medicaid provider enrollment process (including credentialing) does not generally meet PHPs' standards for a credentialing process or the standards necessary for a plan to be accredited by a nationally recognized accrediting organization. As described next, the Department aims to collect the additional information with as little administrative burden for providers as possible.

Centralized Credentialing

To ease provider burden, the Department is planning a centralized credentialing approach with providers submitting information once for both FFS and managed care through a single, standardized application to a state-procured CVO. Under this approach, all providers will be enrolled in Medicaid similar to the current process, including submission of credentialing data to the Department. The CVO will collect and verify provider information and share that information with PHPs. PHPs will be required to accept verified information from the CVO and will not be permitted to require additional credentialing information from a provider.

PHPs will then, through their internal Provider Network Quality Committee (PNQC), use the verified information to determine if a provider meets internal quality standards of each PHP to serve as a provider of services to that PHP's customers (Medicaid and NC Health Choice beneficiaries). This process is based on the managed care authorizing legislation⁷ that provides that PHPs must include all willing providers in their networks, except when a PHP is unable to negotiate rates or when there are quality concerns. Therefore, under centralized credentialing, the Department will use a CVO with certification from a nationally recognized accrediting organization to verify the credentials of all providers, and PHPs will rely upon the verified information to decide if a provider meets the PHP's quality standards and can be offered a contract.

⁶ NCTracks Operation Contact Center – User Guide: “How to Enroll in North Carolina Medicaid as an Individual”, rev. 20170531, <https://www.nctracks.nc.gov/content/dam/jcr:efbac4a4-cfa2-4835-a1c4-fdde48441529/JA%20-%20How%20do%20I%20enroll%20in%20North%20Carolina%20Medicaid%20as%20an%20Individual%2020170531.pdf> .

⁷ Section 5.(6)d. of Session Law 2015-245.

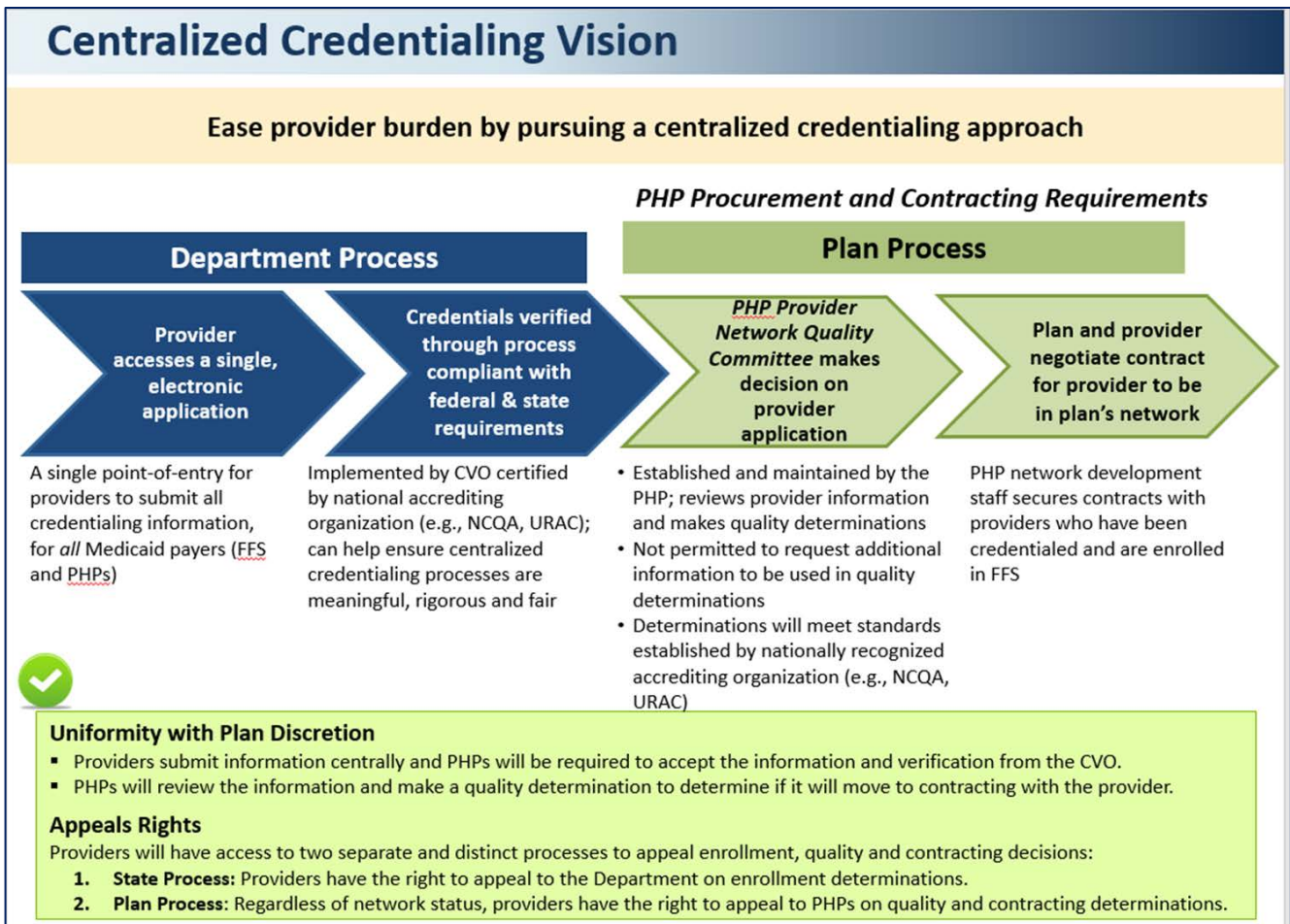
PHPs will only be permitted to reimburse enrolled Medicaid providers regardless of the provider’s network participation status.

The Department will set uniform credentialing and recredentialing policies, including parameters for PHP quality determinations, dispute resolution processes for PHPs and providers, and appropriate oversight. Consistent with federal rules, the Department’s credentialing policies will apply uniformly across PHPs to primary, behavioral, substance use disorders and LTSS providers.⁸ PHPs will follow the same policies and procedures for in-state, “border” (i.e., providers that reside within 40 miles of the North Carolina state line) and out-of-state providers.

Under centralized credentialing, the CVO, who will be certified by a nationally recognized accrediting organization, will conduct one streamlined process for provider credentialing and recredentialing using standards established by the accrediting organization. This streamlined process will facilitate providers requesting to enroll with a PHP for the first time and those providers who are currently participating in Medicaid or NC Health Choice.

Figure 1 below illustrates the envisioned provider enrollment and PHP contracting process.

Figure 1: Centralized Credentialing Vision



⁸ 42 CFR 438.214(b).

Guidelines for PHP Quality Determinations

PHPs' quality determinations will comply with the following Department guidelines:

- Each PHP will define, document and publish its policies for applying quality standards to make quality determinations.
- Each PHP will ensure its quality standards:
 - Assess a provider's ability to deliver care,
 - Include specific examples/thresholds for why a provider or type of provider would receive an adverse quality determination by the PHP (e.g., malpractice thresholds),
 - Describe the process by which the standards are applied, and
 - Are not discriminatory.

PHPs will be expected to submit their quality standards, including any significant changes, as part of the policies and procedures for Department review. PHPs will have discretion to make quality determinations, consistent with the PHP's written policy as approved by the Department. Through regular oversight of PHP operations, audits and monitoring provider complaints, the Department will review whether a PHP is following its approved policies in make quality determinations.

PHP Provider Network Quality Committee

PHPs each will establish and maintain a Provider Network Quality Committee (PNQC) that makes quality determinations relating to providers. The PNQC will:

- Be chaired by a physician who is either the PHP's Chief Medical Officer (CMO) or the CMO's designee.
- Make quality determinations that meet standards established by the CVO.
- Meet regularly to make quality determinations, as outlined in the PHP request for proposal service level agreements.
- Make quality determinations within the timeframes required by the Department and the selected CVO.

Quality Determination Timeframes for PHPs and the CVO

Once the PHPs receive all CVO-verified information, the Department expects to require PHPs to complete quality determinations for 90% of providers within 30 calendar days and for 100% of providers within 45 calendar days. PHPs will then provide written notices of quality determination to providers within five business days of the PNQC's decision. Overall, the Department expects the entire enrollment, credentialing and quality review process to take no more than 75 days. The Department welcomes feedback from stakeholders on these timeframes.

Notification and Provider Appeals

The Department will permit two separate and distinct provider appeals processes relating to provider enrollment, credentialing and contracting:

1. At the Department level for appeals regarding enrollment as a provider in Medicaid; and
2. At the PHP level for quality and contracting determinations.

For appeals under the first process, the Department or its agent will notify providers of appeals rights and manage the appeals process. The Department expects to leverage the current provider notification and appeals process for these appeals.

For appeals under the second process, PHPs will notify providers of appeals rights and manage the appeal process according to the Department requirements. When a PHP makes an adverse quality determination, a provider, regardless of network status, has the right to appeal the determination to the PHP as part of the PHP's broader appeals processes. Within five business days of the PNQC determination, the PHP will send written notice to the provider of the quality determination. For adverse quality determinations, the notice will include information on the right to appeal the decision and the reason for the adverse quality determination. Providers then must submit a written request for an appeal with the PHP within 30 calendar days from the date the provider receives the written notice of the adverse quality determination from the PHP. PHPs may for good cause extend the deadline to submit an appeal.

The notice will include information on the appeal process, including the submission of supporting evidence and the timeframe for submitting that information (15 calendar days). PHPs may extend the period for submission of supporting information by another 30 calendar days if the nature of the required evidence or supporting documentation is voluminous or for other good cause. All appeals decisions will be rendered by a PHP no later than 30 calendar days following receipt of a complete appeal request.

For appeals related to an adverse decision about recontracting with a provider based on the provider's ability to deliver care (measurement of a provider's performance against quality measures/metrics and engagement in quality strategy implementation), review of these appeals must include a peer review of the submitted information by a clinical peer of the provider who filed the appeal. Other appeals of adverse decisions relating to recontracting based on recredentialing information will follow the PHP's regular appeals processes.

The PHP's provider appeals process will be submitted to the Department prior to use, and will be included in the PHP's Provider Manual and its provider contracts, and will be available in written format to providers upon request.

Recredentialing

Providers will be required to be recredentialed every three years through the CVO. Consistent with the initial credentialing process, the certified CVO will collect and verify certain provider information centrally and PHPs will accept all verified information. However, with limited exceptions, the education and work history will not be verified during recredentialing. PHPs will be required to assess a provider's ability to deliver care through its PQNC at the time of recredentialing, including measuring a provider's performance against quality measures/metrics and engagement in quality strategy initiatives. PHPs will be required to meet the same timeframe as initial quality determinations and prior to the three-year timeframe "expiring."

Accredited Credentialing

To ensure that PHPs are held to consistent, current standards for quality, access and timeliness of care, PHPs will be required to attain accreditation from a nationally recognized accrediting body, such as the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC), within the first three years of operations. The Department will select a single accrediting body to ensure that PHPs are held to a uniform standard, aligned with the Department's quality goals and objectives. As accrediting organizations establish standards for accredited plans, the centralized credentialing process that will be

established by the Department must meet the standards of the accrediting organization to ensure that the plans are able to meet that standard.

To gauge the status of the current Medicaid provider screening, enrollment and credentialing process, the Department compared the current process against the standards of one nationally recognized accrediting organization's credentialing standards. While the State's current Medicaid FFS provider enrollment process meets the federal requirements⁹ that requires Medicaid providers to be screened and enrolled, the Department needed to identify any additional data or process standards required under the national standard that were not reflected in the current processes and data collection. The identified additional data and process standards that are required under accreditation for practitioners and typically required by PHPs to credential health care facilities are found in Appendices C and D, respectively.

Addressing Additional Data Needs During the Transition Period

The Department anticipates that procurement, implementation and operationalization of a new CVO may take up to 24 months. Given the identified additional data and process standard needs to meet an accrediting organization's credentialing standards, the Department will establish a transition period that will similarly minimize burden on providers.

This transition period will begin when the PHP RFP is awarded, and will end when the Department's new CVO solution¹⁰ is fully implemented. During the transition period, the Department's existing enrollment data will be supplemented with additional needed data, and this complete provider information will be used by PHPs as the basis for PHP quality determinations. Specifically, the Department proposes to contract with a national provider data clearinghouse for verified primary-source information that meets an accrediting organization's standards for an accredited credentialing process. To establish a credentialing process that meets accreditation standards, the Department proposes that the provider data clearinghouse vendor will match the clearinghouse data to the Department's data for providers enrolled in the Medicaid program. PHPs will be expected to accept the information collected for Medicaid enrollment and the data from the national clearinghouse, and use that combined data to make quality determinations until the CVO solution is fully implemented.

Until full implementation of the CVO, the Department will continue to enroll providers in the Medicaid program through NCTracks.¹¹ After full implementation, the Department will require that currently enrolled Medicaid providers move through the new centralized credentialing approach for recredentialing.

Additionally, during transition, the Department or the national provider data clearinghouse will provide PHPs with verified provider information in a usable format. PHPs will receive a file with the verified provider information collected for providers currently enrolled in Medicaid joined with national clearinghouse data. The verified provider data will be regularly provided to PHPs beginning with the PHP RFP award, through the readiness reviews, and then throughout the transition period.

If the Department cannot procure a national provider data clearinghouse that can provide all additional provider data, verify all data in a manner that meets the Department's expected standards, or do so at a cost or timeframe that is acceptable to the Department, other possible temporary solutions will be proposed by the Department while it implements the full CVO solution. This may include a) requiring PHPs to use existing

⁹ 2016 Medicaid Managed Care final rule and 21st Century Cures Act.

¹⁰ Includes procurement of a Provider Data Management solution.

¹¹ Provider Enrollment - <https://www.nctracks.nc.gov/content/public/providers/provider-enrollment.html>.

enrolled provider data as is, b) permitting PHPs to collect the additional data in limited circumstances, or c) a combination thereof. The Department welcomes feedback on its proposed solution for the transition period and other mitigation options.

Indian Health Care Providers Enrollment and Credentialing

An Indian Health Care Provider (IHCP) must enroll as a provider in the Medicaid program to be able to be paid by a PHP for services provided to a beneficiary who is an Indian. According to federal regulation,¹² PHPs must accept a provider who is an IHCP on the same basis as any other provider of health care services under the program if the IHCP meets generally applicable State and other requirements for participation as a provider under the program. PHPs must also contract with IHCPs health care services furnished to an Indian on the same basis as with any other provider qualified to participate to deliver health care services under Medicaid managed care. Any requirement that the IHCP must meet generally applicable Department or other requirements for participation, including being licensed or recognized under state or local law where the provider is located to furnish health care services, will be deemed to have been met if the entity meets all the applicable standards for licensure or recognition, regardless of whether the entity obtains a license or other documentation under such laws.

When making contracting decisions relating to IHCPs, PHPs will uniformly exercise quality determinations across all providers, including IHCPs.

IV. Oversight and Monitoring

The Department expects to require PHPs to maintain written provider contracting policies and procedures, including policies and procedures for preventing and monitoring discriminatory practices. PHPs will submit the policies and procedures to the Department in advance of use, and before implementing significant changes to the policies. The Department plans to require that PHPs report the following related to credentialing determinations on at least a quarterly basis:

- Number of pending/approved/denied applications by provider type,
- Average timeframes for determination (including those processed within 30 or 45 days),
- Explanations for delays in credentialing determinations, and
- Summary of provider appeals made to the PHP; reporting will be coordinated with other Department reporting requirements for PHPs.

PHPs will also be subject to periodic audits by the Department or its external quality review organization (EQRO). Audits will be coordinated with other Department oversight requirements for PHPs.

¹² Section 408(a)(2) from 25 U.S.C. §1647a.

Appendix A: Glossary

The following is a list of terms as used in this paper.

TERM	DEFINITION
Credentialing	The process of collecting and verifying provider qualifications (e.g., the provider’s training and education, licensure, liability record). For managed care, this includes determining whether a PHP allows the provider in its network. The Department intends to collect and verify provider credentials centrally. PHPs will accept verified information and determine whether to allow providers in network.
CVO	“Credentials Verification Organization” is an organization that collects data and verifies the credentials of providers as part of the credentialing process.
Indian Health Care Provider (IHCP)	Means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 USC 1603).
Managed Care Organization	As defined in 42 CFR 438.2, an entity that has, or is seeking to qualify for, a comprehensive risk contract and meets specified requirements, including the solvency standards of 42 CFR 438.116. North Carolina Medicaid managed care refers to MCOs as PHPs.
Provider	The umbrella term used to refer to individual practitioners and facilities / entities / organizations / atypical organizations / institutions.
Provider Enrollment	The process by which a provider is enrolled in a state’s Medicaid program. Credentialing is a component of enrollment. Note: The 2016 Medicaid Managed Care final rule and 21 st Century Cures Act require all Medicaid providers to be screened and enrolled by a state. However, enrollment as a provider by a state does not obligate managed care providers to participate in the state’s FFS program.
Provider Contracting	The process by which the PHP negotiates and secures an agreement with credentialed providers to be included in the PHP’s network.
Quality Standards	The factors that PHPs may apply to determine if it will move to contracting with a provider.

Appendix B: Federal Requirements – Provider Screening, Enrollment, Credentialing

Fee-for-Service Medicaid (42 CFR Part 455)

The State Medicaid Agency must complete the following activities.

- Enrollment and screening of providers – Require all enrolled providers to be screened.
- Verification of provider licenses – Have a method for verifying providers’ licenses; confirm licenses are not expired or with limitations.
- Revalidation of enrollment – Revalidate enrollment of all providers at least every 5 years
- Termination or denial of enrollment – Terminate or deny enrollment of providers meeting certain criteria (e.g., providers convicted of certain criminal offenses, providers terminated by Medicare or other states’ Medicaid or CHIP programs); give providers terminated or denied enrollment appeals rights.
- Criminal background checks – Require providers to consent to criminal background checks and fingerprinting when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse.
- Federal database checks – Routinely check federal databases to confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider.
- Site visits – Conduct pre-enrollment and post-enrollment site visits of providers who are designated as “moderate” or “high” categorical risks to the Medicaid program.
- National Provider Identifier – Require all claims to contain an NPI.
- Screening levels for Medicaid providers – Screen all applications (initial and re-enrollment) based on categorical risk level of “limited,” “moderate,” or “high.”
- Other State screening methods – Can establish provider screening methods in addition to or more stringent than the above.

Medicaid Managed Care (42 CFR 438.602, 214)

- **Screening and enrollment and revalidation of providers.** The State must screen and enroll, and periodically revalidate, all MCO network providers in accordance with the requirements of Part 455 (*including the above requirements*).
- **Credentialing and recredentialing requirements.** The State must establish a ***uniform credentialing and recredentialing policy*** that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, and requires each MCO to follow those policies. Each MCO must follow a documented process for credentialing and recredentialing of network providers.

Appendix C: Gaps between North Carolina's Current Medicaid Provider Enrollment Process and the NCQA¹³ Standards for Practitioners

A. Education and Training

- Highest level of training completed by the practitioner, including board certification, residency or medical / professional school graduation
- No time limit for verification; must verify and document highest training level when reporting information plans
- The Department does not collect or verify medical education and training

B. Board Certification

- Current board certification status, if practitioners state they have has board certification
- Must report verification to plan within 120 calendar days of conducting the verification
- Providers may enter board certification in optional field; the Department does not verify information

C. Malpractice History

- Malpractice settlements from the past five years
- Must report verification to plan within 120 calendar days of conducting the verification
- The Department does not collect or verify malpractice information

D. Work History

- Work history from the past five years, including gaps
- Must report verification to plan within 305 calendar days of reviewing information provided by the practitioner
- The Department does not collect or verify work history

E. DEA or CDS Certification

- Practitioner who prescribes medications has a current DEA or CDS certification in North Carolina
- No time limit; certification must be documented and valid when information reported to the plan
- The Department does not collect DEA certification on a mandatory basis

F. Licensure

- Practitioner has a valid, current license to practice in North Carolina
- Must report verification to plan within 120 calendar days of conducting the verification

¹³ Pursuant to the Department's program design, all PHPs will be required to obtain accreditation from a yet-to-be-specified nationally recognized accrediting organization. NCQA is used in this appendix for illustration purposes only.

- No gap in current verification source, but the Department does not observe time limit and certain processes are currently manual

G. Provider Attestations

- Practitioner attestations regarding ability to perform essential functions, illegal drug use, history of loss of licenses, history of felony convictions, limitations of privileges or disciplinary actions, current malpractice coverage, and correctness / completeness of the application
- Must report verification to plan within 305 calendar days of reviewing information provided by the practitioner
- The Department collects some, but not all, attestations required by NCQA

H. State Licensing Board Sanctions

- State licensing board sanctions from the past five years
- Must report verification to plan within 120 calendar days of conducting the verification
- No gap in current verification source, but the Department does not observe time limit; must note that LexisNexis acts as an agent, and packages and provides verified information to the Department

I. Medicare/Medicaid Sanctions

- Medicare and/or Medicaid sanctions from the past five years
- Must report verification to plan within 120 calendar days of conducting the verification
- No gap in current verification source, but the Department does not observe time limit; must note that LexisNexis acts as an agent, and packages and provides verified information to the Department.

Appendix D: Gaps between North Carolina's Current Medicaid Provider Enrollment Process and Common MCO Information Standards for Facilities

A. Liability Insurance

- Copy of current insurance certificate
- Verification of effective and expiration dates
- Coverage amounts, including per occurrence and aggregate limits
- The Department does not collect information on liability insurance

B. Accreditation

- Evidence of accreditation from the Joint Commission or other appropriate accrediting body (e.g., AAAHC, HFAP, IMQ, CARF, CHAPS, ACHC, AOA)
- For facilities without accrediting bodies, additional information may be required, including information on quality management program, reports on disciplinary action from the last five years; letters of recommendation attesting to quality or cost-effectiveness of care; documented policies for coverage arrangements or onsite quality assessment on quality management program; reports on disciplinary action from the last five years; letters of recommendation attesting to quality or cost-effectiveness of care; and documented policies for coverage arrangements or onsite quality assessment
- The Department requires accreditation for facilities with accrediting bodies, but does not collect additional information required by plans for facilities without accrediting bodies