POLICY AND PROCEDURE

POLICY NAME: Credentialing and Re-Credentialing Policy	**POLICY ID:** WNC.CRED.01
BUSINESS UNIT: WellCare of North Carolina	**FUNCTIONAL AREA:** Credentialing
EFFECTIVE DATE: 07/01/2021	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 03/27/2023	
REGULATOR MOST RECENT APPROVAL DATE(S): 07/18/2023	

POLICY STATEMENT:
This uniform Credentialing and Re-credentialing policy outlines the expectations of the Department with regard to provider credentialing, allowing a provider to be included in the Health Plan's network.

PURPOSE:
The purpose of this policy is to ensure WellCare of North Carolina (WNC) is in compliance with all applicable state Medicaid contract requirements, which govern the credentialing and re-credentialing of its providers of care.

SCOPE:
This policy applies to WellCare of North Carolina (WNC) (collectively, the "Health Plan") and covers credentialing and recredentialing policies for both individual and organizational providers. The policy shall apply to all types of providers, including but not limited to acute, primary, behavioral health, substance use disorders, and Long-Term Services and Support (LTSS) [42 C.F.R.§ 438.214(b)(1)].

DEFINITIONS: N/A

POLICY:
Establishment and Review of Credentialing Policies and Procedures

The Health Plan maintains documented policies and procedures for Credentialing, Re-credentialing and between-cycle monitoring and maintenance of providers. Credentialing Department leadership and the North Carolina Department of Health and Human Services (DHHS), on an ongoing basis (but at least annually), reviews credentialing policies and procedures in order to make any changes necessary to maintain compliance with the State contract and related guidance, the Company's iCare Compliance Program and Code of Conduct and Business Ethics. The Health Plan shall submit any significant policy changes to the Department for review and approval at least sixty (60) calendar days prior to implementing such changes. All previous versions of this policy will be published on the Health Plan website and include the policy effective date.

The Health Plan shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.

The Health Plan shall submit the Credentialing and Re-credentialing Policy to the Department for review and approval thirty (30) days after the Contract Award. The Health Plan may utilize the draft Policy submitted as part of the Offeror's Proposal and Response prior to approval by the Department with notification to the provider that the Policy is subject to amendment based upon Department review and approval.

Screening, Enrollment, Credentialing & Re-credentialing based on the North Carolina Medicaid Provider Enrollment File submission

The Health Plan will not be making a Quality Determination as described in the RFP or use objective credentialing quality standards to evaluate providers. Instead, at the Department's request and with their representation that the Medicaid Provider Enrollment File and the described process complies with state and federal screening, enrollment, and credentialing law, the Health Plan will consider any providers included by DHHS in the Medicaid Provider Enrollment File submission as being screened, enrolled, and credentialed and acceptable for network inclusion. The Health Plan will not make an independent screening, enrollment, or credentialing determinations and will not request the submission of additional documentation from any provider.

WNC's Provider Enrollment and Dis-enrollment

1. The Health Plan shall follow the screening, enrollment, Credentialing and Recredentialing in this policy for in-state, border (i.e., providers that reside within forty (40) miles of the North Carolina state line), and out-of-state network providers.
2. The Health Plan shall accept provider screening, enrollment, credentialing and verified information from the Department, or designated Department vendor;
3. The Health Plan shall not request any additional screening, enrollment, or credentialing from a provider without the Department's written prior approval;
4. The Health Plan shall not be permitted to delegate any part of the centralized screening, enrollment, or credentialing approach to another provider entity during the credentialing transition period; and
5. The Health Plan shall not solicit or accept provider screening, enrollment, credentialing or verified information from any other source except as permitted by the Department.
6. The Health Plan shall make timely network contracting decisions using the process outlined in the Credentialing and Re-Credentialing Policy.
    a. During the Provider Credentialing Transition Period, as a provider is re-credentialed through the Provider Enrollment process, Well shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment file. The Health Plan process shall occur no less frequently than every five (5) years consistent with the Department policy and procedure.
    b. After the Provider Credentialing Transition Period, the Health Plan shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the providers on the daily Provider Enrollment File. WellCare process shall occur every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.
7. Through the uniform credentialing process, the Department will screen and enroll, and periodically revalidate, all Health Plan network providers as Medicaid providers in compliance with state and federal law.
    a. The Health Plan may execute network provider contract, pending the outcome of Department screening, enrollment, and revalidation, of up to one hundred twenty (120) days but must terminate a network provider immediately upon notification from the state that the network provider cannot be enrolled, or the expiration of the (1) one hundred twenty (120) day period without enrollment of the provider and notify affected Members.
8. The Health Plan shall suspend claims payment to any provider for Dates of Services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise fail to meet Department requirements.
9. The Health Plan shall reinstate payment to the provider upon notice that the Department has received the requested information from the provider. If the provider does not provide the information with fifty (50) days suspension, the Department will terminate the provider from Medicaid.
10. The Health Plan shall not be liable for interests or penalties for payment suspension at re-credentialing.
11. Without waiving any sovereign immunities, and to the extent permitted by law, including the NC Tort Claims Act, and subject to Section III.D.5. Availability of Funds, DHHS shall indemnify, defend, and hold harmless WNC, its officers, agents, and employees from liability of any kind, including but not limited to claims and losses accruing or resulting to any other person, firm, or corporation that may be injured or damaged, arising out of or resulting from incomplete and/or inaccurate credentialing information provided to the Health Plan by the Department or its Provider Data Contract, Contract Verification Organization, or other Department vendor providing such information to the Health Plan and relied upon by the Health Plan in credentialing a provider for participation in the Health Plan network. The obligations set forth in the preceding sentence shall survive termination or expiration of the Contract. The Health Plan shall have the option to participate at its own expense in the defense of such claims or actions filed and the Health Plan shall be responsible for its own litigation expenses if it exercises this option. In no event shall the Health Plan be deemed to be in breach of this Contract as a result of it having relied and/or acted upon the credentialing information provided to it by DHHS. The Health Plan shall have no liability to DHHS in respect to any act or omission arising under, resulting from, or relating to the PHP's use of and reliance on such credentialing information.
12. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from

participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549.

Termination as a Medicaid Provider by the Department

The Health Plan shall remove any provider from the network, claims payment system, and terminate its contract consistent with the effective date provided by the Department with the provider within one (1) business day of receipt a notice from the Department that the Provider is terminated as a Medicaid provider. This applies to all providers regardless of the provider's network status.

If the Health Plan suspended provider payment, then upon notice by the Department that the provider is terminated from Medicaid, the Health Plan shall release applicable claims and deny payment.

WNC Provider Termination

The Health Plan may terminate provider from its network with cause. Any decision to terminate must comply with the requirements of the Contract.

The Health Plan shall comply with the Program Integrity Provider Termination Requirements outlined in Section V.J.2. Program Integrity.

The Health Plan will provide written notice to the provider of the decision to terminate to the provider. The notice, at minimum, will include:

- The reason for the decision.
- The effective date of termination.
- How to request an appeal.

General

Confidentiality

The Health Plan maintains the confidentiality of all information and documentation obtained in the screening, enrollment, and credentialing/re-credentialing process. The Health Plan requires all employees of the Health Plan to sign a confidentiality statement at the time of employment and to participate in WellCare Health Plan's Inc. Corporate Ethics and Compliance Program – Code of Conduct and Business Ethics, which incorporates HIPAA and general confidentiality and security awareness training. The Health Plan maintains electronic credentialing information and documentation in Health Plan databases. Input of and access to electronic credentialing information and documentation is undertaken by appropriate individuals via individual login and individually determined password. The Health Plan restricts access to only those associates or other authorized Health Plan representatives who have been issued an appropriate login and established a password. Only employees of the Health Plan or persons with authority to act in the peer review/approval process, or agents of the Health Plan performing in a legal capacity, or agents of Accreditation, Federal or State Regulatory Agencies, acting in the capacity of reviewers of the Health Plan, or others as provided by law, may have access to credentialing files. The Health Plan is prohibited from using, disclosing, or sharing provider credentialing information for any purpose other than use in Medicaid Managed Care with the express, written consent of the provider and the Department.

Non-discriminatory Credentialing

The Health Plan does not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional, who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.

The Health Plan does not make decisions relating to screening, enrollment, credentialing, or re-credentialing based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient (i.e., Medicaid) in which the practitioner specializes. This does not preclude the Health Plan from including in its network practitioners who meet certain demographic or specialty needs, for example, cultural needs of members.

The Health Plan does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments. To assure there is no discrimination in the making of screening, enrollment and credentialing

decisions, the Health Plan maintains a heterogeneous PNPC membership and those responsible for making these decisions affirm they will not discriminate when making credentialing decisions. In addition, the Health Plan has established participation requirements and has set criteria to assist in decision making. A report is maintained of all committee reviews and monitored to demonstrate nondiscriminatory credentialing and re-credentialing decisions. The report includes, but is not limited to: Specialty, County, Age and Gender.

Delegation

Delegated credentialing agreements are not permitted.

PROCEDURE:

Criteria for Credentialing & Re-credentialing through review of the North Carolina PDC file submission Doctorate Level and Allied Health Practitioners

1. Application Attestation Date;
2. 5-year work history for new applicants only;
3. Hold and continue to hold a current unrestricted license, in good standing, issued by the State of practice; 4. License Disciplinary Actions;
5. Hold a valid NPI as verified through the CMS National Health Plan and Provider Enumeration System;
6. Hold and continue to hold a current DEA, and if applicable to the state where services are performed, a current CDS or CSR certificate (applicable for MD/DO/DPM/DDS/DMD), with schedules consistent with prescribing practices. (It is acknowledged that practitioners in certain specialties do not maintain DEA/CDS/CSR certificates – such practitioners will be reviewed on a case-by-case basis);
7. Carry and continue to carry professional liability insurance;
8. Hold and continue to hold board certification (applicable to MD/DO/DPM/DDS/DMD) or have verifiable education/training in the specialty requested;
9. Hold and continue to hold current hospital privileges or privileges at an ambulatory surgery center (MD/DO) as applicable to specialty. Privileges are not a requirement for many specialties such as: Allergy, Dermatology, Endocrinology, Genetics, Hospice and Palliative Care, Neurology, Occupational Medicine, Ophthalmology, Pain Management, Pathology, Physical Medicine, and Rehabilitation (PMR), Podiatry, Preventive Medicine, Psychiatry, Radiology, and Rheumatology. Based on the practice setting, the hospital privileges requirement may be waived for practitioners in specialties not listed above.;
    a. Malpractice claims history;
    b. Be and continue to be eligible for participation in Medicare and/or Medicaid with no evidence of any investigation under Medicare or Medicaid or other government entity; and
    c. Not have current sanctions listed under the Office of Inspector General and the System for Award Management Medicaid/Medicare Sanctions report.

Confidentiality

Information and documentation obtained in the credentialing/re-credentialing process is confidential. Employees of the Health Plan are required to sign a confidentiality statement at the time of employment and all employees are required to participate in the WellCare Health Plan's Inc. Corporate Ethics and Compliance Program – Code of Conduct and Business Ethics, which incorporates HIPAA and general confidentiality and security awareness training. Electronic credentialing information and documentation is maintained in Health Plan databases. Input of and access to electronic credentialing information and documentation is undertaken by appropriate individuals via individual login and individually determined password. Access is restricted to those associates or other authorized Health Plan representatives who have been issued an appropriate login and established a password. Only employees of the Health Plan or persons with authority to act in the peer review/approval process, or agents of the Health Plan performing in a legal capacity, or agents of Accreditation, Federal or State Regulatory Agencies, acting in the capacity of reviewers of the Health Plan, or others as provided by law, may have access to credentialing files.

Application Processing Time Frames

The timeframe for processing initial credentialing applications will be performed in accordance with respective to North Carolina specific regulatory requirements:

• For one hundred percent (100%) of providers within forty-five (45) calendar days of the Committee's receipt of complete credentialing and verified information for consideration.

Recredentialing Processing Time Frames

- During the Provider Credentialing Transition Period, no less frequently than every five (5) years.
- After the Provider Credentialing Transition Period, no less frequently than every three (3) years.

Respective Authority of the Corporate Medical Director, State Medical Director or Other Designated Physician and the Credentialing Committee

The State Medical Director has oversight responsibility and accountability for the clinical aspects of the credentialing program at State level and he/she or his/her designee acts as Chairperson of the Credentialing/Peer Review Committee. In accordance with policies and procedures, The Corporate Medical Director is delegated the authority to approve and signoff on credentialing files that are determined to be "clean files." The sign-off date for clean files is the "credentialing decision date." A list of approved new provider "clean files" is brought by the State Medical Director to the Credentialing Committee at the next available Credentialing/Peer Review Committee meeting for information.

Files that do not meet the Health Plan's established "clean file" criteria are brought to the Credentialing/Peer Review Committee by the State Medical Director for review and decision by the Committee. The State Medical Director has the authority to appoint a clinical peer as an ad hoc member of the Credentialing/Peer Review Committee. In such cases, the clinical peer may attend the meeting or may have his or her opinion presented by the State Medical Director or another member of the committee. The Credentialing Committee has the authority to approve or disapprove provider participation.

Non-discriminatory Credentialing and Re-credentialing

The Health Plan does not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional, who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification.

The Health Plan does not make credentialing and re-credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the type of procedure or patient (i.e., Medicaid) in which the practitioner specializes. This does not preclude the Health Plan from including in its network practitioners who meet certain demographic or specialty needs, for example, cultural needs of members.

The Health Plan does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments. To assure there is no discrimination in the making of credentialing decisions, the Health Plan maintains a heterogeneous credentialing committee membership and those responsible for making credentialing decisions affirm they will not discriminate when making credentialing decisions. In addition, the Health Plan has established participation requirements and has set criteria to assist in decision making. A report is maintained of all committee reviews and monitored to demonstrate nondiscriminatory credentialing and re-credentialing decisions. The report includes, but is not limited to: Specialty, County, Age and Gender

Decision Making Criteria

The Health Plan has established participation requirements for the network practitioners and has defined the process and set the criteria used to reach credentialing/re-credentialing decisions. Credentialing/Re-credentialing decisions are based on assessment of a practitioner's verified credentials and ability to provide reasonable standards of care.

Managing Files that meet WNC's established criteria

Practitioners who meet the Health Plan's established "clean file" criteria are reviewed and approved by the Medical Director. Clean files are presented in list format at each meeting of the Credentialing/Peer Review Committee. Files that do not meet

the Health Plan's established criteria for a "clean file" are reviewed by the Credentialing/Peer Review Committee at the next available meeting.

1. "Clean File" - Category 1 file
    a. No malpractice claims with a closure date in the last five (5) years for new applicants and three (3) years for re-applicants;
    b. No reports of disciplinary action, licensure restriction or any type of investigation for new applicants; and
    c. No reports of disciplinary action, licensure restriction or any type of investigation within the last three years for re-applicants.

2. "Clean File" assignment - Category 2 file
    a. *Any file where Category 1 "clean file" requirements are met as well as meeting the following criteria:*
        i. PCP's (Internal Medicine/Geriatrics, Family Practice, Pediatrics, General Practice): ii. Multiple malpractice settlements/judgments totaling collectively $750,000 or under, or one malpractice settlement/judgment equal to or under $500,000.
        iii. Specialists and Obstetricians/Gynecologists:
            1. Multiple malpractice settlements/judgments totaling collectively $1,000,000 or under, or one malpractice settlement/judgment equal to or under $500,000.
            2. State licensure board report with a final date over five years old and unrelated to patient care.
        iv. The Medical Director reviews and validates all Category 2 "clean file" assignments prior to approval. The Medical Director may assign a file that meets Category 2 criteria for review by the Credentialing/Peer Review Committee for the approval decision. Such file will be reassigned to Category 3.

3. Credentialing/Peer Review Committee - Category 3 file Mandatory Review
    a. Applications where one or more of the following is identified:
        i. Malpractice claims history in the last five (5) years for new applicants and three (3) years for reapplicants:
            1. PCP's (Internal Medicine/Geriatrics, Family Practice, Pediatrics, General Practice):
                a. Two (2) or more malpractice settlements/judgments totaling in excess of $750,000.
                b. One (1) or more individual malpractice settlement/judgment in excess of $500,000.
            2. Specialists and Obstetricians/Gynecologists:
                a. Three (3) or more malpractice settlements/judgments totaling in excess of $1,000,000.
                b. One (1) or more individual malpractice settlement/judgment in excess of $500,000.
        ii. Clinical privileges limited, revoked, or otherwise altered by another health care organization, for new applicants
        iii. Clinical privileges limited, revoked, or otherwise altered by another health care organization, within the last three years for re-applicants
        iv. Any loss or limitation of license or any adverse state licensure board action or county/professional/medical association censure (patient care related), for new applicants
        v. Any loss or limitation of license or any adverse state licensure board action or county/professional/medical association censure (patient care related), within the last three years for re-applicants
        vi. Disciplinary action taken by a Federal Organization, for new applicants
        vii. Disciplinary action taken by a Federal Organization, within the last three years for re-applicants
        viii. Criminal action, for new applicants ix. Criminal action, within the last three years for re-applicants
        x. Files that meet Category 2 criteria but are re-assigned by the Medical Director to Category 3.
    b. The Credentialing Committee is the peer review body that has authority to approve or disapprove providers for participation. In particular, the Credentialing Committee performs peer review of those applicants where credentialing has identified issues that may have a bearing on the standard of care the applicant may provide to members.

WNC Provider Enrollment and Dis-enrollment

1. The Health Plan shall accept provider credentialing and verified information from the Department, or designated Department vendor;

2. The Health Plan shall not request any additional credentialing from a provider without the Department's written prior approval;

3. The Health Plan shall not be permitted to delegate any part of the centralized credentialing approach to another provider entity during the credentialing transition period; and

4. The Health Plan shall not solicit or accept provider credentialing or verified information from any other source except as permitted by the Department.

Assessment of Organizational Providers

Criteria for Credentialing & Re-credentialing through review of the North Carolina PDC file submission

1. Facility and Ancillary Providers
    a. Accredited
        i. Hold and continue to hold a current unrestricted license, in good standing, issued by the State of practice (if applicable). ii. Carry and continue to carry liability insurance. iii. Accreditation status. iv. Be and continue to be eligible for participation in Medicare and/or Medicaid with no evidence of any investigation under Medicare or Medicaid or other government entity; and

v. Not have current sanctions listed under the Office of Inspector General and System for Award Management Medicaid/Medicare Sanctions report.

    b. Unaccredited
        i. Hold and continue to hold a current unrestricted license, in good standing, issued by the State of practice (if applicable).
        ii. Carry and continue to carry liability insurance. iii. Be and continue to be eligible for participation in Medicare and/or Medicaid with no evidence of any investigation under Medicare or Medicaid or other government entity; and

iv. Not have current sanctions listed under the Office of Inspector General and System for Award Management Medicaid/Medicare Sanctions report.
v. Quality Management Program
vi. Reports on disciplinary Action from the last five (5) years
vii. Letters of Recommendation
viii. Policies for coverage arrangements or onsite quality assessment

    c. Managing Files that meet WellCare of North Carolina established criteria
        i. Facility and ancillary providers who meet the Health Plan's established "clean file" criteria are reviewed and approved by the Medical Director. Clean files are presented in list format at each meeting of the Credentialing/Peer Review Committee. Files that do not meet the Health Plan's established criteria for a "clean file" are reviewed by the Credentialing/Peer Review Committee at the next available meeting.

1. "Clean" Category 1 file
    a. Accredited Facility and ancillary providers with licensure in good standing (if applicable) and no evidence of Federal or State exclusions or sanctions.
2. Category 3 file Mandatory Review
    a. Unaccredited facility and ancillary providers

b. Files that do not meet the Health Plan's established "clean file" criteria are brought by the State Medical Director to the Credentialing Committee for the approval or disapproval of the Committee.

d. Credentialing Committee Action and Notification

i. The Credentialing/Peer Review Committee reviews all Category 3 applicants and/or renewals and makes a determination.

1. Approval Determination

a. When the determination of the Credentialing/Peer Review Committee is favorable to the applicant, the approval determination is sent to the provider within 5 days of the decision.

2. Adverse Determination

a. When the Credentialing/Peer Review Committee determination is averse to the applicant and/or renewal applicant, the State Medical Director or designee in a timely manner informs the applicant within 5 days by special notice that he/she is entitled to appeal the decision.

b. Appeals will be accepted within thirty (30) calendar days from receipt of notify of the decision. Appeal time frame may be extended by an additional thirty (30) calendar days for good cause.

c. The Health Plan must acknowledge receipt of an appeal request within five (5) calendar days.

REFERENCES:
Provider payment suspension procedures are covered in Special investigations Unit's policies and procedures.
WNC.NM.01, Good Faith Contracting Policy
WNC.NM.02, Medicaid Regulatory Requirements Policy
42 C.F.R.§ 438.214(b)(1)]
North Carolina Tort Claims Act
Section III.D.5. Availability of Funds

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES:
Credentialing Department Staff

Corporate Medical Director - Authorizes approval to "clean file" participation in accordance with the Credentialing Program "clean file" guidelines. The Corporate Medical Director maintains ongoing liaison with the State Medical Directors in connection with the Credentialing Program and is an ex-officio member of the State's Credentialing Committee.

Medical Director, Health Plan Market - Responsible for ensuring the Credentialing Program is applied uniformly and has the State specific responsibility and accountability for the application of all clinical aspects of the Credentialing Program, Credentialing Committee and Peer Review activities at the State level. They report ongoing corporate credentialing activities to the Credentialing Committee, and ensures the Committee receives all required information in order to make credentialing, re-credentialing and peer review decisions.

State Medical Director - Responsible for credentialing compliance with State, Federal and Accreditation regulations, and standards.

Board of Directors – Accountable and responsible for the quality of health care and other services rendered to members participating through the Health Plan. The Board of Directors supports and has the final responsibility for the assurance of a comprehensive and integrated Credentialing Program. The Board of Directors has given authority to the Credentialing Committee to approve or decline provider participation or re-credentialing. The BOD receives the minutes and report of the QIC containing the decisions of the Medical Director and Credentialing/Peer Review Committee.

Corporate Medical Director - Delegates authority to approve "clean file" participation in accordance with the established "clean file" guidelines.

Chief Executive Officer - Member of the Board of Directors and has the authority to act on behalf of the Board of Directors. The Chief Executive Officer provides the resources, equipment and personnel reasonably required to maintain and support the Credentialing Program.

Credentialing and Peer Review Committee - Defined by the Health Plan's Quality Improvement Program.

Credentialing Committee - Oversees credentialing and re-credentialing quality determinations, discusses whether providers are meeting reasonable standards of care. The Committee performs Peer Review on cases with potential quality of care or conduct issues.

Quality Improvement Committee (QIC) - Receives the minutes of the Credentialing/Peer Review Committee and forwards a report to the Board of Directors.

REGULATORY REPORTING REQUIREMENTS:
All Policies and Procedures ("Documents") are required to be reviewed at least biennially, unless required more frequently by state regulation or contractual obligation. The review includes collaboration with Stakeholders and may also require regulatory or state approvals. Upon completion of the review, the Documents must be approved and published in RSA Archer to be valid. To facilitate this timing, reviews should commence 90 days prior to one calendar year from the current New, Reviewed or Revised date.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	New Policy	07/01/2022
Ad Hoc Review	Updated WellCare of North Carolina policy to Centene Corporation template and numbering with content from previous policy and procedure: NC35-CR-001, NC35-CR-001-PR001	07/01/2022; 8/29/2022; 09/23/2022; 10/18/2022
Ad Hoc Review	Changed WellCare references to the Health Plan; formatting changes	07/01/2022; 08/29/2022; 09/23/2022; 10/18/2022
Ad Hoc Review	Updated policy to include amendment updates • V.D.2.g Credentialing and ReCredentialing process. • V.D.2.i Network Provider Credentialing and ReCredentialing process	08/26/2022
Ad Hoc Review	Updated Policy to: • Remove 2.a.i.6 • Add 2.a.i.12	03/27/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.