

Comments/Concerns from September 22 MAAC Executive Committee Meeting

1. Joint Roundtable Meetings with MCOs
 - a. Is it possible for DHS to assist in setting up provider training sessions where each of the MCOs attends and all answer specific questions, discuss operational processes, etc.? No DHS presentation, just each of the MCOs doing an overview of how to do business with them as providers?
 - b. Would like to set up by provider type, (primary care/specialists, long term care, etc.)
2. Provider Network
 - a. General misunderstanding on what the six month and two year network means and how providers will contract, bill, etc.
 - i. Lindsay drafted factsheet for policy staff approval to address this topic
 - b. Concerns about what happens on 7/1 when MCO networks are effective
 - i. How are members being educated on whether or not their provider will actually be in network permanently?
 - ii. Any proactive outreach we can do?
 - iii. How to encourage providers to not wait on contracts
 - iv. Is there any handoff involved when providers are no longer available?
 - c. When will the MCO provider networks be available? At what point will a provider directory be published?
 - i. Will those be online?
 - ii. What is being included in the member enrollment packet in terms of a provider directory?
 - iii. How does the six months/two years impact who is included in the initial MCO provider directory? Wouldn't it be easiest to just link to Medicaid's current directory if all are included?
 - d. Network readiness
 - i. What does this actually mean during the readiness review? How is it being evaluated?
 1. Suggested Readiness Review be a topic in November
 - e. Out of state providers
 - i. How are MCOs handling these providers? Will contracts be available?
3. Rates
 - a. When will presentation be posted?
 - b. Can information be shared publically with other members of organizations?
4. Contracts
 - a. Status of MCO contracts with DHS/new date?
 - b. DHS approval of MCO provider agreements
 - i. When will this be completed?
 - ii. Providers are not/being encouraged to not sign contracts until DHS has approved the templates and released rate floor, thus causing potential issues with getting providers contracted in time
 - iii. MCOs are setting firm deadlines for contracts to be returned, but providers are not comfortable signing now, what's the impact here?
 - c. How will DHS communicate the signing of both the MCO contracts and the approval of the MCO provider agreements?
5. Member Choice Period

- a. General confusion on when the 90 days begins (communicated it begins on December 18, per MMIS dates), but there was debate on this, stating that it should begin on January 1
- 6. Member Packet from MCO
 - a. When does the 5 days begin? When will the MCOs receive the enrollment file and how quickly will members be receiving information?
 - i. This is an outstanding IME Modernization Project issue and discussion
- 7. Confusion on Enrollment Broker
 - a. Despite using name Iowa Medicaid Member Services, there is still a disconnect that the name means the enrollment broker, some still seem to think another entity will be doing choice counseling
 - b. Want consistent use of terms, but also confused
 - i. Shared the Choice Counseling document with members on 9/23/15
- 8. Case Management and Integrated Health Homes
 - a. Inconsistency in how MCOs are communicating on IHH and TCM
 - i. Some are saying they will have programs, others are saying they won't, need clarification on what will be continued and how it's administered
 - ii. Will the MCOs be using the same IHH network as Magellan?
- 9. Role of Public Health Agencies
 - a. How will public health agencies be involved with MCOs and providing services?
 - i. Gerd discussed afterwards with Kristie Oliver



GEORGIA DEPARTMENT
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Centralized Credentialing Verification Organization



Presentation to: Medical Care Advisory
Committee

Presented by: Lynnette R. Rhodes, Esq.

Date: August 19, 2015



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Mission

The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight.

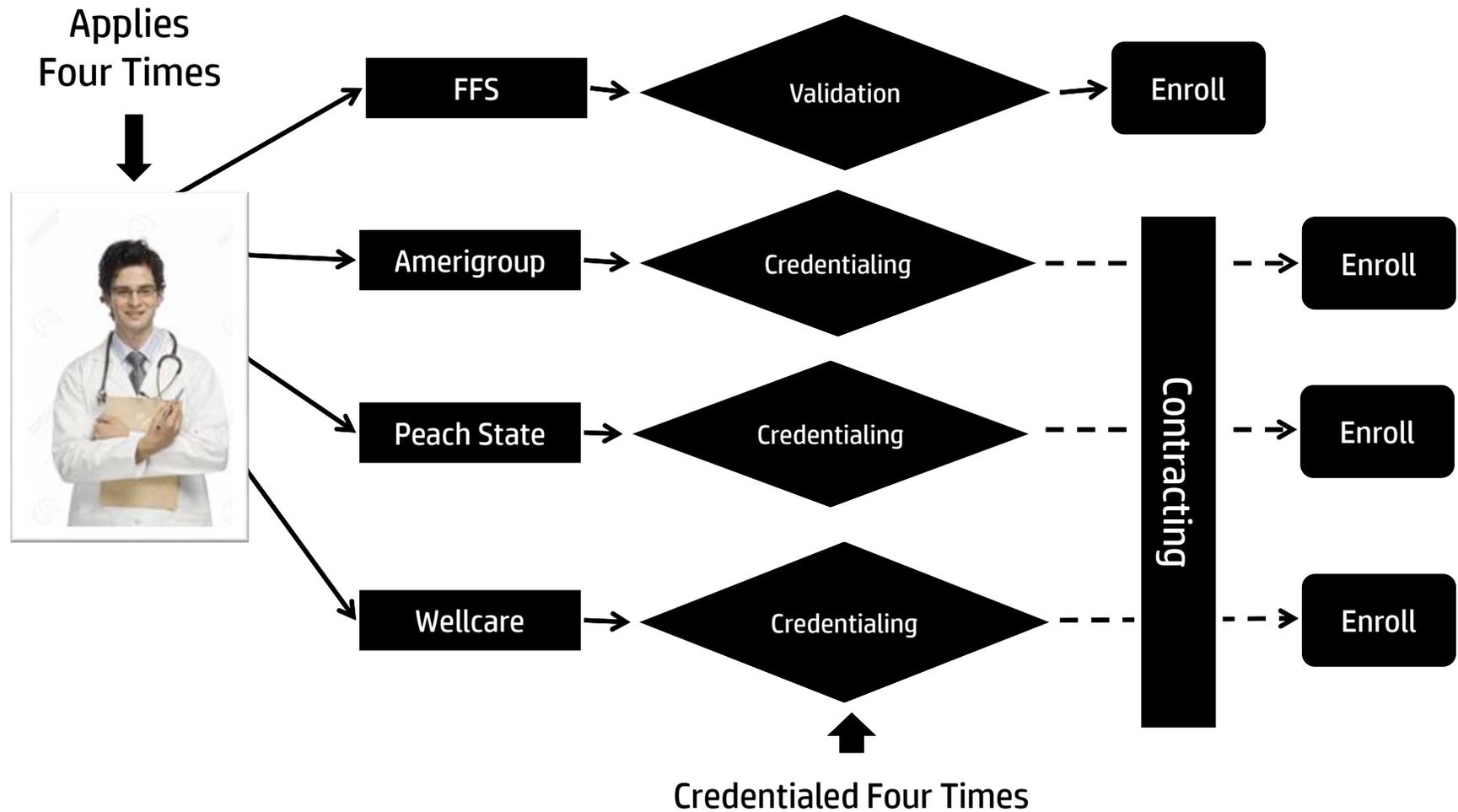
We are dedicated to A Healthy Georgia.

Centralized Credentialing Verification Organization

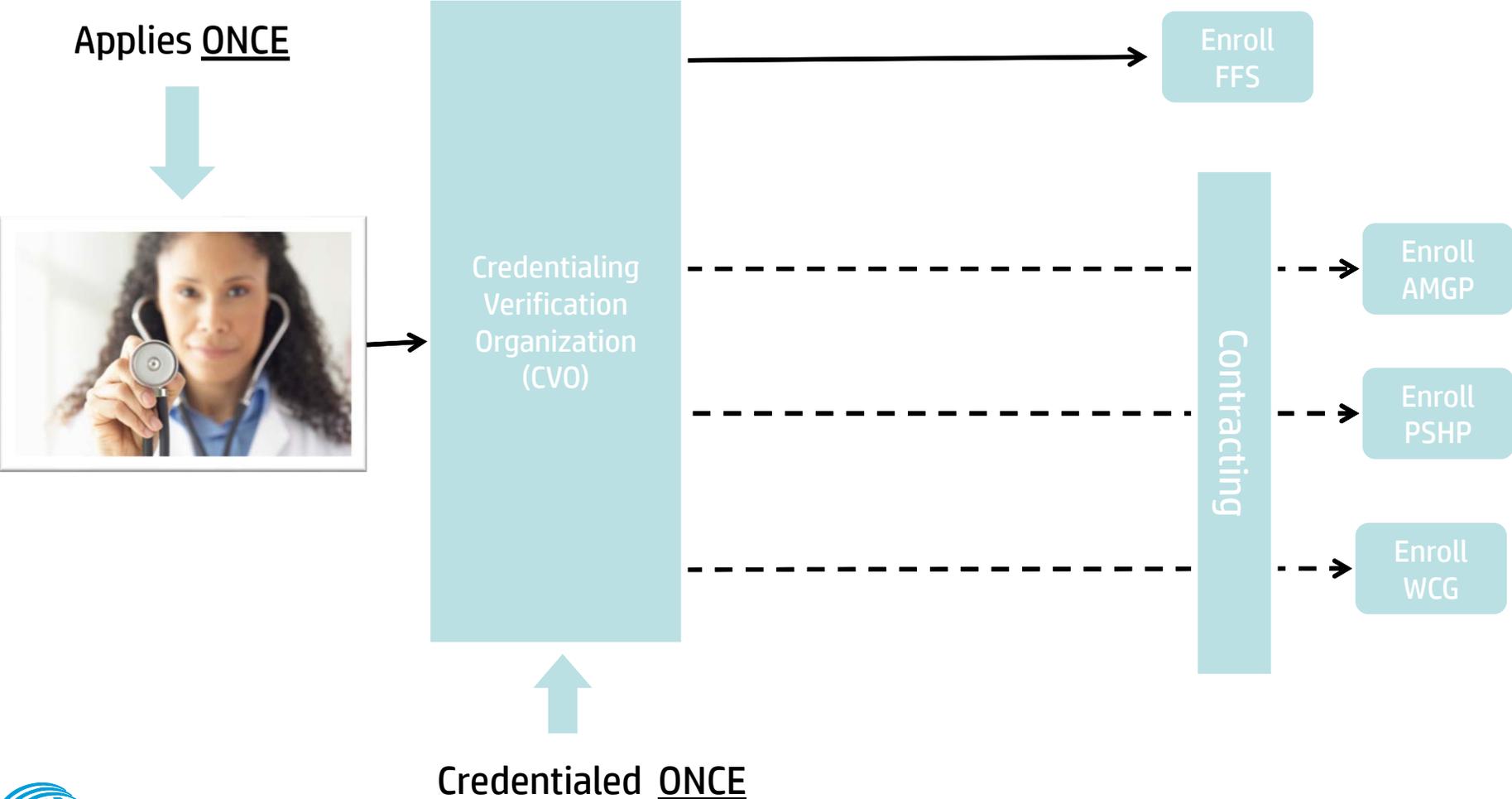
- Streamlined Credentialing Process with a single point of entry;
- CMOs delegate credentialing authority to DCH;
- Electronic Process;
- One Credentialing Committee;
- CMOs will receive a credentialing/recredentialing packet which contains credentialing information and credentialing decision;
- Providers will be notified of their credentialing status via GAMMIS;
- CMOs *shall* accept the State's credentialing decision;
- CMO *may not* ask for additional information related to credentialing.



Old Process



New Credentialing Process



CVO Web Portal

- All applications (initial credentialing and recredentialing) will be submitted through the existing HP web portal;
- Panels have been revised to capture additional provider information;
- Supporting documentation must be uploaded before application can be submitted;
- Checklist by provider type and category of service will identify required credentialing documentation.



CCVO Activities

- Confirm receipt of/verify Curriculum Vitae (CV);
- Verify licenses and certifications with all required licensing boards and authorities, including those in other states;
- Verify practitioner Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substance (CDS) certification;
- Verify practitioner education (highest level), training, and work history, including any gaps of six months or greater;
- Record/verify practitioner malpractice insurance coverage and claims history;
- Verify social security numbers and dates of death for the individual practitioner, owners, authorized officials, delegated officials, and supervising physicians;
- Verify Peer references;
- Verify Hospital Privileges;
- Verify Taxpayer ID numbers;



CCVO Activities

- Verify taxpayer ID numbers;
- Verify practitioner medical board sanctions;
- Verify practitioner Medicare/Medicaid sanctions;
- Interface with National Plan and Provider Enumeration System (NPPES) to verify National Provider Identifier (NPI);
- Interface with the National Practitioner Data Bank (NPDB) to check for adverse actions;
- Interface with the U.S. Department of Health and Human Services Office of the Inspector General (OIG), the List of Excluded Individuals/Entities (LEIE) and Excluded Parties List System (EPLS) and the State Medicaid Termination Database to determine the exclusion status for enrolling/recredentialing providers and persons with a five percent (5%) or greater ownership or control interest and any agent or managing employee of the provider;



CCVO Activities

- Validate Medicare providers using Medicare's Provider Enrollment Chain Ownership System (PECOS);
- Conduct review of fraud and abuse sanctions against the provider;
- Provide a Credentialing Committee Review; and
- Periodically review the checklist requirements against the NCQA guidelines and ACA requirements to ensure compliance.



National Practitioner Data Bank

- CVO will not provide the results of the NPDB search to the CMOs.
- Provider profile will indicate that NPDB has been checked.
- CMOs must maintain a copy of the provider profile for auditing purposes per NCQA guidance.



Credentialing Committee

– Credentialing Committee Staffing:

- Chief Medical Director (1) – voting rights
- Associate Medical Directors (4) – voting rights
- DCH Representative (1) – voting rights
- CMO Representatives (3) – voting rights
- Credentialing Coordinator
- Peer Expert Specialists (As Needed)
- Peer Expert Non-Physician Practitioners (As Needed)
- Each member serves for a one year period of time. Appointments automatically renew.
- Credentialing Committee will reflect, to the extent possible, the provider mix of the Georgia Families and Georgia Families 360° population.
- Credentialing Committee shall meet regularly and no less than once per month.



Credentialing Committee Responsibilities

- Adhere to NCQA guidelines;
- Review provider information gathered by the CVO and make a credentialing decision (approval or denial);
- Consult Peer Review Specialists when necessary;
- Review results of site visits;
- Provider applications will be categorized as follows:
 - Clean - Meets standards with no adverse findings;
 - Denied - Does not meet standards with adverse findings
 - Requires Review - Low Risk/High Risk
- Assist in developing or revising policies and procedures;



Credentialing Timeline

- Credentialing Timeline Includes the following:
 - HP verifies provider submitted all required documents;
 - If application is incomplete, notice of missing documents will be sent to provider;
 - Provider must submit missing documentation in order for application to be processed. Incomplete applications will be denied;
 - CVO will conduct database exclusionary checks (federal and state);
 - CVO will conduct PECOS Credentialing Verification;
 - CVO will conduct PSV Credentialing Verification ;
 - DCH PE conducts finger printing and background checks;
 - Site Visits;
 - Rate Setting Activities (facilities);
 - CVO Credentialing Committee Review;
 - Appeals Process; and
 - Enrollment



Recredentialing Timeline

- Abbreviated Process;
- Providers must be credentialed every thirty six months (3 years) per NCQA guidelines;
- Will use the earliest initial credentialing or recredentialing effective date;
- Recredentialing through the new CVO may be performed earlier than the three (3) year cycle due to the transition;



Recredentialing Timeline

- HP/Aperture will begin provider outreach five (5) months in advance of their recredentialing due date;
- Firm cut-off date for recredentialing;
- Providers that miss their recredentialing date must go through initial credentialing.



Provider Site Visits

- Site Visits will be conducted by DCH/HP;
- Field Inspection Checklists will be utilized for site visits;
- Credentialing Committee will review results of site visits.



Appeals Process

- DCH will process all CVO appeals;
- Per O.C.G.A. § 33-21A-8, Dentists appeals are heard before the Office of State Administrative Hearings.



HP Provider Call Center

- Provider Call Center has been updated to include prompts for credentialing and recredentialing inquiries;
- Increased call center staff;
- Call Center Staff has been trained on credentialing and recredentialing process;
- HP Provider Call Center can be reached by dialing 1-800-766-4456 (Monday through Friday from 7:00AM – 7:00PM except State Holidays)



Contracting Process

- Credentialing and Contracting are separate and distinct;
- Successful Credentialing does not guarantee the provider will be enrolled in the CMO network;
- Upon receipt of credentialing decision, CMO will be expected to expedite contracting process;
- CMO may not use the contracting process to circumvent credentialing decision.



Transition Period

- August 1, 2015, all *new provider applications* seeking enrollment with one more CMOs will be credentialed through the new CVO;
- August 1, 2015 through November 30, 2015, CMOs will process all *existing applications seeking initial credentialing* for those providers that submitted an application *prior to August 1, 2015*;
- August 1, 2015 through November 30, 2015, CMOs will continue to *recredential* all providers currently enrolled in their respective health plans;
- Effective December 1, 2015, all providers will be credentialed and recredentialled through the new CVO. CMOs will no longer perform credentialing and recredentialing services for enrolled providers. (See exception below)
- *Note: CMOs will be responsible for delegated credentialing and recredentialing for Independent Practice Associations and Provider Hospital Organizations.*



Phase II Considerations

- FFS Only Providers Will Be Credentialed and Recredentialed by CVO;
- Verify Out Of State Exclusions/Sanctions;
- Capturing PCP Delegation/Specialty;
- Criteria For Imaging Providers (NIA Magellan);
- Capturing the Application Submission Date on 7400 File;
- Search Functionality for CMOs other than ATN;
- Capturing all documents submitted for credentialing in one file for CMOs to download;
- Reports that will allow CMOs to identify those providers that are due for recredentialing;
- Combining Large Groups during the Credentialing Process;
- Requirements for Supervising/Sponsoring Physicians;
- Requiring Alternative Plans for Hospital Admitting Privileges;
- Including Specialty Codes on 7400 File
- Adding DBHDD/DAS Providers;



Provider Education and Information

- Frequently Asked Questions are available at the following link:
- http://dch.georgia.gov/sites/dch.georgia.gov/files/CVO_FAQs_07_14_2015.pdf.
- GAMMIS contains information about the credentialing process and instructions on how to use the portal.
- HP Provider Call Center can be reached at 1-800-766-4456.
- Inquiries may be submitted to the DCH CVO mailbox at cvo.dch@dch.ga.gov.
- HP will be conducting webinars during the month of August 2015.
- HP provider representatives are available to provide training and assistance.



FAQ



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Amerigroup
RealSolutions
in healthcare



peach state
health plan.

Credentialing Verification Organization Process Frequently Asked Questions July 14, 2015

Effective August 1, 2015, Georgia's Department of Community Health (DCH) will implement a new NCQA certified Centralized Credentialing Verification Organization (CVO) that will be responsible for credentialing and recredentialing Medicaid providers currently enrolled or seeking to enroll with Georgia's Care Management Organizations (CMO).

Credentialing and recredentialing services will be provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This new streamlined process will result in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

Answers to your most commonly asked questions regarding the Centralized CVO initiative are listed below. If your question is not listed below; please contact DCH via email at cvo.dch@dch.ga.gov.

1. **When will the CVO begin accepting provider applications?**

It is anticipated that the CVO process will be implemented August 1, 2015.

2. **Why is the current provider enrollment process changing?**

Currently, a provider seeking to enroll with multiple Care Management Organizations (CMO) must be credentialed or recredentialed with each individual CMO. This process requires that a provider submit credentialing and recredentialing materials to each individual CMO in order to be credentialed or recredentialed. This process results in multiple submissions and has proven to be administratively burdensome to providers. The current process also results in inconsistencies in credentialing and recredentialing outcomes.

The new streamlined process will allow providers currently enrolled with a CMO or seeking to enroll with a CMO to submit a provider enrollment application and all credentialing or recredentialing materials through one single web portal. This streamlined process eliminates the need to submit credentialing and recredentialing materials to multiple CMOs.

3. What are the advantages of DCH using a CVO?

- One streamlined Credentialing/Recredentialing process
- Single electronic application process
 - Increases efficiency
 - Eliminates multiple submissions of credentialing and recredentialing materials
 - One Credentialing Committee
- Providers will be credentialed and recredentialed by one centralized CVO
- Consistency in credentialing and recredentialing processes and decisions
- Shortened time period for providers to receive credentialing and recredentialing decisions
- Synchronized re-credentialing process and cycles
- Provider has the ability to track application/credentialing status
- Credentialing and recredentialing decisions will be shared with providers and the CMOs

4. What is the purpose of the Centralized Credentialing Verification Organization?

The CVO will conduct one streamlined process for provider credentialing and re-credentialing. This streamlined process will facilitate providers requesting to enroll with a CMO for the first time as well as those providers that are currently participating in the Georgia Families or Georgia Families 360° programs.

5. Who will be required to go through credentialing verification process?

All individual practitioners and facilities currently enrolled or seeking to enroll with a CMO will be credentialed and recredentialed through the new Centralized CVO. Independent Physician Practice Associations (IPA) and Physician Hospital Organizations (PHO) that conduct their own credentialing and to whom the CMOs delegate credentialing are excluded from this process.

6. Who reviews the provider credentialing and recredentialing materials?

The CVO and the Credentialing Committee will review all credentialing and recredentialing materials submitted by providers. The Credentialing Committee is responsible for credentialing Medicaid providers enrolled or seeking enrollment in the Georgia Families or Georgia Families 360° programs. The Credentialing Committee is responsible for reviewing the results of primary source verifications, verification of state and federal databases, site visits, criminal background checks, fingerprinting and reviews of Medicare's Provider Enrollment Chain Ownership System (PECOS) in order to issue a decision affirming or denying an applicant's credentialing status.

7. How long will it take for a provider to be credentialed or recredentialed?

Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within forty five (45) calendar days from the date of submission. Incomplete applications that do not contain all required credentialing and recredentialing materials will be returned to the provider with a request to supplement all missing materials. Incomplete applications that are not supplemented with requested missing materials will be denied and will result in a delayed credentialing or recredentialing decision.

8. Is there a fee to be credentialed or recredentialed?

No. There is not a fee associated with credentialing or recredentialing. However, federal regulations require that certain new, re-enrolling or revalidating providers pay an application fee prior to executing the Medicaid Statement of Participation or provider agreement. The following are exempt from the application fee:

- a. Individual physicians or non-physician practitioners;
- b. Providers who are enrolled in either of the following:
 - i. Title XVII of the Social Security Act
 - ii. Another state's Title XIX or XXI plan
- c. Providers that have paid the application fee to:
 - i. Another state
 - ii. A Medicare contractor

9. Will training be provided on the process for submitting an application?

Yes. HP provider representatives will provide training and assistance as needed. Beginning August 1, 2015, providers may contact HP for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

10. Will there be a Transition Period?

Yes. The transition process is as follows:

- Effective August 1, 2015, all **new provider applications** seeking enrollment with one or more CMOs will be credentialed through the new CVO.
- From August 1, 2015 through November 30, 2015, the CMOs will process any and **all existing applications** seeking **initial credentialing** for those providers that submitted an application **prior to August 1, 2015**.
- From August 1, 2015 through November 30, 2015, the CMOs will continue to **recredential** all providers currently enrolled in their respective health plans.
- Effective December 1, 2015, all providers will be credentialed and recredentialed through the new CVO. Beginning December 1, 2015, the CMOs will no longer perform credentialing or recredentialing services for enrolled providers.

Note: The CMOs will be responsible for the delegated credentialing and recredentialing for Independent Practice Associations (IPA) and Provider Hospital Organizations (PHO).

FAQ



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11. If I am credentialed by the CVO will I still need to contract with each of the CMOs?

Yes, you will need to enter into a Provider Agreement with each CMO you are interested in contracting with. Contracting and credentialing are separate and distinct processes. Each CMO will decide which provider they would like to enroll in their network.

12. What if my practice already has an existing contract with one or more of the CMOs? Will I still obtain credentialing and re-credentialing certification through the Centralized CVO?

Yes, providers joining a practice with an existing CMO contract on or after August 1, 2015 will go through the Centralized CVO if initial credentialing is required. Contracted providers originally credentialed by one or more of the CMOs will fall under the Centralized CVO's re-credentialing timeline beginning December 1, 2015.

13. What if I currently have a credentialing application in process with one or more of the CMOs prior to the August 1, 2015 go-live?

Credentialing applications received by the CMOs prior to August 1, 2015 will be processed by the CMOs.

14. How do I find out the status of my application?

The existing HP Provider Call Center will be enhanced to respond to inquiries regarding credentialing and recredentialing applications. Additionally, providers may obtain information regarding the status of their application on the HP provider enrollment web portal at www.mmis.georgia.gov. Beginning August 1, 2015, providers may contact the HP Provider Call Center by dialing 1-800-766-4456 to obtain assistance with credentialing and recredentialing.

15. What is the process if I need to be re-credentialed?

The CVO will perform re-credentialing for both current and new providers every three (3) years. Providers requiring re-credentialing will be notified by DCH at least 90 calendar days in advance of the recredentialing due date.

If you are a current network provider belonging to more than one CMO and have a different credentialing effective date with either plan, then your re-credentialing due date will be based on the earliest initial credentialing or re-credentialing effective date. Therefore, initial re-credentialing with the CVO may be performed earlier than the three (3) year cycle due to the transition.

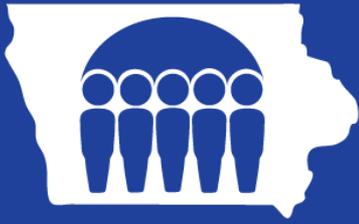
FAQ

16. Additional questions regarding the Credentialing Verification Organization Process?

Visit the DCH provider portal – GAMMIS – at www.mmis.georgia.gov.

Questions regarding the CMO contracting process should be directed to the specific CMO (see contact information listed below).

CMO Name	Provider Services	Web Site	Email
WellCare	1-866-300-1141	https://georgia.wellcare.com/prospectiv_providers/new	GAPR@wellcare.com
Peach State	1-866-874-0633	http://www.pshpgeorgia.com/provider-quick-reference-information/	PSHPproviderservices@centene.com
Amerigroup	678-587-4840	https://providers.amerigroup.com/pages/ga-2012.aspx	gaproupdates@amerigroup.com



IA Health Link Member/Provider Transition Update



Member Activities

- Member Populations
- Member Benefits
- DHS Member Outreach & Education
- Stakeholder Outreach & Assistance
- Member Enrollment

Member Enrollment Activities

Overview of Process

Step 1: Introductory Mailing

Step 2: Tentative MCO Assignment

Step 3: MCO Contacts Member

Step 4: New Member Enrollment

Step 5: New Member HCBS Waiver

Step 6: MCO Changes for 'Good Cause'

Step 7: Enrollment Broker Role



Member Populations

Included:

Majority of Medicaid members

- Low income families and children
- *hawk-i*
- Iowa Health and Wellness Plan
- Long Term Care
- HCBS Waivers

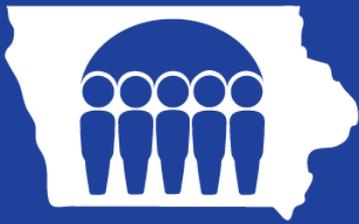
Excluded:

- PACE - can opt in to MCO
- Programs where Medicaid already pays premiums: HIPP, Medicare Savings Program only
- Medically Needy
- American Indians/Alaskan Natives (members can opt-in)
- Undocumented persons eligible for short-term emergency services only



Member Benefits

- Physical health care in inpatient and outpatient settings, behavioral health care, transportation, etc.
- Facility-based services such as Nursing Facilities, Intermediate Care for Persons with Intellectual Disabilities, Psychiatric Medical Institution for Children, Mental Health Institutes and State Resource Centers
- Home and Community-Based Services (HCBS) waiver services
- Dental services are “carved out” – continue same as today



DHS Member Outreach & Education

- Tele-townhall meetings
- Events and trainings
- Newsletters
- Member educational materials
- Member mailings
- Earned media
- Community partnerships
- Coordination with stakeholders and providers
- Advisory and member-based focus groups
- Website content
- Webinars



Stakeholder Outreach & Assistance

- Stakeholder toolkit will be available online and to all stakeholders to support accurate information in the transition to current Medicaid members
- Posted week of September 8
- Information includes:
 - IA Health Link Program Overview
 - Links to FAQs, Factsheets and DHS Website updates
 - Help in selecting an MCO Materials
 - Member Promotional Materials
 - Member Introductory Mailings



MCO Stakeholder Outreach

- MCOs have begun to reach out to stakeholders to assist in promoting an understanding of managed care benefits
- DHS must approve public facing materials such as marketing materials and member letters
- DHS has held stakeholder meetings with more to come, webinars upcoming including enrollment help



Member Enrollment Activities

Overview of Enrollment Process

September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016
Introductory Mailings by population	MCO Enrollment Begins	Enrollment assistance continues	December 17, 2015: Last Day to Make MCO Choice for January 2016	January 1: Begin Coverage with MCO		March 19: Member must have Good Cause to make change
				December 18, 2015- March 18, 2016: Member can change MCO without Good Cause		



Step 1: Introductory Mailings

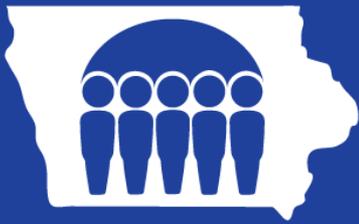
- Introductory mailings sent to members per the following schedule, and posted online:
 - Long Term Care, hawk-I, Other Medicaid groups and Current managed care versions
 - Mailing throughout September
- Mailings will include:
 - Timeline
 - FAQ
 - Links to education materials, toolkits online
 - Contacts for questions



Step 2: Tentative MCO Assignment

Member enrollment packets mailed October through November

- Tentative assignment included and based on algorithm to keep families together under one MCO
- Staggered mailing by program enrollment similar to introductory mailing
- Current members have until December 17 to choose for January 2016, with an additional 90 days after the January assignment to change MCOs for any reason
- DHS notifies MCO of selection through enrollment file



Step 3: MCO Contacts Member

MCOs will distribute enrollment materials to new members within 5 business days of receipt of member enrollment selection

- Examples of enrollment materials:
 - Provider directory
 - MCO contact information
 - Services available
 - Grievance and appeal information
 - Member protections, rights, and responsibilities
 - Information on how to contact the Enrollment Broker
 - Contact information and role of the Ombudsman



Step 4: New Member Enrollment

- Starting December 8, 2015, and ongoing, the date of eligibility for new members will impact the date they are enrolled with an MCO
 - This is because there is a point in which there is a IT system cut off to review to the MCO to ensure the beginning of the month capitation
- When the member is eligible but is unable to be enrolled in the MCO in the month in which they apply - services will be paid for by the Medicaid Fee for Service program until they are enrolled with the MCO the following month
 - Both medical and behavioral services



Step 5: New Member - HCBS Waiver

- Slots will continue to be authorized through approval of waiver applications and state legislation
- DHS will continue to manage the waiting list and assignments
- Some members are not Medicaid eligible prior to being given an HCBS waiver slot. The department is in the process of determining how best to implement HCBS services in these instances
 - Timing of level of care determination
 - Financial determinations
 - Service planning critical to MCO assignment and member choice



Step 6: MCO Changes for 'Good Cause'

- Members may disenroll from their MCO at any time throughout the year for reasons of “good cause”
- “Good cause” reasons can include:
 - A member’s provider is not enrolled with the MCO and that provider disenrollment impacts the members’ health outcomes
 - A member needs related services to be performed at the same time and not all related services are available in the MCO network
 - If there is a change in eligibility (for example PACE)



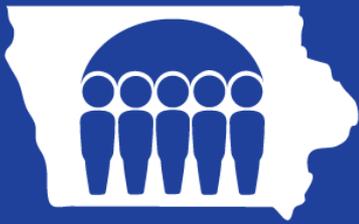
Good Cause Cont.

- To make a change:
 - Members call the Iowa Medicaid Enrollment Broker to request disenrollment for “good cause”
 - Members tell the Enrollment Broker which MCO they want to switch to
 - If a member has a question about whether they have a “good cause” they can call the Enrollment Broker for more information



Member Services

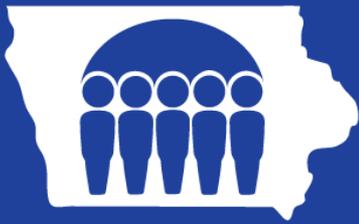
- Member Services is the independent Enrollment Broker and responsible for providing information and conflict free choice counseling for members in the selection of a MCO
- Key activities to share information and support member selection of MCO:
 - In-person meetings throughout state with special focus on long term care members, schedules upcoming and posted online
 - Email: IMEMemberServices@dhs.state.ia.us
 - Call Center: 1-800-338-8366, 8am-5pm, M-F
 - Members can select their MCO through voice system option 24/7 daily. Can leave message for call back



Member Services Cont.

Member Services will offer health plan choice counseling to members. Choice counseling includes answering member questions about each health plan such as:

- Is my provider in the MCO network?
- Is my pharmacy in the MCO network?
- Does the MCO have specialists close to my community?
- Does the plan have value-added services that would benefit me?
- Are there special health programs that would help me?
- Does the MCO have call centers or helplines available beyond regular business hours?



IA Health Link Provider Activities

- MCO Provider Network Requirements
- Case Management Requirements
- Provider Education and Training, Resources
- Provider Enrollment Process Overview
- DHS Enrollment Timeline
- DHS Provider Enrollment Renewal
- MCO Provider Enrollment
- MCO Provider Enrollment Timeline
 - Questions and Answers



MCO Provider Network Requirements

Physical & Behavioral

- MCOs will use all current Medicaid providers for the first six months
- MCOs network effective July 1, 2016
- Strict network adequacy

Waiver & Long Term Care

- MCOs will use all current LTC waiver providers, if they contract with the MCO, for the first two years
- MCO network effective January 1, 2018
- Strict network adequacy



MCO Network Requirements Cont.

- MCOs must have an adequate provider network as defined in the MCO contracts with DHS
 - Example Access Standards:
 - PCP – Within 30 minutes or 30 miles from all members
 - Specialists – Within 60 minutes or 60 miles for at least 75 percent of the members
 - HCBS – Within 30 minutes or 30 miles from members in urban counties and 60 minutes or 60 miles from members in rural counties
 - An MCO must use non-network providers if there is a gap in coverage for a particular service
 - MCOs are to extend authorization of long term care services from an out-of-network provider to ensure continuity of care



MCO Case Management Requirements

- Members able to keep their current case management agency until at least June 30, 2016, as long as provider(s) choose to participate with the MCOs
- All case management activities must be transitioned to the MCOs no later than December 31, 2016
- MCOs will determine how to manage case assignments for community-based case management
- MCOs may provide community-based case management themselves or sub-contract with current case managers and must ensure staff maintains appropriate credentials, education, experience and orientation



DHS Provider Education and Training

- Statewide training in 11 locations across Iowa in September
- Provider toolkits available early September 2015
- Tele-townhall meetings
- Events and trainings
- Monthly newsletters
- Provider educational materials updated continually
- Stakeholder emails
- Informational Letters 1537 and 1539 and upcoming

Annual Provider Training Schedule

Location	Date
Sioux City	Monday, September 14
Council Bluffs	Tuesday, September 15
Bettendorf	Wednesday, September 16
Burlington	Thursday, September 17
Fort Dodge	Monday, September 21
Mason City	Tuesday, September 22
Waterloo	Wednesday, September 23
Cedar Rapids	Thursday, September 24
Dubuque	Monday, September 28
Ottumwa	Tuesday, September 29
Des Moines	Wednesday, September 30



Provider Education and Training Cont.

- Provider Toolkit was posted the week of September 8:
 - Intro letter and project overview
 - General provider questions/FAQ
 - Provider MCO enrollment information
 - Annual provider training schedule and information
 - Member mailing summary
 - Sample member FAQs
 - Sample member newsletter content
 - Contact information for questions (for providers and members)
 - Member introductory mailings



Provider Enrollment Process Overview

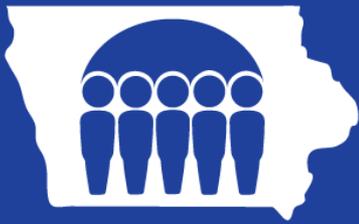
- All in-state and out-of-state providers, whether providing services under MCO or FFS, must enroll with Iowa Medicaid to ensure continuity of care for members
- Providers will enroll with Iowa Medicaid prior to MCO
- Provider Services will continue the IME provider enrollment process
- DHS will collaborate with MCOs to develop a provider enrollment process that is as streamlined and as efficient as possible for providers



DHS Enrollment Timeline

MCO networks are effective January 1, 2016. Over the next six months IME will:

- Enroll behavioral care providers previously enrolled in Magellan
- Enroll providers in the MCO networks who have not previously been enrolled in Iowa Medicaid
- Implement a provider enrollment renewal process
 - Schedule will be announced by Informational Letter
- Providers may scan updated paper work to the new enrollment email address
 - IMEProviderEnrollment@dhs.state.ia.us



DHS Provider Enrollment Renewal

- Per ACA requirements, IME is required to conduct increased licensure verification and database checks than it has in the past
- The volume of Iowa Plan providers and MCO providers that are newly enrolling impacts the scheduled re-enrollment capacity
- Due to the number of providers that will be impacted, IME is beginning a staged rollout process
- Informational letters and training will be available to relevant providers at the time of the staged rollout
- The goal is to re-enroll all current health care providers over the next year while also beginning the HCBS waiver provider recertification process



MCO Provider Enrollment

- Each MCO will develop its provider network, enrolling all current Medicaid providers when possible
- DHS will provide Medicaid provider enrollment information to each MCO to assist in preventing a duplication of efforts for providers
- MCOs will each have their own credentialing process to meet their accreditation standards
- If an MCO recruits a new provider, it will be expected to assure that provider is also enrolled by IME
- Out-of-state and other non-contracted providers may enter into single case agreements with providers as necessary to serve the needs of members in special situations



Iowa Department of Human Services

Provider Enrollment Timeline																		
Duration	3 months			3 months			3 months			3 months			3 months					
Section 1																		
	IL's Letters Websites Magellan	Mental Health Providers																
	Info. And Comm. to MCOs	MCO Providers																
	Ask MCOs for unenrolled providers																	
Informational Letters		Start High Risk, Moderate Risk + Site Visits					High Risk Fingerprint Providers											
Informational Letters	Re-enrollment						ACA Target Completion Date			Other Providers								
							Informational Letters	Waiver Recertification Providers										
Month-Year	Jul.-15	Aug.-15	Sept.-15	Oct.-15	Nov.-15	Dec.-15	Jan.-16	Feb.-16	Mar.-16	Apr.-16	May.-16	Jun.-16	Jul.-16	Aug.-16	Sept.-16	Oct.-16	Nov.-16	Dec.-16



Questions & Answers



Member Questions

Question	Answer
What if I missed the cutoff to change my MCO?	Please call the Member Services Unit at 1-800-338-8366
What if my provider isn't in my selected network?	You may use the 90-day period to select an MCO in which your provider is accessible to you
What if I don't like my MCO and want to change?	After January 1, 2016, you have 90 days to choose a different MCO, then you will stay with your MCO unless for good cause
Will my family be part of my MCO?	Families can choose to be in the same MCO, tentative assignment are made to do just that



Member Questions Cont.

Question	Answer
Will members still pay premiums if they do so today?	Yes, per existing requirements
Will there be appeal rights?	Yes, with the MCO and then the state
Will my benefits change? If my level of care changes, who do I contact for review?	Benefits stay the same unless level of care needs change or eligibility changes. Members can contact Member Services for more information about benefits
Who authorizes services?	MCOs do. Based on state policy and administrative rule, the state reviews if level of care changes



Provider Questions

Question	Answer
How will service authorizations work?	MCOs will honor existing service authorizations for at least 3 months
How does claims payment work?	MCOs are required to pay within similar timeframes that Medicaid currently pays
How many networks can providers be a part of?	Providers can be part of all of the networks, or just one. Networks, however, must be statewide
What about utilization management?	MCOs are responsible for utilization management, and their policies must be approved through DHS



Provider Questions Cont.

Question	Answer
When can I start working with MCOs?	Providers may begin working with the MCOs immediately
How do I get in contact with them?	See Informational Letter 1539 for contacts for each MCO
Will the enrollment paperwork across MCOs be the same?	Iowa Medicaid's enrollment application will be the same, but the MCOs may have additional requirements



Information and Questions

	Contact Information
General Information	http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization
Modernization Stakeholder Questions	Email: MedicaidModernization@dhs.state.ia.us
Modernization Member Questions	Contact Member Services Phone: 1-800-338-8366 Email: IMEMemberServices@dhs.state.ia.us
Modernization Provider Questions	Contact Provider Services Phone: 1-800-338-7909 Email: IMEProviderServices@dhs.state.ia.us

KS Facility/Provider - Initial and Re-credentialing Application

ATTACHMENTS NEEDED please include with your completed application the following items for each location.

- W-9 Form completed, signed and dated
- Copy of current State License/Approval (as applicable)
- Copy of Medicare/Medicaid Participation Certification (as applicable)
- Copy of Certifications and/or Accreditation Certificates (e.g. TJC, Medicare, etc.)
- Copy of CLIA certification (as applicable)
- Copy of Declaration Sheet and/or Certificate of Insurance
 - o **For HCBS Providers** who are not providing medical or behavioral health services **General** Liability Insurance Policies
 - o **All other provider types: BOTH** Current **Professional** Malpractice and Comprehensive **General** Liability Insurance Policies

Please note:

- ✓ All applications must complete all questions (unless otherwise noted)
- ✓ Please check the N/A box if not applicable
- ✓ Applications that do not include all requested documents and responses to questions will not be able to be processed.
- ✓ Please return all documents via the method below:
 - **Sunflower:** Robyn Stratton, 534 South Kansas Ave Ste 305, Topeka, KS 66603.
 - **UnitedHealthcare:** Please return this application along with your contract to the address provided on your cover letter or directly to your assigned UnitedHealthcare Contractor.
 - **Amerigroup:**
 - o If FedEx / UPS: Amerigroup, ATTN: Angela Pimentel, 1801 Sara Drive, Ste. H, Chesapeake, VA 23320
 - o If regular mail: Amerigroup, ATTN: Angela Pimentel, PO Box 62509, Virginia Beach, VA 23466

1. Facility / Provider Name & Address:

Legal Name: _____
 DBA Name: _____
 Corporate Name (if different): _____

Type of Component (As listed on License or Accreditation):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Ambulatory Surgical Center | <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Diagnostic Imaging Center | <input type="checkbox"/> Rehabilitation Facility |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Hospice | <input type="checkbox"/> Hospital | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> FQHC | <input type="checkbox"/> RHC | <input type="checkbox"/> Renal Dialysis Center | <input type="checkbox"/> HCBS |
| <input type="checkbox"/> Other _____ | | | |

Federal Tax ID Number: _____ Is this Tax ID used for all locations? Yes No
 *If No, please list on a separate sheet of paper all Tax ID numbers and the Legal Name for each

Primary Address: _____

City _____ County _____
 State _____ Zip _____
 Phone (_____) _____ - _____ Ext: _____ Fax: (_____) _____ - _____

Office Hours Open 24 hours - or complete hours of operations below

MON	TUES	WED	THU	FRI	SAT	SUN

Credentialing Contact / Office Manager _____

Phone (___) ___ - ___ Ext: _____ Fax: (___) ___ - _____

E-Mail Address: _____

Billing Address: Same as Primary Yes No **If same as primary, do not complete this section**

Address _____

City _____ State _____ Zip _____

Phone (___) ___ - ___ Ext: _____ Fax: (___) ___ - _____

Mailing Address: Same as Primary Yes No **If same as primary, do not complete this section**

Address _____

City _____ State _____ Zip _____

Phone (___) ___ - ___ Ext: _____ Fax: (___) ___ - _____

2. CORPORATE/SYSTEM OWNER (as provided on W-9): N/A

Name: _____

DBA Name: _____

Address: _____

City _____ State _____ Zip _____

Phone (___) ___ - ___ Ext: _____ Fax: (___) ___ - _____

3. ADDITIONAL PRACTICE / OFFICE LOCATIONS? Yes No **If yes, lease list other practice/office addresses. If additional space is needed, please attach a separate page.**

1	STREET _____							
	CITY _____		COUNTY _____		ST _____		ZIP _____	
	Office Hours							
	<input type="checkbox"/> Open 24 hours - or complete hours of operations below							
	PHONE _____	FAX _____	MON	TUES	WED	THU	FRI	SAT
HANDICAP ACCESSIBLE ADA COMPLIANT	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A							

2	STREET _____							
	CITY _____		COUNTY _____		ST _____		ZIP _____	
	Office Hours							
	<input type="checkbox"/> Open 24 hours - or complete hours of operations below							
	PHONE _____	FAX _____	MON	TUES	WED	THU	FRI	SAT
HANDICAP ACCESSIBLE ADA COMPLIANT	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A							

3	STREET							
	CITY		COUNTY		ST	ZIP		
	Office Hours							
<input type="checkbox"/> Open 24 hours - or complete hours of operations below								
PHONE	FAX	MON	TUES	WED	THU	FRI	SAT	SUN
HANDICAP ACCESSIBLE	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A							
ADA COMPLIANT	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A							

QUESTIONS #4 & #5 APPLY TO HCBS PROVIDERS ONLY

4. FOR HCBS PROVIDERS: SERVICES Check the services you provide

AUTISM WAIVER

- | | |
|---|--|
| <input type="checkbox"/> AU550 AUTISM SPECIALIST | <input type="checkbox"/> AU551 INTENSIVE INDIVIDUAL SUPPORTS |
| <input type="checkbox"/> AU554 FAM ADJUSTMENT COUNSELING | <input type="checkbox"/> AU553 PARENT SUPPORT |
| <input type="checkbox"/> AU173 INTERPERSONAL COMM.THERAPY | <input type="checkbox"/> AU552 RESPITE CARE |

FRAIL ELDERLY (FE) WAIVER

- | | |
|--|---|
| <input type="checkbox"/> FE410 ADULT DAY CARE | <input type="checkbox"/> FE509 MEDICATION REMINDER |
| <input type="checkbox"/> FE441 ASSISTIVE TECHNOLOGY | <input type="checkbox"/> FE515 NURSING EVALUATION VISIT |
| <input type="checkbox"/> FE510 ATTENDANT CARE SERVICE – PROVIDER DIRECTED LEVEL I | <input type="checkbox"/> FE252 PERS - INSTALL |
| <input type="checkbox"/> FE511 ATTENDANT CARE SERVICE – PROVIDER DIRECTED LEVEL II / III | <input type="checkbox"/> FE253 PERS – RENTAL |
| <input type="checkbox"/> FE518 COMPREHENSIVE SUPPORT – PROVIDER-DIRECTED | <input type="checkbox"/> FE237 TARGETED CASE MANAGEMENT |
| <input type="checkbox"/> FE530 FINANCIAL MGMT SERVICE (FMS) | <input type="checkbox"/> FE514 WELLNESS MONITORING |
| <input type="checkbox"/> FE531 HOME TELEHEALTH-INSTALL/TRAIN | SELF DIRECTED SERVICES |
| <input type="checkbox"/> FE532 HOME TELEHEALTH-MONTHLY | <input type="checkbox"/> FE511 ATTENDANT CARE |
| | <input type="checkbox"/> FE518 COMPREHENSIVE SUPPORT |
| | <input type="checkbox"/> FE513 SLEEP CYCLE SUPPORT |

PHYSICAL DISABILITY (PD) WAIVER

- | | |
|--|--|
| <input type="checkbox"/> PD500 ASSISTIVE SERVICES | <input type="checkbox"/> PDSCS SLEEP CYCLE SUPPORT (SCS) |
| <input type="checkbox"/> PD530 FINANCIAL MGMT SERVICE (FMS) | <input type="checkbox"/> PD237 TARGETED CASE MANAGEMENT |
| <input type="checkbox"/> PD535 HOME-DELIVERED MEALS (HDM) | SELF DIRECTED SERVICES |
| <input type="checkbox"/> PD509 MEDICATION REMINDER SVC | <input type="checkbox"/> PDPSS PERSONAL SERVICES |
| <input type="checkbox"/> PD367 PERS SYSTEM / INSTALL/MONTHLY | <input type="checkbox"/> PDSCS SLEEP CYCLE SUPPORT |
| <input type="checkbox"/> PDPSA PERSONAL SVC-AGENCY DIRECTED | |

TECHNOLOGY ASSISTED (TA) WAIVER

- | | |
|--|---|
| <input type="checkbox"/> TA530 FINANCIAL MGMT SERVICE (FMS) | <input type="checkbox"/> TA557 LONG-TERM COMMUNITY CARE ATTENDANT-AGENCY DIRECTED |
| <input type="checkbox"/> TA560 HEALTH MAINT. MONITORING | <input type="checkbox"/> TA556 SPECIALIZED MEDICAL CARE/RESPITE |
| <input type="checkbox"/> TA559 HOME MODIFICATION | SELF DIRECTED SERVICES |
| <input type="checkbox"/> TA555 INDEPENDENT CASE MANAGEMENT | <input type="checkbox"/> TA558 LONG-TERM COMMUNITY CARE ATTENDANT |
| <input type="checkbox"/> TA561 INTERMITTENT INTENSIVE MED CARE | |

TRAUMATIC BRAIN INJURY (TBI) WAIVER

- | | |
|--|---|
| <input type="checkbox"/> TB503 ASSISTIVE SVCS (Contractors or DME) | <input type="checkbox"/> TB363 PERSONAL SVCS– AGENCY DIRECTED |
| <input type="checkbox"/> TB177 BEHAVIOR THERAPY | <input type="checkbox"/> TB170 PHYSICAL THERAPY |
| <input type="checkbox"/> TB178 COGNITIVE THERAPY | <input type="checkbox"/> TB366 SLEEP CYCLE SUPPORT (SCS) |
| <input type="checkbox"/> TB530 FINANCIAL MGMT SERVICE (FMS) | <input type="checkbox"/> TB173 SPEECH/LANGUAGE THERAPY |
| <input type="checkbox"/> TB536 HOME-DELIVERED MEALS | <input type="checkbox"/> TB540 TRANSITIONAL LIVING SKILLS |
| <input type="checkbox"/> TB509 MEDICATION REMINDER SERVICES | SELF DIRECTED SERVICES |
| <input type="checkbox"/> TB171 OCCUPATIONAL THERAPY | <input type="checkbox"/> TB366 SLEEP CYCLE SUPPORT |
| <input type="checkbox"/> TB268 PERS SYSTEM / INSTALL / MONTHLY | <input type="checkbox"/> TB363 PERSONAL SERVICES |

5. FOR HCBS PROVIDERS - SERVICE COUNTIES Check all counties you will be providing the above checked services
****If you provide different services in different counties, please attach explanation.**

- | | | | | | | |
|-------------------------------------|-----------|-----------|-------------|--------------|----------|------------|
| <input type="checkbox"/> Allen | Coffey | Geary | Johnson | Miami | Pratt | Sherman |
| <input type="checkbox"/> Anderson | Comanche | Gove | Kearny | Mitchell | Rawlins | Smith |
| <input type="checkbox"/> Atchison | Cowley | Graham | Kingman | Montgomery | Reno | Stafford |
| <input type="checkbox"/> Barber | Crawford | Grant | Kiowa | Morris | Republic | Stanton |
| <input type="checkbox"/> Barton | Decatur | Gray | Labette | Morton | Rice | Stevens |
| <input type="checkbox"/> Bourbon | Dickinson | Greeley | Lane | Nemaha | Riley | Sumner |
| <input type="checkbox"/> Brown | Doniphan | Greenwood | Leavenworth | Neosho | Rooks | Thomas |
| <input type="checkbox"/> Butler | Douglas | Hamilton | Lincoln | Ness | Rush | Trego |
| <input type="checkbox"/> Chase | Edwards | Harper | Linn | Norton | Russell | Wabaunse |
| <input type="checkbox"/> Chautauqua | Elk | Harvey | Logan | Osage | Saline | Wallace |
| <input type="checkbox"/> Cherokee | Ellis | Haskell | Lyon | Osborne | Scott | Washington |
| <input type="checkbox"/> Cheyenne | Ellsworth | Hodgeman | Marion | Ottawa | Sedgwick | Wichita |
| <input type="checkbox"/> Clark | Finney | Jackson | Marshall | Pawnee | Seward | Wilson |
| <input type="checkbox"/> Clay | Ford | Jefferson | McPherson | Phillips | Shawnee | Woodson |
| <input type="checkbox"/> Cloud | Franklin | Jewell | Meade | Pottawatomie | Sheridan | Wyandotte |

6. LICENSURE/CERTIFICATIONS

Medicare Certified: YES NO (If YES, attach a copy CMS letter indicating Medicare # & effective date)

Medicare Numbers: _____

Medicaid Certified: YES NO (If YES, attach a copy State letter indicating Medicaid # & effective date)

Medicaid Numbers: _____

LICENSE TYPE	STATE	LICENSE #	EXP. DATE

CLIA Number:

Expiration Date:

Other License/Certificate - Type	Number	Expiration Date

7. INSURANCE – Please complete applicable section A or B below:

Professional Liability/Malpractice Liability (Malpractice not required for HCBS providers who are not providing medical or behavioral health services) No Coverage

Name of Corporate Entity on Declaration Sheet and/or Certificate of Insurance: _____

Name of Carrier	Eff. Date	Exp. Date	Coverage Amount Per Occurrence	Coverage Amount Aggregate	Policy #

Comprehensive General Liability No Coverage

Name of Carrier	Eff. Date	Exp. Date	Coverage Amount Per Occurrence	Coverage Amount Aggregate	Policy #

QUESTIONNAIRE (*Please answer all questions and provide explanation for affirmative answers.)
Applications that do not include all requested responses and explanations will not be able to be processed.

1. Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed? YES NO
2. Has the business been denied participation, suspended from or denied renewal from Medicare or Medicaid? YES NO
3. Has business ever had its professional liability coverage cancelled but not renewed? YES NO
4. Has the business been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body? YES NO N/A

ACCREDITATION/CERTIFICATION section to be completed by non-HCBS providers only
 (Attach a copy of current Accreditation certificate or survey.)

A.

<input type="checkbox"/>	AASM	AAAHHC	AAAASF	ABC	ACHC	ACR	AOA	ASDA	BOC Int'l.
<input type="checkbox"/>	CABC	CACH	CAP	CARF	CCAC	CHAP	COA	COLA	CORF
<input type="checkbox"/>	DNV	HCU	HFAP	HQAA	IAC	NABP	NBAOS	TJC	_____

Other: _____

NOT ACCREDITED (complete section B below)

Date of initial accreditation: ____/____/____ Date of next survey _____

Date of last survey: ____/____/____

B.

Has provider had an on-site survey by CMS or State agency? Yes No Date of last State survey: ____/____/____

If no, successful completion of a health plan onsite visit will be required to complete credentialing. You will be contacted by the Health Plan to schedule the visit.

Non accredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with your Corrective Action Plan (if deficiencies were cited), OR attach letter from government agency stating Facility is in substantial compliance with most recent survey standards. Facilities who don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

Component Attestation/Consent & Release Form

Sunflower State Health Plan

Decline Sunflower State Health Plan

I hereby understand that as a prospective/current Sunflower State Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Sunflower State Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Sunflower State Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Sunflower State Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Sunflower State Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Sunflower State Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

UnitedHealthcare

Decline UnitedHealthcare

ANY ALTERATION OR FAILURE TO SIGN AND DATE THIS FORM WILL RESULT IN THE DELAY OF PROCESSING THIS APPLICATION

By signing below, I attest that I am the duly authorized representative of the Component, that all information on the Application pertains to the above-named Component, and that such information is current, complete and correct.

Your signature is required to complete this application. Stamped signatures are NOT acceptable.

Amerigroup

Decline Amerigroup

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Amerigroup of any changes thereto. I understand that this application does not entitle me to participation in Amerigroup. By applying for appointment as an Amerigroup Participating Provider, I authorize the Plan, its medical director and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by Amerigroup, its medical director and appropriate representatives of all records and documents, excluding medical records of non-members of Amerigroup's Plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for Participating Provider status with Amerigroup. I consent and agree that Amerigroup will complete a criminal history background check to determine if I or any Subcontracted Providers have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my Subcontracted Providers to undergo such background checks. I hereby release Amerigroup and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individuals and organizations from any liability that provide information to Amerigroup or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Ancillary Agreement between me or my group and Amerigroup, as such terms may be applicable to me.

I understand that as an applicant for participation in Amerigroup, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from Amerigroup, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the Committee's decision either in writing or by appearance before the Credentialing Committee, if they so request.

Business Name: _____
Authorized Representative Name _____
(Print or Type)

Title: _____

Signature: _____

Date: _____

