# State and Federal Regulatory Addendum Attachment E to the UnitedHealthcare Credentialing Plan

United Healthcare®

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Note: Council for Affordable Quality Healthcare (CAQH) is known as DataSpring's CAQH Provider Data Portal.


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# Alabama

Alabama (AL) Administrative Code (section 420-5-6-.11) requires Health Maintenance Organizations (HMOs) to:

1. Recredential licensed independent practitioners every three (3) years. (Effective Nov. 2019)
2. Update expired drug enforcement agency, and professional liability insurance for licensed independent practitioners upon expiration.
3. Have a medical director with a current license to practice medicine granted by the Medical Licensure Commission of Alabama.
4. An AL HMO may delegate credentialing, with oversight. Delegation must be approved by the AL Department of Public Health.

AL Insurance Code (section 27-56-4)

HMOs and Preferred Provider Organizations may not require an eye care provider (optometrist and ophthalmologists) to hold hospital privileges as a condition of participation in or receiving payment from the policy, plan, or contract.

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# Alaska

No additional credentialing requirements.

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# Arizona

Health Maintenance Organizations (HMOs) are required to review the performance of and recredential contracted free-standing urgent care centers at least once every two years. (ARS 20-1077).

Credentialing; loading; timeliness; exceptions ARS 20-3453

1. Health insurer shall conclude the process of credentialing within 60 calendar days and loading the applicants information into their billing system within 30 calendar days after the date the insurer receives a complete application.
2. Health Insurer shall provide written or electronic notice of an approval or denial of a credentialing application to an applicant within seven calendar days after the conclusion of the credentialing process.
3. Health insurer is not responsible for compliance with the above timelines if the applicant is subject to delegated credentialing. Health insurer shall conclude the loading process for the applicant within ten calendar days after the health insurer receives a roster of demographic changes related to newly credentialed, terminated or suspended participating providers.

Acknowledgment of receipt of an application; notification of incomplete applications ARS 20-3454

1. Health insurer shall promptly review and provide written or electronic acknowledgement to an applicant within seven days after the health insurer's receipt of the applicant's application.
2. Health insurer shall notify the applicant in writing or by electronic means that an application is incomplete within seven calendar days after the date the health insurer received the application. Health insurer shall include detailed list of items required to complete the application.
3. Health insurer may deem the application withdrawn if applicant does not provide complete application after thirty calendar days if the request for information.
4. Health insurer will send the applicant a proposed contract that is complete and ready for execution upon receipt of complete application.
5. Health insurer that participates in a health insurer credentialing alliance is deemed to be in compliance with this section, ARS 20-3404.

## Arizona UnitedHealthcare Community Plan Requirements[1,2]

UnitedHealthcare Community Plan participates with the Arizona Association of Health Plans (AzAHP) credentialing alliance[3] which provides for

- One common application;
- One common verification;
- One common recredential date;

Arizona Community Plan requirements include:

1. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)).

1 Requirements of the State Medicaid Contract.
2 Chapter 900, Policy 950 of Arizona Health Care Cost Containment System (AHCCCS)
3 Credentialing delegates are not required to use the Alliance

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2. Must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process. Temporary or provisional credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. This includes providers in a Federally Qualified Health Center (FQHC) and hospital-employed physicians. Contractor shall have 14 days from receipt of a complete application, accompanied by minimum documents identified in initial credentialing.
3. Timely verification of information must be conducted timely, by evidence of approval or denial of a provider within 60 days of a receipt of complete application. Inclusion of information from quality improvement activities at the time of recredentialing.
4. Claims payment system load time 95% within 30 calendar days of credentialing approval. Effective date should be no later than the date of the Credentialing Committee decision or the Contract effective date, whichever is later.
5. All Credentialing decisions are reviewed and approved by the Arizona Provider Advisory Committee which is the local credentialing committee. Committee members consist of participating Arizona Medicaid Providers and the Committee is chaired by the Local Medical Director. The local Medical Director(s) may approve initial Credentialing and/or Recredentialing files which have been determined to meet state-specific requirements, or may request additional review by the Arizona Provider Advisory Committee.
6. Credentialing/Recredentialing files may include state-specific information and/or data to be utilized in Credentialing/Recredentialing determinations. This state-specific information and/or data may be established and maintained separately from the criteria described in the UnitedHealthcare Credentialing Plan used to evaluate Credentialing/Recredentialing determinations. State-specific information and/or data are defined in the local health plan credentialing policies.
7. Credentialing of behavioral health residential placement settings that utilize behavioral health technicians and behavioral health paraprofessional staff in accordance with Chapter 900, Policy 950 of the AHCCCS Medical Policy Manual (AMPM).
8. All physicians and certified nurse midwives who perform deliveries shall have hospital privileges for obstetrical services. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Verification of element by Applicant attestation.
9. Contractor shall notify providers (practitioner/facility/organizational) of their credentialing decision (approved or denied) within 10 days of Credentialing Committee decision.
10. For recredentialing, the Contractor shall provide notification regarding recredentialing denial to the providers (practitioner/facility/organizational) within 10 days of Credentialing Committee decision.
11. As provided in 42 CFR 438.214(c) and 42 CFR 438.12(a), the Contractor's provider credentialing and selection policies shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

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# Arkansas

1. The Arkansas (AR) State Medical Board's Centralized Credentialing Verification Service (ASMB – CCVS) is mandated for primary source verification for credentialing physicians, unless a physicians assents to the use of a separate credentialing verification organization. (Arkansas Code Ann. section 17-95-107.) Physicians include M.D., D.O and M.B. only. (Arkansas Code Ann. section 17-95-202; Ark. State Med Bd., CCVS User Guide, Page 12, available at **https://www.arccvs.org/pdf/usermanual.pdf**.) Insurers, Health Maintenance Organizations (HMOs) and managed care organizations are:
   - **a)** Prohibited from seeking credentialing information from the physician or sources other than the Arkansas State Medical Board that is available from the ASMB-CCVS
     - Credentialing organization that utilize the credentialing information system offered by the board shall not attempt to collect duplicative information from individual physicians or originating sources, but nothing in this section shall prevent any credentialing organization from collecting or inquiring about any data not available from or through the board, nor from reporting to or inquiring of the National practitioner Data Bank. (AR Code § 17-95-107 (2023))
   - **b)** Required to collect credentials information from the ASMB-CCVS, as long as the ASMB-CCVS:
     - is an National Committee for Quality Assurance (NCQA) -certified Credentials Verification Organization (CVO);
     - complies with Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). CVO standards;
     - complies with credentialing rules and regulations of the AR Division of Health of the Department of Health and Human Services;
     - maintains evidence of compliance with the standards set forth; and
     - charges fees in compliance with AR law.
2. Health care insurers (including HMOs) are required to make a credentialing decision:
   - **a)** for providers other than physicians, within 180 days of receiving a completed application; and
   - **b)** for physicians, within 60 days of receiving a completed application. The 60-day time frame is suspended (or tolled) from the time the health care insurer requests credentialing information from the ASMB-CCV until the time that ASMB-CCV notifies the health care insurer that the file is complete and available for retrieval. (Arkansas Code Ann. 23-99-411)
3. Health care insurers (including HMOs) are required:
   - **a)** to send written acknowledgment of an application from any provider within ten (10) days of receipt.
   - **b)** to notify applicant in writing within 15 days if application is incomplete.
     - **i)** notice to include list of items required for application to be complete.
     - **ii)** if notice is not sent within required time frame, application is deemed to be complete.
     - **iii)** if requested information is not received within 90 days, application may be treated as abandoned and credentialing may be denied.
   - **c)** to notify network physicians in writing at least 90 days before the deadline to submit a recredentialing application.
     - **i)** required to give at least 45 days written notice prior to terminating physician for failure to submit a recredentialing application.
     - **ii)** if the physician submits the recredentialing application during the 45 day period, the termination shall not take effect.

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**iii)** during the 45 day period, insurer prohibited from notifying members or general public that physician will be terminated unless termination is for reason other than failure to recredential. (Arkansas Code Ann. 23-99-411)

4. If a credentialed physician changes employment or location, opens an additional location, or joins a new group or clinic, health care insurer may only require submission of the new information as is necessary to continue the physician's credentials, and may not require a new credentialing application.
5. For payment purposes, a healthcare insurer shall treat an applicant physician as a participating physician from the date of submission of a substantially completed application once an applicant physician has been approved through an insurer's credentialing process. (Arkansas Code § 23-99-411(a)(6)(i))

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# California

California Health & Safety Code 1374.197 effective January 1, 2023, a health care service plan that provides coverage for mental health and substance use disorders and that credentials health care providers of those services for its network shall assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Upon receipt of the application by the credentialing department, the health care service plan shall notify the applicant within seven (7) days, to verify receipt and inform the applicant whether the application is complete. The 60-day timeline shall apply only to the credentialing process and does not include contracting completion. This is only applicable to Delegated Capitated groups that include behavioral health providers .

California Health & Safety Code 1374.198 and California Insurance Code Section 10144.565 effective **January 1, 2027:**

1. The plan or its delegates will make a determination regarding the credentials of a provider within 90 days after receiving a completed provider credentialing application, including all required third-party verifications.
2. Upon receipt of the application the plan or its delegate shall notify the applicant within 10 business days to verify receipt and inform the applicant whether the application is complete.
3. The plan shall activate the provider upon successful approval and notify the applicant of the activation within 10 days of approval if the approval occurs prior to the end of the 90-day timeline.
4. The 90-day timeline shall apply only to the credentialing process and does not include contracting completion.
5. If the health care service plan or its delegate does not meet the 90-day requirement, the applicant's credentials shall be provisionally approved for 120 days unless any of the following apply:
   - **a)** The applicant is subject to discipline by the licensing entity for that applicant.
   - **b)** The applicant has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank.
   - **c)** The applicant has not been credentialed by the health care service plan in the past five years.

California Health & Safety Code 1380.2 and California Insurance Code Section 10110.9, effective **January 1, 2028:**

1. The plan or its delegate shall subscribe to and use the most recent version of the Council for Affordable Quality Healthcare (CAQH) credentialing form and shall comply with the CAQH credentialing processes.
2. The plan or its delegate shall only request additional information from a provider to clarify and confirm information that is provided on the CAQH credentialing form, including verification of information not specifically disclosed on the provider's application.
3. The provider shall respond to the request within 10 business days. The plan or its delegate shall minimize the number of requests for additional information from providers.
4. A provider shall submit their credentialing form and maintain their credentialing information in the CAQH database in a manner consistent with CAQH standards.

California Health & Safety Code (CA H&SC) 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

California Code 28 CCR1300.74.16 (e) establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

In order to comply with this regulation, at the time of credentialing, recredentialing and on an annual basis, we identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

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For the purposes of this section an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:

1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or
2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or
3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
   - **a)** In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
   - **b)** In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or
4. Meets the following qualifications:
   - **a)** In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
   - **b)** Has completed any of the following:
     - **i)** In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
     - **ii)** In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
     - **iii)** In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

A health insurer shall not discriminate, with respect to the provision of, or contracts for, professional services, against a licensed provider solely on the basis of a civil judgment issued in another state, a criminal conviction in another state, or another professional disciplinary action in another state if the judgment, conviction, or professional disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in California. California Insurance Code Section 10133.641(b).

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# Colorado

### Timely Credentialing of Physicians

1. **a)** Within seven (7) calendar days after a carrier receives an application, the carrier is required to provide a receipt to the physician applicant in written or electronic form.
   **b)** Upon receiving an application, a carrier shall promptly determine whether the application is complete. If the carrier determines that the application is incomplete, the carrier shall notify the physician applicant in writing or by electronic means within ten (10) calendar days. The notice must describe the items that are required to complete the application.
   **c)** If a carrier receives a completed application but fails to provide the physician applicant a written or electronic receipt as required (above) the carrier is required to consider the physician applicant a participating physician effective no later than 53 calendar days following the carrier's receipt of the application.
2. **a)** The carrier is required to conclude the process of credentialing a physician applicant within 60 calendar days after receipt of the completed application.
   **b)** The carrier is required to provide each physician applicant written or electronic notice of the outcome of the physician applicant's credentialing within 10 calendar days after the conclusion of the credentialing process.
   **c)** After concluding the credentialing process for a physician applicant and making a determination regarding the physician applicant's credentialing application, the carrier shall provide, at the physician applicant's request, all non-proprietary information pertaining to the physician's application and to the final decision regarding the application. As outlined in the UnitedHealthcare's Credentialing Plan Section 8.2 - Applicant Rights.
3. The carrier is required to make the following non-proprietary information available to all physician applicants, and shall post the information on its website:
   **a)** Credentialing policies and procedures;
   **b)** A list of the information required to be included in a physician application;
   **c)** A checklist of materials that must be submitted in the credentialing process;
   **d)** Designated contact information, including a designated point of contact, an e-mail address, and a telephone number to which the physician applicant may address any credentialing inquiries; and
   **e)** The authority of the Insurance Commissioner to enforce requirements and impose penalties for violations.
4. **a)** A carrier may recredential a participating physician if such recredentialing is:
      **i)** required by federal or state law or by the carrier's accreditation standard; or
      **ii)** permitted by the carrier's contract with the participating physician.
   **b)** A carrier shall not require a participating physician to submit an application or participate in a contracting process in order to be recredentialed.
5. Except as described in subsection eight (8) of this section (see #4, above), and as may be provided in a contract between a carrier and a participating physician, a carrier shall allow a participating physician to remain credentialed and include the participating physician in the carrier's network unless the carrier discovers, information indicating that the participating physician no longer satisfies the carrier's guidelines for participation, in which case the carrier shall satisfy the requirements described in section 10-16-705(5) before terminating the participating physician's network participation.

### Colorado Revised Statutes 10-16-705.7

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## Colorado UnitedHealthcare Community Plan Requirements

The Contractor shall ensure all Network Providers are enrolled with the Department as Medicaid Providers consistent with provider disclosure, screening, and enrollment requirements. Validation will be conducted by the Provider Operations area as being enrolled with the State Medicaid Program.

The Contractor shall complete the credentialing and contracting processes or deny network admission within ninety (90) days for at least ninety percent (90%) of all Provider applications. The ninety (90) days begins upon the submission of a Provider's written request to contract with the Contractor.

The contracting and credentialing measurement period ends on the actual date of a signed and fully executed contract or when the Contractor sends a formal document denying the provider admission to the Contractor's network. The practice of contract back-dating does not constitute compliance to this process for the purpose of reporting or meeting the measurement period standards.

The measurement period shall be tolled in the event the Contractor and the Provider are in active contract negotiations, and the Contractor has sent written notice to the Provider that the Provider's credentialing application has been approved.

The Contractor shall deny the application from the contracting process if a Provider's application is not complete within eighty (80) days. The Contractor shall notify the Provider if the application is not complete prior to denial of the application.

The Contractor shall respond to all Provider inquiries related to their credentialing and contracting within two business days.

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# Connecticut

Managed care organizations are required to credential providers, but there are no specific credentialing criteria identified. (CT Annotated Statutes sect. 38a-478-c (a) (5))

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# Delaware

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to obtain primary source verification of professional liability coverage[4] and hospital privileges at initial credentialing and on recredentialing. (Code of DE Regulations 18-1400-1403 sect. 11.2.4)

4 A copy of professional liability declaration sheet will serve as evidence of primary source verification.

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# Florida

Florida (FL) Annotated Statutes (section 641.495) requires Health Maintenance Organizations (HMOs):

1. to designate as a medical director a physician licensed in FL; and
2. to maintain a copy of the current Florida medical license for each participating physician. (MD, DO, DC and DPM). (Note: pursuant to FL Annotated Statutes section 641.19(12(d) physician services are provided by MD, DO, DC and DPM). Copy of license or screen print from licensing board will serve as evidence of primary source verification for current license.

Physicians who choose not to carry malpractice insurance, as allowed by Florida law, are required to submit a copy of UnitedHealthcare's "Physicians Responsibility for Medical Malpractice Agreement," demonstrating that they have met the state requirements.

## Florida UnitedHealthcare Community Plan Requirements[5,6]

Florida UnitedHealthcare Community Plan requirements include:

1. Site visits at initial credentialing and recredentialing for primary care physicians (PCPs) only. To include the following elements:
   - **a)** Evidence that the Managed Care Plan has evaluated the provider's facilities using the Managed Care Plan's organizational standards.
   - **b)** Evidence that the provider's office meets criteria for access for persons with disabilities and that adequate space, supplies, proper sanitation, smoke-free facilities, and proper fire and safety procedures are in place; and
   - **c)** Evidence that the provider's medical record keeping practices were assessed.
2. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)) and the National Plan and Provider Enumeration System (NPPES) and Agency for Health Care Administration (AHCA) Public Record Search online tool.
3. Current Curriculum Vitae or completed credentialing application with a five-year working history must be obtained at both initial credentialing and recredentialing.
4. Verification on good standing of privileges at the hospital designated as the primary admitting facility by the physician or good standing at the hospital by another physician with whom the physician has entered into an arrangement for hospital coverage. Verification of element by Applicant attestation.
5. Attestation on total active patient load is no more than three thousand (3,000) patients per physician.
6. Participate in workgroups with other Managed Care Plans, the Agency and other stakeholders to focus on reducing redundancies in the provider onboarding process.
7. All providers to be fully enrolled/onboarded within 60-days. The 60-day metric will be measured by the number of days between the day the Managed Care Plan receives a full and complete provider enrollment application and the day the Agency successfully receives the provider on the Managed Care Plan's Provider Network Verification (PVN) file. The Managed Care Plan agrees to submit the date it receives full and complete provider applications to the Agency on the PNV file when requested.
8. Agree to allow the Agency to procure a provider enrollment and/or credentialing vendor for entire Medicaid program, including Managed Care Plan onboarding and credentialing, as determined by the Agency.

5 Requirements of the State Medicaid Contract.
6 All documents requiring primary source verification and evidence of professional liability insurance (PLI) or acceptable alternative must be available in the credentialing file.

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9. The Managed Care Plan shall ensure that all providers are eligible for participation in the Medicaid program and actively enrolled with the Agency. Validation will be conducted by the Provider Operations area as being enrolled.
10. The Managed Care Plan shall deem providers with a valid Limited Enrolled or Fully Enrolled agreement with the Agency as having met all requirements described below:
    - **a)** Proof of each provider's current license or authority to do business, including documentation of provider qualifications, as specified in the service-specific policy; if the provider is located in Georgia or Alabama, the provider's license and permit must be current and applicable to the respective state in which the provider is located.
    - **b)** No revocation, moratorium, or suspension of the provider's license by the licensing authority in this or any state, if applicable.
    - **c)** No sanctions imposed on the provider by Medicare or Medicaid, without proof of reinstatement or other documentation that all obligations under the sanction have been met.
    - **d)** Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105), and conviction of crimes (42 CFR 455.106).
    - **e)** A level II background check pursuant to Section 409.907, F.S.

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# Georgia

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to credential providers according to established standards, but no specific credentialing requirements are identified. (GA Comp. Rules and Regulations sect. 120-2-80-.08(2) (f).

HMOs are required to maintain the current license[7] or registration number for all licensed independent practitioners (LIPs). (GA Comp. Rules and Regulations sect. 290-5-37-.07(4) (d)). Copy of license or screen print from licensing board will serve as evidence of primary source verification for current license.

UnitedHealthcare also accepts the Georgia credentialing forms found at the following link:
**http://www.georgiacredentialing.org/applications.html**

7 Licenses will be verified at the time of initial credentialing, recredentialing and upon expiration.

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# Hawaii

No additional credentialing requirements.

## Hawaii UnitedHealthcare Community Plan Requirements

Additional query of HI Med-Quest Medicaid Provider Exclusion List is required for Practitioners and Facilities:
**https://medquest.hawaii.gov/en/plans-providers/provider-exclusion-reinstatement-list.html**

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# Idaho

No additional credentialing requirements.

## Idaho UnitedHealthcare Community Plan Requirements

Additional query of Idaho Medicaid Exclusion List is required for Practitioners and Facilities:
**https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers**

Completely process credentialing applications from all types of providers within one hundred twenty (120) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider contract. This includes review, approval, and loading approved applicants to its provider files in its claims processing system or denying the application and ensuring the provider is not used under the contract.

Health Plan must adhere to Managed Care Standards at 42 CFR § 438.214 and 42 CFR § 422.204

The Contractor must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, as detailed in 42 CFR 438.12(a)(2); and 42 CFR 438.214(c).

Policy and procedures shall include:

1. A training plan designed to educate staff in the credentialing and re-credentialing requirements.
2. Provisions for monitoring and auditing compliance with credentialing standards.
3. Provisions for prompt response and corrective action when non-compliance with credentialing standards is detected.
4. A description of the types of providers that are credentialed.
5. Methods of verifying credentialing assertions, including any evidence of prior provider sanctions.
6. Prohibition against employment or contracting with Providers excluded from participation in Federal Health Care Programs; and
7. Methods for certifying that each provider license is current with the appropriate Idaho Licensing Bureau using the License and Certification Requirements for each Individual Provider Type.

Upon the state's ability to implement, the state will screen and enroll and periodically revalidate all network providers per §438.602(b)(1). The Contractor must accept provider credentialing and verified information from the Department and will not request any additional credentialing information from a provider without the Department's written prior approval. MCO is not prohibited from collecting other information from providers necessary for the MCO's contracting process. The MCO shall not solicit or accept provider credentialing or verified information from any source other than the Department, except as expressly permitted by the Department.

The Contractor must ensure all network providers are enrolled with the Idaho Department of Health and Welfare (IDHW) Medicaid Management Information System (MMIS) as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements described in 42 CFR 455 Subparts B and E. Validation will be conducted by the Provider Operations area as being enrolled with IDHW.

The Contractor must implement and maintain written credentialing and recredentialing policies consistent with Idaho Department of Health and Welfare (IDHW) uniform credentialing and recredentialing policies that address acute, primary, behavioral, substance use disorder, and LTSS providers, as appropriate and applicable and Federal and State regulations for selection and retention of providers, credentialing and recredentialing, and nondiscrimination, as detailed in 42 CFR 438.12(a)(2); 42 CFR 438.214(b)(1)-(2).

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# Illinois

Laws and regulations apply to health care plans such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Insurance Companies, etc.

Requirements with respect to health care professionals, such as physicians and chiropractors. Please see the Health Care Professional Credentials Data Collection Act:

1. Health care plans are required to accept, from health care professionals, the Illinois Uniform Health Care Credentials form and may require the health care professional to submit any additional credentials data requested.
2. Each health care plan must complete the process of credentialing or recredentialing of the health care professional within 60 days after submission of all credentials data and completion of verification of the credentials data. 410 ILCS 517/15(f); 77 Ill. Adm. Code 965.140(b).
3. **a)** All health care plans must obtain recredentialing data on a health care professional according to the single credentialing cycle except when a:
   - health care professional submits initial credentials data to a health care plan;
   - health care professional's credentials data change substantively; or
   - health care plan requires recredentialing as a result of patient or quality assurance issues. (410 ILCS 517/20; 77 Ill. Adm. Code 965.300)

   **b)** Data collection for health care plans will coincide with a single credentialing cycle that entitles health care plans to collect recredentialing data once, and not more than every three years, except as noted in Section 3(a). (77 Ill. Adm. Code 965.300).

   **c)** Data collection:
   - will be based on the last digit of each health care professional's Social Security number;
   - will provide for a one-month notification period for each digit during which each health care plan notifies those persons being recredentialed of the time period during which data is expected to be submitted; and
   - will provide for a two-month collection period for each digit during which each health care plan receives data from those persons being recredentialed. (77 Ill. Adm. Code 965.300)

   **d)** The single credentialing cycle reflects a six month "OPEN" period when health care plans cannot collect data from a health care professional, except as noted in Section 3(a). (77 Ill. Adm. Code 965.300)

   **e)** Once recredentialing has begun in accordance with the single credentialing cycle, a health care plan may continue to request data from a health care professional outside of the published single credentialing cycle if it is not submitted by the deadline date. (77 Ill. Adm. Code 965.300).

   **f)** Illinois law does not preclude a health care plan from meeting any quality assurance requirement of an entity related to credentialing for the purpose of accreditation or otherwise. (77 Ill. Adm. Code 965.300).

   **g)** A health care plan may apply to the Director of Insurance via letter for an exemption from the single credentialing cycle. (77 Ill. Adm. Code 965.310).
4. Health care plans may delegate credentialing and recredentialing activities as long as the delegated entity follows the requirements set forth in the Health Care Professional Credentials Data Collection Act. (410 ILCS 517/15(k); 77 Ill. Adm. Code 965.140(e)).
5. Effective January 1, 2025, an insurer or managed care plan shall not use a health care provider's preferred method of payment as a factor when deciding whether to provide credentials to a health care provider. (215 ILCS 5/355.6(e)).

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# Indiana

Insurers, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to (pursuant to Indiana (IN) statutes: 27-13-43-2 (HMO), and 27-8-11-7(Insurer/PPO) (effective January 1, 2024) :

- Use the Uniform Credentialing Application from the Council for Affordable Quality Healthcare (CAQH), and:
- Notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by the provider not later than five (5) business days after the entity receives the completed unclean credentialing application form. Notice must (1) provide a description of the deficiency and (2) state the reason why the application was determined to be an unclean credentialing application; and
- Upon failing to issue a credentialing determination within fifteen (15) business days after receiving a completed clean credentialing application form from a provider, shall provisionally credential the provider in accordance with the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization. The provisional credentialing is valid until a determination is made on the credentialing application of the provider; and
- Notify a provider concerning the status of the provider's completed clean credentialing application when:
  **a)** the provider is provisionally credentialed; and
  **b)** a final credentialing determination is made concerning the provider.

## Indiana UnitedHealthcare Community Plan Requirements

1. The Contractor shall use FSSA's standard provider credentialing form during the credentialing process or gather the information identified on the form during the provider network participation request process. The IHCP MCE Practitioner Enrollment Form and IHCP MCE Hospital/Ancillary Provider Enrollment Form can be found on the IHCP Provider Enrollment Transactions page at **in.gov/medicaid/providers**.
2. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
3. Additional requirements for verification of sanctions on Practitioners and Facilities through FSSA Termination of Provider Participation in Medicaid and CHIP at initial and recredentialing.
   **https://www.in.gov/fssa/ompp/4973.htm**
4. Obtain and primary source verify status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility at initial and recredentialing
5. Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing (NPDB is not applicable to chiropractors and podiatrists).
6. Information from the State Board of Chiropractic Examiners or the Federation of Chiropractic Licensing Boards.
7. Information from the State Board of Podiatric Examiners
8. Initial visit to the offices of all potential primary medical providers, including all obstetricians and gynecologists (OB/GYNs). The initial site visit must also document evaluation of the medical record keeping practices at each site to ensure conformity with the maintenance of medical records.
9. Recredentialing practice site visit must be conducted to determine if there have been changes in the facility, equipment, staffing, or medical record keeping practices that would affect the quality of care or services provided to members. Primary medical providers, OB/GYNs, and other high-volume specialists must be included in this site visit.

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10. Recredentialing process must include data from at least three of the following six sources:
    - Member complaints
    - Quality reviews (practice-specific)
    - Utilization management (profile of utilization)
    - Member satisfaction (practice-specific)
    - Medical record review
    - Practice site reviews
11. The Contractor shall process all (Practitioner, Facility) initial credentialing applications and recredentialing applications within thirty (30) calendar days of receipt of a complete application. The Contractor shall ensure all credentialed providers are loaded into the Contractor's provider files and claims system within seven (7) business days of credentialing. The Contractor shall set the provider's enrollment date to the initial date the provider's credentialing application was received by the Contractor or State's credentialing vendor.
12. Contractor must seek practitioner expertise on current practice in the medical community and advice on modifying the criteria, as appropriate. This expertise can be obtained from a committee with participating practitioner representation or from consultation with participating practitioners.
    - Participating practitioners must complete applications for membership on such a committee
13. The State will implement a model for provider enrollment and credentialing consistent with the provisions of IC 12-15-11-9.
14. The State must approve all subcontracts, and changes in subcontractors or material changes to subcontracting arrangements.
15. Network providers will be required to participate in the State Medicaid program. Validation will be conducted by the Provider Operations area as being enrolled with IHCP as a contracted provider.
16. The Contractor shall provide a portal for providers seeking credentialing that will allow the provider to communicate with the MCE, submit their credentialing documentation, and to see the status of their credentialing process. The Contractor shall have a central repository solution for all documentation and correspondence that is related to and occurs during the provider network participation process. Contractors must retain the request for participation form, all supporting documents submitted by the provider, all credentialing files, and contract related documents as well as written and email correspondence in the repository.
17. The same provider credentialing standards must apply across all Indiana Medicaid programs.
18. MCEs must notify providers when an incomplete network participation request is received. Notification of an incomplete network participation request will be sent to providers within five (5) business days after receipt of initial request. The MCE must include the specific item on the application resulting in its status as unclean credentialing application.
19. As provided in 42 CFR 438.214(c) and 42 CFR 438.12(a), the Contractor's provider credentialing and selection policies shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

**Effective January 1, 2024**

If a decision on a clean credentialing application is not made within 15 business days of receipt of the application, the MCE must consider the provider to be provisionally credentialed. To be considered provisionally credentialed, a provider must meet the standards established by NCQA. The MCE must ensure the following activities are complete: Provide a written letter notifying the requesting provider of the decision to provisionally credential the provider (as well as a decision letter on the provider's full credentialing status); Complete the full credentialing process through its medical director or Credentialing Committee; Provider's provisional credentialing status must remain valid until the sooner of the MCE's full credentialing determination or sixty calendar days after the provisional credentialing



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decision; Provider must remain unlisted on the MCE's provider directory until the provider has completed the full network participation process.

The provisional credentialing requirement does not apply to the following: Recredentialing providers; Delegated credentialing arrangements.

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# Iowa

Credentialing Process

1. A health insurer shall notify of its credentialing determination of physician, advanced registered nurse practitioner, or physician assistant's request for credentialing within fifty-six (56) calendar days from the date of the request.
2. If a physician's, advanced registered nurse practitioner's, or physician assistant's request for credentialing is denied by the health insurer, the health insurer shall provide a reason for the denial, in writing, to the physician, advanced registered nurse practitioner, or physician assistant.
   Section 514F.6, Code 2025

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# Kansas

No additional credentialing requirements.

## Kansas UnitedHealthcare Community Plan Requirements[8]

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of KS Medicaid Terminated Provider List is required for Practitioners and Facilities: **https://www.kdhe.ks.gov/172/Medicaid**

Contractor shall utilize the State Provider enrollment system to access all necessary applications and associated documentation within two (2) Business Days from the receipt of the daily file from the Fiscal Agent, as it will be the system of record and is intended to maximize standardization of documentation and minimize repetitive effort on the part of the Providers.

The Contractor shall use the State Provider enrollment system for any information to the maximum extent possible unless using information in the State Provider enrollment system would not meet National Committee for Quality Assurance (NCQA) guidelines.

The Contractor shall initiate primary source verification within five (5) Calendar Days of receipt of a completed credentialing application and, except when additional time is needed due to a delay by the primary source in providing required information, ensure that credentialing of all service Providers applying for Participating Provider status is completed within forty-five (45) Calendar Days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the Provider notifying them of the decision. The Contractor shall follow up with Providers as necessary to obtain any necessary information and shall provide regular updates to Providers on the status of their application. Credentialed Providers must be entered/loaded into the CONTRACTOR(S)' Claims payment system within seven (7) Calendar Days of credentialing committee approval.

The Contractor shall ensure that Participating Providers are eligible for payment by the CONTRACTOR(S) as a Participating Provider as of the date of the Provider's enrollment with the Kansas Medical Assistance Program (KMAP).

Provider selection requirements must comply with 42 CFR § 438.12. Contractor Provider selection policies and procedures must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

The State intends to implement centralized credentialing and re-credentialing applicable to all KanCare MCOs. The MCO shall assist the State with the transition and implementation of centralized credentialing and re credentialing and comply with the State's requirements. Until the State implements centralized credentialing and re-credentialing, the MCO must establish and implement a credentialing and re-credentialing process for its Participating Providers.

8 Requirements of the State Medicaid Contract.

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# Kentucky

Insurers, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are:

1. Required to accept either the Council for Affordable Quality Healthcare (CAQH) provider application or the Kentucky (KY) Application for Provider Evaluation and Reevaluation Part A (KAPER-1). (KY Administrative Regulations – 806 KAR 17:480.) Insurer/HMO/PPO may accept the CAQH application in lieu of KAPER-1.
2. When KAPER-1 is used, additional information that is not relevant to the scope of practice, health care setting, or service of the health care provider, is not to be requested and may not recredential more frequently than every three years.
   - **a)** Within 30 days of receipt of a complete KAPER-1 (12/05), Part A, electronically or in writing:
     - **i)** Notify the health care provider of any omitted and questionable information included on the form; and
     - **ii)** Offer assistance to the provider.
   - **b)** Within 60 days of receipt of KAPER-1 (12/05), Part A, provide notification electronically or in writing to the health care provider of the status of credentialing. This time period may be extended if, due to extenuating circumstances:
     - **i)** Additional time is required by the insurer to consider information submitted on the KAPER-1 (12/05), Part A; and
     - **ii)** The health care provider is informed of the need for more time, including information relating to the extenuating circumstance which caused the delay. Provide electronic or written notification as established in paragraph C of this sub-section every 30 days after the initial notification until a final determination regarding credentialing has been issued to the health care provider.
   - **c)** Provide electronic or written notification every 30 days after the initial notification until a final determination regarding credentialing has been issued to the health care provider.
3. When CAQH is used an insurer issuing a managed care plan shall notify an applicant of its determination regarding a properly submitted application for credentialing within 45 (HB 69, Section 8 amends KRS 302.17A-576) days of receipt of an application containing all information required by the most recent version of the CAQH credentialing form. Effective July 15, 2008, nothing in this section shall prevent an insurer from requiring information beyond that contained in the credentialing form to make a determination regarding the application. (304.17A-576).
4. Required to appoint a KY-licensed medical director (KY Revised Statutes section 304-17A-545).
5. The recredentialing process is to include an assessment of data collected through quality improvement activities. (KY Revised Statutes section 304.17A-545(4) (d).).

## Kentucky UnitedHealthcare Community Plan Requirements

1. The Contractor and any subcontractor shall complete the Credentialing or Recredentialing of a Provider within thirty (30) Days unless federal or state law or regulation requires a different completion time.
2. The Contractor shall contract with the Provider within thirty (30) calendar days of credentialing and shall load the contract and configure the system within ten (10) Days of the executed contract. If additional time is needed to load the contract and configure the system, the Contractor may take an additional fifteen (15) Days if it has notified the Provider of the need for additional time. The Contractor is not required to contract with a Provider if the Contractor and provider are unable to agree on the terms and conditions for participation.
3. A Provider's claims become eligible for payment as of the date of the Provider's credentialing application date. The Contractor shall not require a Provider to appeal or resubmit any clean claim submitted during the time period between the Provider's credentialing application date and the completion of the credentialing process. A Provider whose credentialing is denied should be paid on a non-par basis.

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4. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
5. Additional requirements for verification of sanctions on Practitioners and Facilities through the Kentucky Medicaid Provider Termination and Exclusion list.
**https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/terminated.aspx**
6. Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing.
7. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth. Copy of license or screen print from licensing board will serve as evidence of primary source verification for current license.
8. Documentation of censure by the State or County professional association which is included in the NPDB query.
9. Documentation of curtailment or suspension of medical staff privileges which is included in the NPDB query.
10. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age.
11. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation.
12. If a provider requires review by the Contractor's Credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.
13. Upon request of a provider, the Contractor shall provide support to the provider in submission of required materials to the Department for processing of the enrollment.
14. The Contractor shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), KRS 205.532, KRS 205.560(12), 907 KAR 1:672, 304.17A-576, or other applicable federal and state laws and regulations unless the Department contracts with a Credentialing Verification Organization (CVO) to perform such services.
15. Enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.
16. Effective 07/15/2018, HB 444 Section 10(1)(a) amended KRS 216B.020 no longer requires Rural Health Clinic (RHC) to be licensed or surveyed through the Office of Inspector General (OIG). Provider must be actively enrolled with Medicare as an RHC.
17. Kentucky Medicaid Fee-For-Service (FFS) Program participation is not a condition of participating in the UnitedHealthcare Community Plan Managed Care provider network.

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# Louisiana

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept either the Louisiana (LA) Standardized Credentialing Application form, or its successor, or the current form used by the Council for Affordable Quality Healthcare (CAQH).
(LA Revised Statutes sect. 22:1009(B) (3)).
2. Notify provider applicants of all defects rendering the application incomplete within 30 days of receipt. (LA Revised Statutes sect. 22:1009(B) (2) (a)).
3. If the information is not received, notify the provider applicant within 60 days of request for additional information. (LA Revised Statutes sect. 22:1009 (B) (2) (b)).
4. Complete credentialing process within 90 days from receipt of all information needed for credentialing. (LA Revised Statutes sect. 22:1009 (B) (1)).
5. UnitedHealthcare adheres to the Louisiana Revised Statute 22:1874 (5)(a) (which incorporates Act 897) for practitioners joining an existing, contracted medical group;
   - **a)** To be temporarily approved to receive claims payment upon submitting their completed UnitedHealthcare application, and then will be fully credentialed upon application approval.
   - **b)** If the new provider is an advanced practice registered nurse or a physician assistant, proof of membership on a hospital medical staff shall not be required if the provider providers a written attestation identifying the collaborating or supervision physician, if a physician relationship is required by law.[9]

## Louisiana UnitedHealthcare Community Plan Requirements[10] (Community Plan terms 12/31/2025)

1. The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean review, approve and load applicants to its provider files in its claims processing system.
2. If the MCO declines request of providers to be included in the network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR §438.12(a)(1)]
3. UnitedHealthcare Community Plan encourages all participating physicians who are not yet board certified to become board certified.
4. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
5. Additional requirements for verification of sanctions on Practitioners and Facilities through the Louisiana Exclusion Database. **https://adverseactions.ldh.la.gov/SelSearch**

9 If a collaborating or supervising physician is no longer required for a physician assistant (PA) or a nurse practitioner (NP) by LA law, the PA or NP will be required to comply with the requirement for Hospital Staff Privileges set out in section 4.2.12 of the UnitedHealthcare Credentialing Plan.

10 Requirements of the State Medicaid Contract.

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6. Recredentialing (L.A.Revised Statutes sect. 46:§ 460.72 – MCO shall comply with the following notice provisions regarding contracted provider recredentialing:
   a) MCO shall provide a minimum of three written notices to a contracted provider with information regarding the re-credentialing process, including requirements and deadlines for compliance. The first notice shall be issued by the MCO no later than six months prior to the expiration of the provider's current credentialing. The notice shall include the effective date of termination if the provider fails to meet the requirements and deadlines of the recredentialing process.
   b) The MCO shall send the written notice to the last mailing address and last email address submitted by the provider.
   c) If the provider fails to submit all required documents and meet all recredentialing requirements, the MCO shall send a termination notice via certified mail to the provider's last mailing address with an effective date of termination to be fifteen days after the date of the notice.
7. In accordance with 42 C.F.R. §438.602(b) and upon LDH implementation of a provider management system, the MCO shall not enter into a network provider agreement with a provider to provide services when not otherwise appropriately screened by and enrolled with the State according to the standards under 42 C.F.R. Part 455, Subparts B and E.
8. Prior to entering into a provider agreement, the MCO shall ensure that providers have been properly credentialed to ensure provider facilities, organizations, and practitioners meet all qualifications and requirements for participation in the Medicaid program.
9. If the MCO has NCQA Health Plan Accreditation, those credentialing policies and procedures shall meet LDH's credentialing requirements.
10. The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.
11. To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the Contractor from the delegated credentialing agent are loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.
12. The MCO shall notify LDH when it denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.
13. LDH reserves the right to contract with a single National Committee for Quality Assurance (NCQA)-certified Credential Verification Organization (CVO). If this option is pursued, the MCO and its subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract. When LDH implements a CVO, the MCO shall:
   a) Accept the final credentialing decisions of the CVO.
   b) Within thirty (30) calendar days of receipt of an approved credentialing load providers in its claims processing system.
   c) Provide information to the State's provider management contractor on contracted providers.
   d) Participate on the CVO's Credentialing Committee to evaluate provider credentialing files (including recredentialing files) using a peer review process. The credentialing committee is responsible for credentialing decisions which shall be accepted by the MCO.
14. Credentialing P&P's shall be submitted to LDH during readiness review, and subsequently any time a change is made, and annually thereafter by contract year.
15. Ensure Primary Care Providers maintain hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital. Verification of element by Applicant attestation.

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16. The Contractor shall comply with interim credentialing requirements in accordance with La. R.S. 46:460.62.

17. The Contractor shall consider providers who maintain hospital privileges or are members of the medical staff of a hospital, FQHC, or RHC to have satisfied, and be otherwise exempt from having to satisfy, any credentialing requirements of the Contractor, in accordance with La. R.S. 46:460.61. The Contractor shall verify that these providers satisfy the exemption criteria and load them to its provider files and into its Claims processing system within thirty (30) Calendar Days of receipt of documentation supporting the exemption. The Contractor shall track the providers who were credentialed by a hospital, FQHC, or RHC, including the expiration or termination of privileges and/or employment. Prior to expiration or upon notice of termination, such that the provider no longer maintains any hospital privileges and is no longer a member of the medical staff of any hospital, FQHC, or RHC, the Contractor shall follow its standard process for credentialing a new provider. This exemption does not remove the Contractors obligation to screen providers for exclusions prior to contracting and on a regular basis in accordance with the interval specified in the Contract.

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# Maine

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Within 30 days of receiving the application, the carrier shall notify the provider that the application is complete or furnish a list of all corrections needed. ((Code of ME Rules 02-031-850 section (7)(G)(3)).
2. Obtain primary source verification, or secondary verification from the National Practitioner Data Bank (NPDB), of the health professional's license history for the preceding 10 years in ME and all other states, including a chronological history of the license, dates, times and places of all applications for license privileges, any action taken on the application, any challenges to licensure or registration, or the voluntary or involuntary relinquishment of a license.
   (Code of ME Rules 02-031-850 section (7)(G)(9)(a)).
3. Make credentialing decisions within 60 days of receipt of a completed credentialing application. If unable to complete credentialing within 60 days, carrier must apply for an extension on a form prescribed by the Superintendent and provide a detailed explanation of the reason(s) it is unable to make a decision. If the problem is not specific to a particular application, the carrier must provide a written remediation plan to bring its credentialing review practices into conformity with the 60-day limit. ((Code of ME Rules 02-031-850 section (7)(G)(2)).
4. The effective date of network participation is the date the carrier receives a complete application. ((Code of ME Rules 02-031-850 section (7)(G)(3)).
5. Offer an appeal procedure, including the right to a hearing, for dealing with provider concerns relating to the denial of credentialing for not meeting the objective credentialing standards of the plan and the contractual relationship between the provider and HMO/PPO. (24 A.M.R.S. § 4303).

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# Maryland

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the uniform credentialing form, designated by the Insurance Commissioner as DataSpring, Council for Affordable Quality Healthcare ("CAQH"), and are prohibited from requesting additional information. This also applies to credentialing Delegated Entities that are not hospitals or academic medical centers. (Code of Maryland (MD) Regulations sections 31.10.26.01 et. seq. and MD Ins. Code sect. 15-112.1(c)).
2. Return incomplete applications to applicants within 10 days of receipt, identifying additional information required. (MD Insurance Code section 15-112(g)(4)(ii).
3. Upon receipt of a completed application, notify applicants within 10 days that application is complete. If the application is received via an online credentialing system (i.e. "CAQH"), and the online credentialing system notifies the applicant that the application has been received by the carrier, the HMO/PPO is not required to notify the applicant directly. (MD Insurance Code 15-112 (g)(4)(i)).
4. Notify applicants within 30 days of receipt of completed application of intent either:

   **a)** to continue to process the application, or

   **b)** to reject application. (MD Insurance Code section 15-112(d)(3)(i)).
5. Where the carrier notifies the provider of the intent to continue to process the application, the carrier must process applications within 120 days of notice and inform providers of the final determination of whether the application is accepted or rejected. The notice of acceptance requirement applies to only initial credentialing applications. (MD Insurance Code section 15-112(g)(3)(iii)).
6. Verify whether or not provider is accepting new patients at initial credentialing and recredentialing, and update online directory accordingly. (MD Insurance Code sections 15-112(b)(4) and (n)).[11]
7. Maintain an application log with the following information:
   - Name of provider requesting application
   - Date provider requested application
   - Date application sent or delivered to provider
   - Date application received from provider
   - Date application returned to provider with request for additional information
   - Date received back from provider following request for additional information
   - Date provider notified of rejection or intent to continue credentialing process
   - Date of acceptance or rejection upon completion of credentialing process (Code of MD Regulations sect. 31.10.16.03(D).)
8. Maintain application log for a minimum of three years or until the next market conduct exam, whichever occurs last. Shall:
   - Date stamp an application received from a provider upon initial receipt, and
   - Maintain a copy of each application, and any correspondence regarding the application, for a minimum of three years or until the next market conduct exam, whichever occurs last.
9. HMOs are also required to assess performance of physicians and nurse practitioners on recredentialing based on an analysis of data obtained through quality improvement activities. (Code of MD regulations sec. 10.07.11.07E3)

11 Open panel status is not a criterion for participation

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## Maryland UnitedHealthcare Community Plan Requirements[12]

1. Initial site visits at the time of credentialing for each primary care practitioner (PCP) office, to include both an evaluation of Americans with Disabilities Act (ADA) compliance and medical record keeping practices.
2. Reassess provider site ADA compliance during recredentialing for any PCP who relocated to another location that has not previously been evaluated.
3. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (GSA-EPLS)).
4. Review of Practitioners must include information from the National Practitioner Data Bank (NPDB).
5. Additional query of MD Medicaid Providers Sanctioned List is required for Practitioners and Facilities: **https://mmcp.health.maryland.gov/pages/Provider-Information.aspx**
6. Review of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) certification status at the time of credentialing and recredentialing. EPSDT applies to PCP's only. (General practitioner, Family Practitioner, Pediatrics, and Nurse Practitioners.)
7. Procedures for the termination or withdrawal of a provider from the MCO's provider panel shall include a notice to primary care providers informing them of the enrollee's right to change MCOs as described in COMAR 10.67.02.06A(1)(e). (COMAR 10.67.09.03(B)(5)(c).)
8. Verification that practitioners and facilities are actively enrolled in Medicaid at time of credentialing and recredentialing. **https://encrypt.emdhealthchoice.org/searchableProv/main.action**
9. An MCO may include, as appropriate, any of the following practitioners to serve as the primary care provider for an enrollee:
    - General practitioner;
    - Family practitioner;
    - Internist;
    - Pediatrician;
    - OB/GYN;
    - Physician assistant;
    - Certified nurse midwife;
    - Nurse practitioner certified in any of the following areas of specialization
        - Adult;
        - Pediatric;
        - Geriatric;
        - OB/GYN;
        - School nurse; or
        - Family; and
    - A physician practicing in a specialty area other than those enumerated in §A(5)(b)—(e) of regulation 10.67.05.05.

12 Requirements of the State Medicaid Contract.

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# Massachusetts

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to (211 Code of Massachusetts. Regulations. 52.09):

1. Comply with National Committee for Quality Assurance Managed Care Organization accreditation standards for credentialing and recredentialing, and are permitted to adopt additional credentialing criteria.
2. Accept credentialing/recredentialing applications in a format specified by the Commissioner (Integrated Massachusetts Application for Initial Credentialing/Appointment), and submitted in paper or electronic format, including facsimile and electronic mail. An online process for the purpose of processing credentialing applications may be implemented. A credentialing application which is appropriately signed and dated by the Provider, and which includes all of the applicable information requested from the Provider by the Carrier.
3. Notify the applicant if application is incomplete no later than 20 business days after receipt.
4. Notify initial credentialing applicant within 75 days of receipt of the status of the application, including reasons for any delay in completion and a timeline of the expected resolution of the application.
5. Complete 95% of clean and complete initial credentialing applications within 60 days of receipt.
6. Complete 95% of clean and complete recredentialing applications within 120 days of receipt.
7. A Carrier that delegates to or contracts with another entity for the performance of some or all of the functions governed by M.G.L. c. 176O and/or 211 CMR 52.00 shall be responsible for ensuring compliance by said entity with the provisions of M.G.L. c. 176O and 211 CMR 52.00. (211 CMR 52.01.)

## Massachusetts UnitedHealthcare Community Plan Requirements[13]

Inclusion of data from quality improvement activities at the time of recredentialing.

Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)).

Additional query on List of Suspended or Excluded MassHealth Providers is required for Practitioners and Facilities: **http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/list-of-suspended-or-excluded-masshealth-providers.html**

Primary Care Physicians in the Senior Care Options Product, (MDs/DOs, NPs and PAs practicing as Internal Medicine, Family Practice, Geriatric Medicine, and/or OB/GYN) are required to complete annual continuing medical education (CME) units in geriatric practice and at least two years of experience in the care of people over the age of 65.

Federal database check on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES).

Primary source verification on current DEA.

Providers shall conform with recognized managed care industry standards such as those provided by NCQA and relevant State regulations, when obtaining Continuing Medical Education (CME) credits or continuing Education Units (CEUs).[14]

PCPs and specialty physicians shall be board certified or board eligible. Health Plan to monitor participating physician compliance on averages that ensures percentage of board-certified PCPs and specialty physicians participating in the Provider Network is approximately equivalent to the community average.

Health Plan shall submit policies and procedures annually to EOHHS, if amended.

13 Requirements of the State Medicaid Contract.
14 Criteria are covered under Board of Registration in Medicine - 243 CMR 2.06, Board of Registration of Physician Assistants - 263 CMR 3.05, Board of Registration in Nursing - 244 CMR 4.05.

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Network providers will be required to participate in the State Medicaid program. Validation will be conducted by the Provider Operations area as being enrolled with MassHealth.

Must obtain confirmation of the past ten (10) years of history of malpractice settlements or judgments from the malpractice carrier or must query the National Practitioner Data Bank (NPDB).

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# Michigan

Health Maintenance Organizations (HMOs) are required per Michigan Compiled Laws Service sections 500.3528 and 500.3531 to:

1. A health maintenance organization shall establish written policies and procedures for credentialing verification of all health professionals with whom the health maintenance organization contracts. A health maintenance organization shall apply these standards consistently. This act does not require a health maintenance organization to select a provider as an affiliated provider solely because the provider meets the health maintenance organization's credentialing verification standards. This act does not prevent a health maintenance organization from using separate or additional criteria in selecting the health professionals with whom it contracts. (Sec. 500.3528 (1))
2. A health maintenance organization is considered to meet the requirements of this section if the health maintenance organization is accredited by a nationally recognized accredited body approved by the director. As used in this subsection, "nationally recognized accredited body" includes the National Committee for Quality Assurance. (Sec. 500.3528 (2))
3. A health maintenance organization shall provide for an initial 60-day provider application period during which providers may apply to the health maintenance organization to become affiliated providers. A health maintenance organization that has entered into a contract with an affiliated provider shall provide, at least once every 4 years, for a 60-day provider application period during which a provider may apply to the organization to become an affiliated provider. Notice of this provider application period shall be given to providers upon request and shall be published in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the commencement of the provider application period. Upon receipt of a request by a health care provider, the organization shall provide the written standards required under this chapter to the health care provider. Within 90 days after the close of a provider application period, or within 30 days following the completion of the applicable physician credentialing process, whichever is later, a health maintenance organization shall notify an applicant in writing as to whether the application to become an affiliated provider has been accepted or rejected. If an applicant has been rejected, the health maintenance organization shall state in writing the reasons for rejection, citing 1 or more of the standards. (Sec. 500.3531(7).)

## Michigan UnitedHealthcare Community Plan Requirements[15,16]

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional requirements for Practitioner and Facility verification of sanctions including but not limited to the Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA) Sanctioned Provider List.

Contractor must comply with the requirements of 42 CFR 438.214 regarding credentialing and recredentialing of Providers.

Allow Providers to request retroactive effective date for network participation back to date of receipt of complete application.

15 If the provider is enrolled directly with the MI Medicaid program (proof of which is verified and contained in the credentialing file) there is no further requirement that the health plan query certain databases such as the NPPES, Death Master File or the MDCH.

16 Requirements of the State Medicaid Contract.

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# Minnesota

MN Stat. §62Q.097 Requirements for Timely Provider Credentialing

**Subdivision 1.** Definitions.

(b) "Clean application for provider credentialing" or "clean application" means an application for provider credentialing submitted by a health care provider to a health plan company that is complete, is in the format required by the health plan company, and includes all information and substantiation required by the health plan company and does not require evaluation of any identified potential quality or safety concern.

**Subdivision 2.** Time limit for credentialing determination.

A health plan company that receives an application for provider credentialing must:

1. If the application is determined to be a clean application for provider credentialing, and
   - **a)** if the health care provider submitting the application or the clinic or facility at which the health care provider provides services requests the information,
   - **b)** affirm that the health care provider's application is a clean application and
   - **c)** notify the health care provider or clinic or facility of the date by which the health plan company will make a determination on the health care provider's application;
2. If the application is determined not to be a clean application, the health plan company must:
   - **a)** inform the health care provider of the application's deficiencies or missing information or substantiation **within three business days** after the health plan company determines the application is not a clean application; and
3. Make a determination on the health care provider's clean application **within 45 days** after receiving the clean application unless the health plan company identifies a substantive quality or safety concern in the course of provider credentialing that requires further investigation.
4. Upon notice to the health care provider, clinic, or facility, the health plan company is allowed 30 additional days to investigate any quality or safety concerns.

**Subdivision 3.** Prohibited application questions (effective for credentialing applications submitted on or after Jan. 1, 2025).

An application for provider credentialing must not:

1. Require the provider to disclose past health conditions;
2. Require the provider to disclose current health conditions, if the provider is being treated so that the condition does not affect the provider's ability to practice medicine; or
3. Require the disclosure of any health conditions that would not affect the provider's ability to practice medicine in a competent, safe, and ethical manner.

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# Mississippi

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to follow Code of Mississippi Rules Chapter 011 (98.1) to:

1. Accept the state uniform credentialing application from physicians for initial credentialing and recredentialing.
2. Augment the uniform credentialing application with additional information on supplemental form.
3. Obtain prior approval from the Commissioner of Insurance for supplemental form to the uniform credentialing application.
4. Obtain primary verification of hospital privileges to practitioner's primary admitting hospital at initial credentialing and subsequent recredentialing.
5. Obtain primary or secondary verification of hospital privileges to hospitals other than practitioner's primary admitting hospital at initial credentialing and recredentialing.

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# Missouri

Laws and regulations apply to health carriers, meaning, Health Maintenance Organizations (HMOs).

Requirements with respect to health care professionals, such as physicians, chiropractors, dentists and any other health care practitioners who are licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law:

1. The Universal Credentialing Datasource form (Form UCDS), incorporated by reference and published on October 31, 2006, by the Council for Affordable Quality Healthcare (CAQH), has been adopted and shall be used by all health carriers and their agents when credentialing or recredentialing health care professionals in a managed care plan. (20 CSR 400-7.180 (2011))
2. Within two working days after receipt of a credentialing application, the health carrier shall send a notice of receipt to the practitioner. (376.1578 (1) R.S.Mo)
3. A health carrier shall provide access to a provider web portal that allows the practitioner to receive notice of the status of an electronically submitted application. (376.1578 (1) R.S. Mo.)
4. If a health carrier determines the application is not a completed application, the health carrier shall have ten (10) days from the date the notice of receipt was sent to request any additional information from the practitioner. (376.1578(2) R.S.Mo.)
5. The application shall be considered a completed application upon receipt of the requested additional information from the practitioner. (376.1578(2) R.S.Mo)
6. Within two working days of receipt of the requested additional information, the health carrier shall send a notice to the practitioner informing him or her that he or she has submitted a completed application. (376.1578(2) R.S.Mo)
7. If the health carrier does not request additional information, the application shall be deemed completed as of the date the notice of receipt was sent as required under subsection 1 of this section. (376.1578(2) R.S.Mo)
8. Health carriers may request additional information to explain or provide details regarding responses obtained on the standard form. Health carriers are prohibited from routinely requiring additional information from health care professionals. (20 CSR 400-7.180(3)).
9. If the health carrier demonstrates a need for additional information, the director of the Department of Insurance may approve a supplement to the standard credentialing form. All forms and supplements must meet all requirements as defined by National Committee for Quality Assurance (NCQA). § 354.442(15) R.S.Mo.
10. An onsite examination by the health carrier or their agent of the health care professional's place of business must not, in itself, be considered a routine request for additional information. (20 CSR 400-7.180(4)).
11. Health carrier required to make a decision whether to approve or deny a practitioner's credentialing application within 60 calendar days of receipt of completed credentialing application. (Rev. Stat. MO sect. 376.1578(3).
    - **a)** The 60 calendar day deadline shall not apply if the credentialing application or subsequent verification indicates that the practitioner has:
        - **i)** a history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;
        - **ii)** Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;
        - **iii)** Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or

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**iv)** A judgment or judicial award [but not a settlement] against the practitioner arising from a medical malpractice liability lawsuit. (376.1578(3)(1-4) R.S. Mo.)

## Missouri UnitedHealthcare Community Plan Requirements

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Additional query of MO Medicaid Terminations List is required for Practitioners and Facilities: **http://mmac.mo.gov/providers/provider-sanctions/**

Credentialing process shall not take longer than sixty (60) calendar days pursuant to RSMo 376.1578[17]. The health plan shall ensure providers are included in the network and eligible to receive payment immediately upon completion of the credentialing and recredentialing process.

The Health Plan shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a participant and billed to the health plan by the provider:

- Newly credentialed provider attached to a new contract within ten (10) business days after completing credentialing;
- Newly credentialed hospital or facility attached to a new contract within fifteen (15) business days after completing credentialing;
- Newly credentialed provider attached to an existing contract within five (5) business days after completing credentialing;
- Changes for a recredentialed provider, hospital, or facility attached to an existing contract within five (5) business days after completing recredentialing;
- Change in existing contract terms within ten (10) business days of the effective date after the change.

All network providers must be enrolled with MO HealthNet as a Medicaid provider as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b). Validation will be conducted by the Provider Operations area as being enrolled.

Inclusion of performance monitoring information on records related to advance directives on Primary Care Providers during the time of recredentialing.[18]

The health plan shall promptly notify the state agency of any denial of enrollment due to the results of the provider credentialing or recredentialing process.

17 Credentialing turn-around time is not applicable to the delegated entities.
18 Advanced directive policy determined by the Health Plan.

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# Montana

No additional credentialing requirements.

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# Nebraska

The Health Care Credentialing Verification Act applies to health carriers such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Insurance Companies, that offer closed plans, meaning plans that require covered persons to use participating providers under the terms of the managed care plan, or combination plans having a closed component.

Requirements with respect to health care professionals such as physicians or any other health care practitioners who are licensed, certified, or registered to perform specified health services consistent with state law:

1. A health carrier must obtain primary verification of:
   - **a)** Current level of professional liability coverage, if applicable.
   - **b)** Status of hospital privileges, if applicable.
   - **c)** Current federal Drug Enforcement Agency registration certificate, if applicable;
   - **d)** Graduation from a health care professional school; and completion of postgraduate training, if applicable. (R.R.S. Neb. § 44-7007(1)).
2. At least every three years, the health carrier must obtain primary verification of participating health care professionals:
   - **a)** Current level of professional liability coverage, if applicable.
   - **b)** Status of hospital privileges, if applicable.
   - **c)** Current federal Drug Enforcement Agency registration certification, if applicable.
3. Whenever a health carrier contracts to have another entity perform the credentialing functions required by the Health Care Professional Credentialing Verification Act or applicable rules and regulations, the Director of Insurance must hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of the act and applicable rules and regulations are met. (R.R.S. Neb. § 44-7009).

   An insurer may not refuse to credential a health care provider who is an employee or a contractor of a political subdivision on the basis that the employee or contractor provides medical services in a jail. If an insurer refuses to credential a health care provider who is an employee or a contractor of a political subdivision who provides medical services in a jail, the insurer must give written notice to the provider explaining the reasons for the refusal. R.R.S. Neb. § 44-713(6)(a) & (b).

## Nebraska UnitedHealthcare Community Plan Requirements[19]

1. Practitioners and Facilities to be screened for Medicare/Medicaid exclusions from additional sources including the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)).
2. Completely process credentialing applications within 60 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. Completely process means: review, approved, and load approved providers to its provider files in its system or deny, notify provider, and ensure provider is not used for services.
3. MCO must accept any standardized provider credentialing form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.
4. Inclusion of data from quality improvement activities at time of recredentialing.
5. Additional query of Nebraska Medicaid Excluded Providers List is required for Practitioners and Facilities: **http://dhhs.ne.gov/Pages/Program-Integrity-Sanctioned-Providers.aspx**

19 Requirements of the State Medicaid Contract.

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6. The MCO must begin its credentialing process concurrently with a provider's Medicaid provider enrollment rather than delaying its credentialing process until MLTC has approved a provider's enrollment in Medicaid.
7. If the MCO delegates credentialing, the MCO must obtain MLTC approval of the subcontractor and the credentialing process. MLTC retains final approval of the credentialing subcontractor and process.
8. Network providers will be required to participate in the State Medicaid program. Validation will be conducted by the Provider Operations area as being enrolled with Nebraska Medicaid.
9. Credential behavioral health service providers with provisional licensures as required by the Nebraska Medicaid contract.
10. The MCO must work with all other contracted MCOs to jointly procure a Central Credentialing Verification Subcontractor (CCVS). The CCVS must begin its work at full capacity no later than one (1) year from the start of MCO's Contract Start Date.
11. The CCVS will develop and maintain a portal where all Medicaid providers and prospective Medicaid providers will submit applications to enroll with all contracted MCOs, and where the providers will upload all required materials for the credentialing process.
12. Each provider seeking to be credentialed with any of the MCOs will need to submit a single application to CCVS.
13. CCVS will verify all providers' credentials on behalf of the MCOs for both initial applications and the re-credentialing process every three (3) years.
14. The CCVS must have applicable NCQA accreditation and perform this work in accordance with NCQA credentialing standards.
15. The MCO must ensure that the CCVS generates reporting for all MCOs' credentialing activities. At a minimum, this reporting must include: A monthly volume of credentialing applications, approvals and denials, and re-credentialing activities; Turnaround time reports for all applicants and for clean applications; and an aging distribution.
16. Prior to contracting with a CCVS, the MCOs must obtain MLTC approval of (a) the proposed CCVS and (b) the credentialing process, including components delegated to the MCOs' CCVS. The MCO must require that all licensed medical professionals are credentialed in accordance with MLTC's credentialing requirements. MLTC retains final approval of the credentialing subcontractor and process.
17. If the MCO declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.

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# Nevada

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to accept the Nevada (NV) Division of Insurance credentialing forms and addendum, and may only use a supplemental form to collect additional information required by the state or federal government or an accrediting body.

(NV Adm. Code 679B.0405).

Health Carriers are required to utilize the form Credentialing Denial Letter developed by the Commissioner of Insurance, or an approved alternative, for denials of initial credentialing of practitioners. A copy of each such denial letter is to be submitted electronically to the Commissioner's Office via the System for Electronic Rate and Form Filing (SERFF). (NV DOI Bulletin 21-001, effective Oct. 2021.) (NRS 679B.124)

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# New Hampshire

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) per Revised Statutes of New Hampshire (NH) Annotated 420-J:4 – effective Aug. 10, 2007) are:

1. Required to notify a health care provider within 15 business days if a credentialing application is incomplete.
2. Upon receipt of a clean and complete credentialing application, required to finalize the credentialing process within 30 calendar days for primary care physicians (PCP) and mental health providers and 45 days for specialists. "Clean and complete" means that the application is signed and appropriately dated by the health care provider and includes all applicable information required, as well as affirmative responses on questions related to quality and clinical competence.
3. Required to allow on-call coverage for a participating provider by health care providers who have submitted clean and complete applications, and have a valid license from the respective state licensing board and have been credentialed by the hospital[20]
4. Required to allow a health care provider to deliver services to covered persons when the health care provider has a valid license from the respective state licensing board, and has been credentialed by the hospital, and the health care provider has been credentialed by the health carrier in another state or in the health carrier's NH network based on employment with a particular health care entity.
5. When credentialing verification functions are delegated, the carrier is responsible for monitoring the delegated entity and ensuring that the requirements of this section are met.

20 Network requirement not related to the credentialing process.

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# New Jersey

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) ("Carriers") are required to:

1. Accept the New Jersey (NJ) Universal Physician Application. (NJ Adm. Code 11:24C-1.3).
   - **a)** May accept other applications, but required to notify physicians of the NJ Application available on the Department of Insurance website.
   - **b)** May access physician credentialing information from a recognized, national credentialing database, but prohibited from requiring physicians to use a national database.
2. Required to comply with the following response times:
   - **a)** For physicians who apply by submitting the NJ Universal Physician Application, notify the applicant within 60 days, following the receipt of the application, that the application is incomplete, specifying in writing the information that is missing, otherwise the application shall be deemed complete. (NJ Adm. Code 11:24-3.9)
   - **b)** For practitioners who apply via the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource, notify the applicant within 45 days whether the application is complete or incomplete. Notice may be provided electronically if application contains an e-mail address. In the absence of an e-mail address, notice shall be in writing. If application is incomplete, the notice shall:
     - **i)** Specify the additional information required and the due date; and
     - **ii)** Include the phone number and e-mail address of Carrier's department responsible for accepting information required to complete the application and for providing assistance regarding the credentialing process and the status of the credentialing application. Carriers shall respond to credentialing inquiries within five (5) business days. (NJ Adm. Code 11.24C-1.3(a) (1) and (2).)
3. Complete the initial credentialing process within no more than 90 days of receipt of the complete application. (NJ Adm. Code 11:24-3.9) and NJ Adm. Code 11:24C-1.3)
4. Prohibited from using a health care provider's preferred method of payment as a factor when deciding whether to credential a health care provider. (N.J. Stat. § 17B:30-34.1(e)).

## New Jersey UnitedHealthcare Community Plan Requirements[21]

1. Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing.
2. Inclusion of performance data, including but not limited to quality indicators and utilization management at the time of recredentialing. Delegates must submit timely notifications to UnitedHealthcare of the most recent recredentialing approvals on Practitioners covered under delegation of credentialing arrangements. Quality improvement data will be reviewed at the Health Plan's Provider Advisory Committee (PAC).
3. Site visits at the time of credentialing for primary care physicians, obstetricians and gynecologists, and dentists (to include American's with Disabilities Act (ADA) assessment).[22]
4. Primary source verification of admitting privileges in good standing at a participating Community Plan hospital in New Jersey.
5. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
6. Additional query of NJ Medicaid Debarment List is required for Practitioners and Facilities: **nj_debarment_list.pdf**

21 Requirements of state Medicaid contract.
22 Attestation to ADA compliance and compliance with medical record keeping practices is required. Additional mechanisms other than site visits may be considered as meeting this requirement

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7. Credentialing process shall include notification to practitioners of errors in the credentialing application within three (3) business days of receipt or identification of an error. The credentialing committee shall meet to review credentialing applications monthly and notify each applicant of the status of their application within five (5) business days of the meeting.
8. A dentist with certification in the following specialties: Endodontics, Oral and Oral Maxillofacial Surgery, Periodontics and Prosthodontics must have or have confirmations of application submission, of valid DEA and CDS certificates.
9. As required by the State of New Jersey, any provider that holds a valid DEA or CDS certificate must submit it.
10. Verification of practitioner and facility providers are actively enrolled in New Jersey Medicaid at time of credentialing and recredentialing. Delegated credentialing entities are required to provide the New Jersey Medicaid ID number at the time of roster submission.
11. Evidence of compliance on criminal history record information (CHRI)/background check, electronic visit verification utilization and training requirements. A compliance attestation will be obtained on Home Health Care Providers.
12. For provider types eligible to use the Council for Affordable Quality Healthcare (CAQH) credentialing application who are applying for initial credentialing, the Contractor must accept the CAQH application; for those providers, the Contractor shall not require the provider to resubmit any information that is already included within the CAQH application.
13. Information will be collected on licensed practitioners about the nature and extent of their experience in serving children with special health care needs including developmental disabilities. A health care professional special needs survey form will be obtained during initial credentialing as evidence to satisfy the requirement within practitioner credentialing file.
14. Accept and process provider credentialing application while the New Jersey Medicaid ID is pending. The Contractor shall pay FQHC claims retroactively to the date of submission of a complete credentialing application.

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# New Mexico

Requirements for Health Maintenance Organizations (HMOs), Health Insurers and Non-Profit Health Care Plans. (NM Statutes Annotated sections 59A-22-54, 59A-23-14, 59A-46-54, and 59A-47-49) and (NM Administrative Code sections:13.10.21.9, 13.10.28.10, 13.10.28.11 and 13.10.28.13).

1. When credentialing functions are performed by another entity, the Managed Health Care Plan is required to monitor the delegated entity for compliance with state credentialing/recredentialing regulations.
2. Shall not use any health professional credentialing application form other than the uniform Hospitals Service Corporation or Council for Affordable Quality Healthcare credentialing/recredentialing forms, in electronic or paper format, as determined by the health carrier. Exception to use of these credentialing applications is made for health professionals who practice outside of NM and who prefer to use the credentialing form required by their respective states.
3. The rules for provider credentialing are applicable to the following provider types as defined in NM regulations: physicians, hospitals, or other health care practitioners.
4. Shall notify applicants of its decision to approve or deny the credentialing application within 30 days of receipt of a completed application and all supporting documentation. The timeline for such decision and notification may be extended by up to 15 days if, upon review of a completed application, it is determined that the circumstances presented, including an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage, requires additional consideration. The notification shall be sent:
   - **a)** in writing via US mail at the physical address listed in the application; and
   - **b)** by e-mail if an email address has been provided.
5. Each carrier shall establish an internal process for resolving disputes regarding credentialing between the health carrier and providers. When a provider has not received a decision regarding a credentialing application within 45 days of submitting the completed uniform credentialing application, the provider may request a review of the credentialing application according to the health carrier's internal dispute process.
6. Notify the applicant in writing via U.S. certified mail within 10 working days:
   - **a)** That the credentialing application has been received; and after receipt of an incomplete application requesting any information or supporting documentation that is required in order to approve or deny the credentialing application. The notice will contain a name, address and telephone for credentialing staff who serve as applicant's point of contact.
7. If additional information or documentation is required from the provider and is requested via certified mail, health carrier shall inform the applicant:
   - **a)** that the 30-day time period to approve or deny the credentialing application shall be tolled pending receipt of the requested information or documentation.
   - **b)** If the application remains incomplete and the applicant has been unresponsive to requests for information beyond 45 days the health carrier may deny the application.
8. In the event that any needed verification or verification supporting statement has not been received from third parties within 45 days of receipt of a completed application the health carrier shall issue written notification to the applicant denying the application and detailing the attempts to obtain the information and verifications. Nothing prevents a health carrier from informing the applicant of the inability to obtain needed verifications and information from third parties prior to 45 days after receipt of a completed application. Notice should be provided to the applicant as soon as the health carrier is aware of the inability to obtain third party verifications and information. However, the inability to obtain third party verifications and information does not toll the timeline to approve or deny the credentialing application.

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9. Health carrier shall not require applicant to submit information not required by the uniform credentialing form, other than information or documentation that is reasonably related to information on the application.
10. Health carriers required to establish program that verifies provider credentialing before accepting the provider into the network and listing the provider in the directory.
11. No later than 30 days after receipt of a completed credentialing application, or 30 days plus an additional 15 days where necessary as described above, the carrier shall load into its provider payment system all information necessary to correctly reimburse a newly approved provider according to the provider's contract.
12. A carrier shall reimburse a provider for covered health care services for any claims from the provider that the carrier receives with a date of service more than 30 days after the date on which the carrier received a complete credentialing application for that provider if: (1) the provider: (a) has submitted a complete credentialing application and any supporting documentation that the carrier has requested in writing within the time frame established; (b) the provider has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and (c) the provider has professional liability insurance or is covered under the Medical Malpractice Act; and (2) the carrier: (a) has approved, or has failed to approve or deny, the applicant's complete credentialing application within the time frame established; or (b) fails to load the approved applicant's information into the carrier's provider payment system in accordance with the time frame established. (A provider who, at the time services were rendered, was not employed by a practice or group that has contracted with the carrier to provide services at specified rates of reimbursement shall be paid by the carrier in accordance with the carrier's standard reimbursement rate. A provider who, at the time services were rendered, was employed by a practice or group that has contracted with the carrier to provide services at specified rates of reimbursement shall be paid by the carrier in accordance with the terms of that contract.)
13. Health carrier not obligated to approve all credentialing applications and may deny any application based on existing network adequacy, issues with application, failure by provider to complete credentialing application, or another reason.
14. Each carrier shall develop and adopt a written credentialing plan to support the credentialing verification program, and which shall be provided to the superintendent of insurance upon request.
15. Each carrier shall submit a report to the superintendent of insurance regarding its credentialing process every two years. The report shall include the following: the amount of time taken to review and reach a determination on an application and the number of: applications made to the plan, applications approved by the plan, applications rejected by the plan, and providers terminated for reasons of quality.
16. Recredentialing may not be required more frequently than every three years. Health carrier will notify applicant at least 120 days in advance of all items necessary to complete recredentialing. The recredentialing process must be completed within 45 days of receipt of the applicant's complete recredentialing application and all supporting documents. If application is approved provisionally, then recredentialing shall be required annually. Nothing in this section shall be construed to require a health carrier to credential or provisionally recredential any provider. A health carrier may not require a participating provider to be recredentialed based on a change in provider's TIN or TIN of provider's employer, a change in provider's employer if the new employer is a participating provider or also employs other participating providers.

## New Mexico UnitedHealthcare Community Plan Requirements

1. Participate and collaborate with any statewide initiatives to streamline and standardize the credentialing/recredentialing process.
2. The CONTRACTOR shall assist New Mexico Health Care Authority (HCA) with the transition and implementation of its centralized credentialing and recredentialing module and comply with all HCA requirements related thereto.

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3. Pending the implementation of centralized credentialing and recredentialing by HCR, the CONTRACTOR shall establish and implement a documented process for credentialing and recredentialing its Contract Providers.
4. The CONTRACTOR shall work with all other MCOs to contract with a single, centralized and NCQA approved CVV to process credentialing applications and perform primary source verifications. The CVV's responsibilities shall include the following:
    - Receiving and processing completed applications, attestations, and primary source verification documents for current and prospective Contract Providers.
    - Offering a portal that allows Providers to submit applications and upload all required documentation for the credentialing and recredentialing process online.
    - Performing credentialing verification processes on behalf of the CONTRACTOR for initial credentialing, and for recredentialing every three (3) years.
    - Reporting credentialing and recredentialing metrics on a monthly basis to the CONTRACTOR, to include the volume of credentialing applications and recredentialing activities; time frame for processing applications; credentialing and recredentialing outcomes; and any other metrics required by HCA.
    - Prior to executing a contract with a CVV, the CONTRACTOR shall obtain HCA's prior written approval of the CVV and contract, and the CONTRACTOR's written policies and procedures for its credentialing and recredentialing processes.
5. Meet NCQA standards and State and federal regulations for credentialing and recredentialing, including NMAC 13.10.28.10 and enrollment requirements consisting of 42 C.F.R. § 455.104, § 455.105, § 455.106, § 455.107 and § 1002.3(b).
6. Collaborate with the other MCOs to define and use the same NCQA approved primary source verification sources.
7. 42 C.F.R. § 455.436 federal database checks to identify exclusion status on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.
8. Complete the credentialing and recredentialing process within forty five (45) Calendar Days from the receipt of a completed application with all required primary source documentation, for all Provider types.
9. Notify Providers of credentialing decisions (approved or denied) within ten (10) Calendar Days of the credentialing committee or peer review body decision.
10. The CONTRACTOR shall enter provider specific contract information into its system(s) such that its Claims system(s) is able to recognize the provider as a Contract Provider with accuracy sufficient to pay claims no later than fifteen (15) Calendar Days after a Provider is credentialed. Credentialed providers shall be entered/loaded into the Contractor's claims payment system with an effective date no later than the date the provider was approved by the credentialing committee/peer review body or the Provider agreement effective date, whichever is later.
11. Require Providers to be enrolled through a Provider Participation Agreement with the State Medicaid Agency as a managed care provider. Validation will be conducted by the Provider Operations area as being enrolled with New Mexico Medicaid.
12. The CONTRACTOR shall give HCA prior notice with regard to its intent to subcontract certain significant contract requirements, as specified herein or in writing by HCA, including but not limited to, credentialing.
13. Use a single, standardized credentialing form developed by the Provider Workgroup and collaborate with other MCOs to develop other standard forms used for credentialing and recredentialing.
14. The CONTRACTOR shall ensure that its credentialing and recredentialing process includes verification of the use of Electronic Visit Verification (EVV) for Home Health Providers.

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15. Ensure and verify hospital privileges for practitioners who indicate they have privileges.
16. Ensure and verify that Providers have appropriate licenses and certifications to perform services outlined in their respective Turquoise Care Provider agreements.
17. Maintain records that verify its credentialing and recredentialing activities, including primary source verification and compliance with credentialing/recredentialing requirements.
18. Ensure forms require ownership and control disclosures, disclosure of business transactions, and criminal conviction information. Disclosure of ownership information will be collected by Provider Operations upon enrolling, contracting and every three (3) years thereafter, or at any time there is a revision to the information.

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# New York

1. In New York (NY), Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to notify health care professionals and facilities within 60 days of receipt of a completed initial application as to:
   - **a)** whether the provider is credentialed; or
   - **b)** whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer/health plan shall make every effort to obtain such information as soon as possible and shall make a final determination within 21 days of receiving the necessary documentation. (NY Con. Law Svc. Ins. 4803)(a) and 4806; NY Public Health Law section 4406-d (1)(a)) and 4406-h.
2. NY HMO and PPOs are required to provisionally credential health care professionals under the following conditions:
   - **a)** If the insurer, within 60 days of submission of the completed application, has neither approved nor declined the application of a newly-licensed health care professional who joins a participating group; or
   - **b)** If the insurer, within 60 days of submission of the completed application, has neither approved nor declined the application of a health care professional who has not previously practiced in NY and has recently relocated to NY from another state, to join a participating group practice; and
   - **c)** The group practice notifies the insurer in writing that, should the health care professional's application ultimately be denied, the health care professional or the group practice:
     - **i)** Will refund any payments made by the insurer for in-network services provided by the provisionally credentialed health care professional that exceed any out-of-network benefits payable under the member's coverage plan with the insurer; and
     - **ii)** Will not pursue reimbursement from the member, except to collect the copayment or coinsurance that otherwise would have been payable had the enrollee received services from a health care professional participating in the insurer's network.
   - **d)** However, a provisionally credentialed physician may not be designated as a member's primary care physician until such time as the physician has been fully credentialed. (NY Con. Law Svc. Ins. 4803(b). and NY Public Health Law section 4406-d (1)(b)).
3. In addition, NY HMO and PPOs are required to provisionally credential physicians that become employed by any of the following entities that have a participating provider contract with the insurer and whose other employed physicians participate in the in-network portion of an insurer's network: a general hospital; a diagnostic and treatment center licensed pursuant to article 28 of the public health law; or facility licensed under article 16,31,or 32 of the mental hygiene law. The insurer must provisionally credential physicians joining these entities under the following conditions:
   - **a)** The physician is a newly licensed physician; or
   - **b)** The physician has recently relocated to New York from another state and has not previously practiced in New York; or
   - **c)** The physician has changed his or her corporate relationship such that it results in the issuance of a new tax identification number under which the physician's services are billed for and who previously had a participation contract with the insurer immediately prior to the event that changed his or her corporate relationship.
4. Where the circumstances described above are met the physician shall be deemed provisionally credentialed upon the insurer's receipt of 1) the hospital's and physician's completed sections of the insurer's credentialing application; and 2) written notification that the health care professional has been granted hospital privileges pursuant to section 2805-k of the public health law.

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However, a provisionally credentialed physician may not be designated as a member's primary care physician until such time as the physician has been fully credentialed. (NY Con. Law Svc. Ins. 4803(a) and NY Public Health Law section 4406-d (1)(c))

5. Licensed home care services agencies (LHCSA) shall not be operated, provide nursing services, home health aide services, or personal care services, or receive reimbursement from any source for the provision of such services during any period of time on or after January first, two thousand nineteen, unless it has registered with the Department of Health. (NY S-7507, Ch 57, Part B, Section 9-5, Section 3605-b)
6. All New York insurers are required to adopt and implement a compliance program to review provider credentialing policies and procedures to ensure that the documentation and qualifications required for credentialing mental health and substance use disorder providers are comparable to and applied no more stringently than that of medical or surgical providers. (NYCRR Title 11, § 230.3, (a)(4)(iv))

## New York UnitedHealthcare Community Plan Requirements[23]

In addition to the State Education License Search (New York State Department of Education Office of Professions)

- Professional Discipline. This website contains summary. Information of disciplinary actions taken against licensees by the Board of Regents in New York State since January 1, 1994. **State Education License Search**
- Professional Misconduct and Physician Discipline. This website offers a search capability for public documents regarding Professional Misconduct and Physician Discipline actions taken since 1990 for physicians, physician assistants, and specialist assistants. New York State Department of Health Office of Professional Medical Conduct (OPMC). **https://apps.health.ny.gov/pubdoh/professionals/doctors/conduct/factions/Home.action**

Additional query for Practitioners and Facilities: Office of Medicaid Inspector General (OMIG) - List of Restricted and Excluded Providers. **https://omig.ny.gov/search-exclusions**

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Credentialing and recredentialing files of practitioner and facility providers must include evidence of MMIS ID/ Medicaid FFS enrollment status at time of review. The Active and Pending Enrollment Files are to be checked to verify enrollment in FFS Medicaid prior to credentialing decision. If a practitioner or facility provider is not listed on the Active or Pending Enrollment File, credentialing will be denied. **https://www.emedny.org/info/ProviderEnrollment/ManagedCareNetwork/index.aspx**

Credentialing and recredentialing files shall contain evidence of Social Security Administration Death Master File (SSADMF) review.

23 Requirements of state Medicaid contract

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# North Carolina

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the state uniform provider credentialing application for licensed health care practitioners. (North Carolina (NC) Gen. Stat. 58-3-230)
   - No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing form. (NC Gen. Stat. 58-3-230(b)).
2. Notify the practitioner within 30 days if the application is not accepted for reasons not related to credentialing. (11 NC Adm Code 20.0405(d).)
3. Make a credentialing determination within 60 days of receipt of completed application. (NC Gen. Stat. sect. 58-3-230(a);11 NC Adm. Code 20.0405).
   - **a)** If the application is incomplete, it is required to notify the provider within 15 days of all missing or incomplete information or supporting documents.
   - **b)** If the missing information is not received within 60 days, it is acceptable to close the application or delay the final review pending receipt of the necessary information.
   - **c)** If insurer has not approved or denied the application within 60 days of receipt of the completed application, within five business days of receipt of a written request from the applicant, the insurer is required to issue a temporary credential to the applicant if the applicant has a valid NC professional or occupational license.
     - **i)** The insurer shall not issue a temporary credential if the applicant has reported a history of: malpractice claims, substance abuse, mental health issues, or licensing board disciplinary actions.
     - **ii)** The temporary credential is effective upon issuance and will remain in effect until the credentialing application is approved or denied.
4. Whenever credential verification activities are delegated to a contracting entity, require the contracting entity to comply with all applicable requirements in the NC Adm. Code related to credentialing. (NC Adm. Code 20.0410)

## North Carolina UnitedHealthcare Community Plan Requirements

The Network Provider Credentialing Policy is maintained by the North Carolina Community Plan.

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# North Dakota

No additional credentialing requirements.

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# Ohio

Laws and regulations apply to a health insuring corporation such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Insurance Companies.

The following laws (ORC Ann. 3963.01, 3963.05 and 3963.06) apply to a "contracting entity," meaning, any person that has a primary business purpose of contracting with participating providers for the delivery of health care services (e.g. HMOs, PPOs, Insurance Companies).

Requirements with respect to what constitutes a "Provider". A "Provider" can be a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. A "Provider" is not a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds. (ORC Ann. 3963.01(P)).

1. The Department of Insurance must prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format for physicians. Also, the Department of Insurance must prepare the standard credentialing form for all other providers, except hospitals. (ORC Ann. 3963.05(A) and (E)).
2. The Ohio Department of Insurance (OH DOI) has adopted the CAQH credentialing form, in electronic or paper format, for credentialing of physicians and non-physician individual providers. (Referred to as "Department of Insurance Part A credentialing form.) (OH Adm. Code 3901-1-58(C).)
3. OH DOI has designated the DOI Part B credentialing form to be used to credential hearing aid dealers, home health agencies, hospice care providers and all other providers that are not individuals, with the exception of hospitals. Copies of this form may be obtained from the OH DOI. (OH Adm. Code 3901-1-58(C).)
4. A contracting entity must use the applicable standard credentialing form described in the preceding paragraph when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services. (ORC Ann. 3963.05.)
5. A contracting entity cannot require a provider to supply additional information other than what is required by the applicable standard credentialing form described in paragraph 1 above in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services. (ORC Ann. 3963.05.)
6. The credentialing process outlined in Ohio (OH) law does not prohibit a contracting entity from limiting the scope of any participating provider's basic health care services, specialty health care services, or supplemental health care services. (ORC Ann. 3963.05).
7. If a provider, upon the oral or written request of a contracting entity to submit a credentialing form, submits a credentialing form that is not complete, the contracting entity that receives the form must notify the provider of the deficiency electronically, by facsimile, or by certified mail, return receipt requested, no later than 21 days after the contracting entity receives the form. (ORC Ann. 3963.06).
8. If a contracting entity receives any information that is inconsistent with the information given by the provider in the credentialing form, the contracting entity may request the provider to submit a written clarification of the inconsistency. The contracting entity must send the request described in this section electronically, by facsimile, or by certified mail, with return receipt requested. (ORC Ann. 3963.06).

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9. **a)** Except as otherwise provided in section 7B below, the credentialing process starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity, and the provider must submit the credentialing form to the contracting entity electronically, by facsimile, or by certified mail, with return receipt requested. Subject to section 7C, a contracting entity must complete the credentialing process not later than 90 days after the contracting entity receives the credentialing form from the provider. The contracting entity must allow the provider to submit a credentialing application prior to the provider's employment. (ORC Ann. 3963.06).

   **b)** The credentialing process for a Medicaid-managed care plan starts when the provider submits a credentialing form and the provider's national provider number is issued by the Centers for Medicare and Medicaid Services. (ORC Ann. 3963.06).

   **c)** The requirement that the credentialing process be completed within the 90 day period specified in section 7A does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity is a hospital. (ORC Ann.3963.06).

   **d)** Any communication between the provider and the contracting entity must be electronically, by facsimile, or by certified mail, with return receipt requested. (ORC Ann. 3963.06).

   **e)** If the state medical board or its agent has primary source verified the medical education, graduate medical education, and examination history of the physician, or the status of the physician with the educational commission for foreign medical graduates, if applicable, the contracting entity may accept the documentation of primary source verification from the state medical board's website or from its agent and is not required to perform primary source verification of the medical education, graduate medical education, and examination history of the physician or the status of the physician with the educational commission for foreign medical graduates, if applicable, as a condition for initially credentialing or recredentialing the physician. (ORC Ann. 3963.06).

Health plans doing business with the State of Ohio are prohibited from using any off-shore resources. This would include credentialing and recredentialing functions. (Executive Order 2011-12K).

Facility credentialing in Ohio requires use of a state-mandated facility application.

## Ohio UnitedHealthcare Community Plan Requirements[24]

Additional requirements for verification of sanctions on Practitioners and Facilities including but not limited to: Office of the Inspector General List of Excluded Individuals and Entities and National Practitioner Data Bank, OH Department of Job and Family Services website.

A list of Facility/Ancillary/Organizational types identified as not credentialed by the Ohio Department of Medicaid (ODM) centralized credentialing process. The MCO to credential and recredential provider types that include Diabetes Education Center, Federally Qualified Health Center, Rural Health Clinic, Home Health/Home Fusion, Long Term Acute Care Facility, Physically Disability/Rehabilitation Facility, Portable Diagnostic Imaging Supplier, Rehabilitation Clinic.

To reduce provider burden and promote consistency across Ohio's Medicaid managed care program, the Ohio Department of Medicaid (ODM) will centralize credentialing and recredentialing. Under ODM's centralized credentialing process, providers will submit an application for Medicaid enrollment and credentialing to ODM and will not need to submit credentialing and recredentialing materials to MCOs.

### Centralized Credentialing

1. If credentialing is required for a specific provider type, the MCO must only use providers credentialed or approved through ODM's process.
2. A provider's credentialing status will be indicated in ODM's provider network management system.

24 Requirements of state Medicaid contract



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3. The MCO must accept ODM's credentialing status and must not request any additional credentialing or recredentialing information from an ODM-enrolled provider.
4. The MCO must not credential or recredential any ODM-enrolled providers for provision of services under the Agreement, including provider types that are not credentialed by ODM.
5. The MCO must coordinate and cooperate with ODM in the credentialing and recredentialing of the MCO's network providers.
6. The MCO's Medical Director/Chief Medical Officer (CMO) must participate in ODM's credentialing committee.
7. The MCO must provide to ODM, in the format and at the frequency specified by ODM, the information specified by ODM to inform ODM's credentialing and recredentialing process. This information may include but is not limited to:
   - **a)** The MCOs' credentialing and recredentialing files, including provider demographic information, primary source verification, and results of any site surveys;
   - **b)** Changes in a provider's demographic information;
   - **c)** Changes in a provider's contracting status for any line of business;
   - **d)** Changes in a provider's credentialing status for other lines of business;
   - **e)** Findings from the MCO's ongoing monitoring of network providers, including but not limited to complaints, adverse events, and quality of care issues; and
   - **f)** Information about the provider maintained by the MCO for credentialing or recredentialing the provider for other lines of business.

Prior to contracting with a provider or listing the provider as a network provider, the MCO must validate that the provider is active in ODM's provider network management system and enrolled for the applicable service and/or specialty. If a provider is not active in ODM's provider network management system, the MCO must direct the provider to ODM's portal to submit an application for screening, enrollment, and credentialing prior to contracting.

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# Oklahoma

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Accept the Department of Health Uniform Application for credentialing for all health care practitioners and permitted to require supplemental information. (63 Oklahoma (OK) Stat. 1-106.2).
2. Make information on criteria available to provider and provide applicant with a checklist of material required in the application process.
3. Notify practitioner within 10 days of receipt if application is incomplete, specifying the portion of application that is at issue.
4. Initiate credentialing process within seven days when application is complete.
5. Shall complete the credentialing process within 45 days upon receipt of the primary source verification and malpractice history on a "clean application." A clean application means:
   - **a)** There is no defect, misstatement of facts, improprieties, lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing; and
   - **b)** Professional liability carriers are required to respond to inquiries from health benefit plans within 21 days; the OK State Insurance Commissioner may assess a penalty against a professional liability carrier that fails to respond to a health benefit plan within the 21 day time frame.
6. Permitted to extend credentialing/recredentialing process for 60 days if unable to credential/recredential due to application not being "clean."
   - **a)** If still awaiting documentation at the end of the 60-day extension, required to notify practitioner by certified mail of reason for delay.
7. Practitioner may request an extension of the 60-day period but must do so within 10 calendar days; otherwise the application shall be deemed withdrawn.
8. Under no circumstances shall the entire process exceed 180 calendar days.
   (36 OK Statute 4405.1)

## Oklahoma UnitedHealthcare Community Plan Requirements

The Contractor shall utilize the uniform credentialing application required by OHCA during the credentialing process.

Credentialing and Recredentialing Time Frames

The Contractor shall ensure that credentialing of all Providers applying for Participating Provider status shall be completed as follows, or according to any stricter credentialing timeliness requirements as may be required by the applicable Accrediting Entity with whom the Provider [Contractor] is accredited:

- All applications must be credentialed within 45 days of receipt of a completed application.
- Contractor may request an extension of 15 days from OHCA on a case-by-case basis.

In the event the Contractor delegates credentialing activities to a delegated credentialing agency, the Contractor shall ensure all credentialed Providers are loaded into the Contractor's Provider files and claims system within 15 Calendar Days of receipt from the delegated entity.

Providers seeking to become Participating Providers are required to be enrolled as a contracted Provider with SoonerCare. Validation will be conducted by the Provider Operations area as being enrolled.

Provider selection requirements must comply with 42 CFR § 438.12. Provider selection policies and procedures must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

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The Managed Care Plan will accept the Oklahoma Uniform Credentialing Application (UCA) and the Oklahoma Universal Supplemental Credentialing Form for individual practitioners not registered with CAQH.

Facility/Organizational providers must complete the Oklahoma Uniform Credentialing Application (UCA), excluding sections 3-10, and the Oklahoma Universal Organizational Providers Supplemental Credentialing Form.

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# Oregon

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Credential providers, but no specific credentialing requirements identified. (Oregon Revised Statutes sections 743B.454(2); Oregon Administrative Rules sect. 836-053-1170(1)(c)(B)).
2. Use the Oregon Practitioner Credentialing and Recredentialing Applications.
   (Oregon Administrative Rule 409-045-0035)
   The Oregon Credentialing App can be found at the following Oregon.gov link:
   **http://www.Oregon Health Authority : State Application : Advisory Committee on Physician Credentialing Information : State of Oregon.pdf**
3. Approve or reject a provider's initial credentialing application within 90 days of receipt of a complete application containing all required credentialing information. (Oregon Revised Statutes 743B.454(2))
4. Pay all claims for medical services covered by the health insurer that are provided by a provider during the credentialing period, with the exception of providers previously rejected or terminated as a participating provider in any health benefit plan underwritten or administered by the health insurer, when the rejection or termination was due to the objectively verifiable failure of the provider to provide medical services within the recognized standards of the provider's profession and the provider was given the opportunity to contest the rejection or termination before a panel of peers in a proceeding conducted in conformity with the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101 et seq. A provider may submit claims for medical services provided during the credentialing period during or after the credentialing period. A health insurer may pay claims for medical services provided during the credentialing period during or after the credentialing period at the rate paid to nonparticipating providers.
5. If the application is for a health care provider joining a provider group that is in-network with the health insurer, the health insurer shall pay all claims for medical services covered by the health insurer that are provided by the provider during the credentialing period at the same rate and according to the same payment schedule as in-network providers. However, if the provider does not submit a complete application or does not meet credentialing requirements, the provider group shall reimburse the health insurer in an amount equal to the difference between in-network and out-of-network rates. Within 90 days from the date the health insurer receives the application, the health insurer, in complying with this paragraph, shall notify the provider that the application is not a complete application.
6. If a provider submits a claim for medical services provided during the credentialing period within six months after the end of the credentialing period, the health insurer may not deny payment of the claim on the basis of the health insurer's rules relating to timely claims submission. (ORS 743B454(3) and (4)).

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# Pennsylvania

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to include data from quality improvement activities at the time of recredentialing. (28 PA Code 9.761).

All individual contracted providers are subject to United Healthcare's credentialing and recredentialing process per the current UnitedHealthcare Credentialing Plan in order to be considered participating in the provider network. UnitedHealthcare does not have a credentialing requirement for non-participating providers. (28 PA Code 9.763)

Upon written request, a UnitedHealthcare shall disclose relevant credentialing criteria and procedures to health care providers that apply to become participating providers or who are already participating. (28 PA Code 9.761)

UnitedHealthcare shall submit a report to the Pennsylvania Department of Health regarding its credentialing process every 2 years. The report shall include the following:

1. The number of applications made to the plan.
2. The number of applications approved by the plan.
3. The number of applications rejected by the plan.
4. The number of providers terminated for reasons of quality.

The report is due in even calendar years. (28 PA Code 9.761)

UnitedHealthcare shall not exclude or terminate a health care provider from participation in the plan due to any of the following:

1. The health care provider engaged in any of the following activities:
   - **a)** Advocating for medically necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care.
   - **b)** Filing a grievance pursuant to the procedures set forth in this article.
   - **c)** Protesting a decision, policy or practice that the health care provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the health care provider's ability to provide medically necessary and appropriate health care.
2. The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.
3. The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds. (28 PA Code 9.761

UnitedHealthcare's credentialing policies shall comply with 40 P.S. §991.2121. and 28 PA Code 9.761, 762 and 763.

## Pennsylvania UnitedHealthcare Community Plan Requirements[25]

1. Assessment of Americans with Disabilities Act (ADA) compliance required as part of initial credentialing for primary care physicians (PCP) and dentists.
2. Certified Registered Nurse Practitioners, Certified Registered Midwife or physician's assistant, functioning as part of a PCP team must submit a copy of collaborative agreement with a physician.
3. Additional requirements for verification of sanctions on Practitioners and Facilities including but not limited to the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)) and State Medicaid MediCheck database.

25 Requirements of state Medicaid contract

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4. Federal database check on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES)
5. Credentialing must be completed within sixty (60) days of receipt of the application packet if the information is complete.
6. Adherence to the Principles of Ethics of the American Medical Association, the American Osteopathic Association or any appropriate professional organization involved in a multidisciplinary approach.
7. PCP qualifications: evidence of continuing professional medical education[26]
8. Facility credentialing may include Pediatric Residential Care Centers.
9. Cannot delay processing the application if the provider does not have an Medicaid ID (PROMISe) number that is issued by the DHS.
10. Process cannot be complete until the provider has received its Medicaid ID (PROMISe) number from DHS.
11. Must notify the provider of the status of their credentialing application as follows:
    a) First Correspondence: The PH-MCO must provide an Acknowledgment of Application notification to the provider within ten (10) calendar days of receipt.
    b) Second Correspondence: The PH-MCO will send an Application Status to the provider within thirty (30) calendar days stating:
        i) Their application is clean and is being submitted through the credentialing process or;
        ii) Their application is not clean with a list of items needing to be addressed. If a provider's Medicaid ID (PROMISe) number is not in place at the time of this notification, it may be noted as an outstanding item.
    c) Third Correspondence: A Credentialing Approval/Denial notice will be sent within a maximum of sixty (60) calendar days. If the provider application is denied, the correspondence should include all of the requirements that were not met.
    d) First and Second Correspondence must include language reminding providers that credentialing cannot be completed until their Medicaid Number (PROMISe ID) is in place.
    e) Provider communications electronically is encouraged.
12. Inclusion of data from quality improvement activities at the time of recredentialing.
13. Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing .
14. Membership on the medical staff with admitting privileges to at least one general hospital or an acceptable arrangement with a Practitioner with admitting privileges. Verification of element by Applicant attestation.
15. The PH-MCO must utilize the centralized credentialing vendor when selected by the Department to credential and recredential providers seeking to become a MA-enrolled PH-MCO Network Provider. The centralized credentialing vendor will facilitate the gathering of administrative materials needed for provider credentialing and recredentialing, perform primary source verifications, and provide the results of the primary source verification to the PH-MCO. The PH-MCO will evaluate the information provided by the centralized credentialing vendor and make the final determination of whether a provider will be credentialed or recredentialed with the PH-MCO and added to the PH-MCO's Network. The PH-MCO must establish agreements and cooperate with the Commonwealth-procured centralized credentialing vendor to support the activities of the vendor, including but not limited to data exchange, receipt of verified application materials and other information, marketing, and notification of the outcome of the PH- MCO's credentialing and recredentialing decisions. The PH-MCO will continue to be responsible for meeting the credentialing and recredentialing requirements as per Exhibit M(1) Quality Management, Utilization Management, and Quality Improvement Program Requirements, Standard VIII in the Agreement unless otherwise specified by the Department.

26 Criteria are covered under State Board of Medicine - Chapter 16 State Board of Medicine General Provisions



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16. The PH-MCO shall make the network contract effective date from credentialing application approval retrospective to the date a complete credentialing application was received by the PH-MCO.

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# Puerto Rico

No additional credentialing requirements.

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# Rhode Island[27,28]

1. For adverse decisions resulting in a change of professional provider privileges, health care entities are required to afford due process. (230-RICR-20-30-9.9(C).)
2. Both Drug Enforcement Administration Certificate (DEA) and State Controlled Dangerous Substances Certificate (CDS) are required if applicable. (230-RICR-20-30-9.8(D)(5)).
3. A health care entity must maintain regular and meaningful oversight of each of its delegates to ensure every such delegate is in compliance with network plan requirements. (230-RICR-20-30-9.5(B)).
4. Communication to the applicant of its credentialing and recredentialing decision as soon as practical, but no later than forty-five (45) calendar days after the date of receipt of a completed application. Required to establish written standard defining what elements constitute a complete credentialing or recredentialing application, make the standard available on company website, and distribute standard with written version of the credentialing or recredentialing application. (RI General Laws, Chapters 27-18-83 and 27-41-87.) 230-RICR-20-30-9.8(A)(3)(a).
5. When evaluating whether a practitioner's credentialing application is complete, evidence of malpractice/professional liability insurance includes either current coverage or coverage with a future effective date. Credentialing decisions cannot be delayed or denied solely based on the applicant's malpractice/professional liability insurance having a future effective date. If the credentialing application is approved with a future effective date for the malpractice/professional liability insurance that extends beyond the 45-days notice requirement (see paragraph 4, above), the contracting entity is allowed to make the effective date for claims submission the same as the effective date of the malpractice/professional liability insurance. (Pursuant to a Feb. 25, 2022, e-mail directive from Jay Garrett, Director of Compliance, Office of the Health Commissioner, State of RI.)
6. Required to respond to inquiries from applicants regarding status of a credentialing or recredentialing application as follows: (a) provide automated application status updates at least once every 15 days, informing applicant of any missing application materials until application deemed complete; (b) inform applicant within five (5) business days that the credentialing or recredentialing application is complete; and (c) if credentialing or recredentialing application is denied, notify provider in writing and note any and all reasons for the denial. (RI General Laws, Chapters 27-18-83 and 27-41-87.)
7. During the recredentialing process, required to establish effective communications with in-network licensed independent practitioners, including without limitation:
   - **a)** A two-way communication to assure the provider is informed of the need for recredentialing;
   - **b)** Adequate due diligence in obtaining the current and correct mailing address or other provider-preferred mode of communication to directly communicate with the network provider;
   - **c)** A mechanism to follow up with network providers who have not responded to the initial recredentialing communications with a diligent effort to validate the current physical and/or electronic address used as the mode of communication and confirm receipt of the initial recredentialing communication;
   - **d)** Health care entities shall not terminate a provider if the Plan has failed to properly adhere to these recredentialing requirements.
8. So as long as malpractice/professional liability insurance is effective, the effective date for billing privileges shall be the next business day following approval of the credentialing application. (RI General Laws, Chapters 27-18-83 and 27-41-87; Pursuant to a Feb. 25, 2022, e-mail directive from Jay Garrett, Director of Compliance, Office of the Health Commissioner State of RI.)

27 Credentialing files must contain copies of license, DEA, CDS or copies of verification sources
28 Written version of Credentialing application available upon request.

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9. For credentialing applications received from resident graduates, required to offer transitional/conditional approval process such that a resident graduate who has submitted an otherwise complete application and met all other criteria may be conditionally approved effective upon successful graduation from training program. (RI General Laws, Chapters 27-18-83 and 27-41-87.)
10. A health care entity shall establish a transitional or conditional credentialing approval processes in any provider category where there is an established "need" (geographic "need" or "need" by specialty type such as resident graduates, primary care providers, behavioral health providers or certain specialist providers), and shall include:
    - **a)** "Need" shall be assessed by the Commissioner considering continuity of care for beneficiaries, insufficient network by provider type and/or the inability of the entity to provide timely access to covered services to its beneficiaries.
    - **b)** To be considered for a transitional or conditional credentialing approval, the provider must have:
        - **i)** Submitted an otherwise completed credentialing application and met all other credentialing criteria;
        - **ii)** Successfully graduated from the training program; and
        - **iii)** Includes a mechanism to ensure that providers with transitional, conditional or temporary credentialing approval receive an effective date for billing privileges of the first business day after the transitional, conditional and/or temporary credentialing approval.[29]
11. A health care entity may utilize an alternative credentialing program approved by the Commissioner.
12. A carrier may not refuse to credential an applicant, or terminate a participating healthcare provider's participation, in a provider network based solely on the applicant's or participating healthcare provider's engagement in legally protected healthcare activity, or aiding and assisting with legally protected healthcare activity, provided that the care provided by the applicant or insured was consistent with the applicable professional standard of care and/or did not violate Rhode Island law. (RI General Laws § 5-37.8-2). "Legally protected healthcare activity" is defined as (i) the exercise and enjoyment or attempted exercise and enjoyment by any person of the right secured by Rhode Island to gender affirming healthcare services or reproductive healthcare services; and (ii) the provision or attempted provision of gender-affirming healthcare services or reproductive healthcare services that are permitted under the laws and regulations of Rhode Island and that are provided in accordance with the applicable standard of care by a person properly licensed under the laws of Rhode Island and physically present in Rhode Island, regardless of whether the patient is located in Rhode Island or whether the person is licensed in the state where the patient is located at the time the services are rendered. (iii) Legally protected health care healthcare activity does not include any conduct that could form the basis of a civil, criminal, or administrative action under the laws of Rhode Island had the course of conduct that forms the basis for liability occurred entirely within Rhode Island and/or in violation of Rhode Island law. (RI General Laws § 23-100-2(8))

## Rhode Island UnitedHealthcare Community Plan Requirements[30]

Physician Assistants who wish to become PCPs shall submit documentation of evidence of a collaborative relationship with a Primary Care Physician, via the "Primary Care Qualifications Attestation".

All participating network providers shall be enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements. This provision does not require the network provider to render services to FFS beneficiaries. Validation will be conducted by the Provider Operations area as being enrolled.

29 Refer to the National Credentialing Center's Escalation Policy
30 Requirements of the State Medicaid Contract.



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# South Carolina

No additional credentialing requirements.

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# South Dakota

- If a health insurer (or other entity credentialing on its behalf) receives a request from a health care professional for a credentialing application, then the insurer or entity is required to send the application form to the professional within 10 business days, unless the application is available electronically on a public website.
- Within 90 days of receiving a complete credentialing application, the health insurer (or other entity credentialing on its behalf) must provide the applicant with electronic or written notice of its determination.
  - If an incomplete application is received, the insurer or entity must notify the health care professional of such as soon as possible, but no more than 30 days after receipt, and the notification must itemize everything still needed to make the application complete. The insurer or entity may request additional information if the information provided is inaccurate, incomplete, or unclear.
- The insurer or entity may take additional time beyond the 90 days if a special review (as defined) is required
  - "Special Review" means a supplemental review of a health care professional's completed application for credentialing or change request by a health insurer or other entity responsible for credentialing of health care professionals necessitated by credible evidence received by a health insurer or other entity responsible for credentialing of health care professionals as it relates to investigation of the following: action taken against the applicant's licensure status, action taken against the applicant's professional society status, verified complaints to facilities, or licensing agency regarding the applicant; the applicant's non-completion of training programs; a criminal proceeding brought against the applicant a malpractice claim brought against the applicant; loss of a Drug Enforcement Administration certificate or state-controlled substance certificate; loss of a Medicare or Medicaid certification status; or involuntary termination of credentialing by a different health insurer.

2014 HB 1157.

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# Tennessee

Insurers, Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are:

1. Required to accept the Council for Affordable Quality Healthcare (CAQH) provider application in addition to the health insurance entity's own application. (Tennessee (TN) Code Ann. 56-7-1009).
2. If health insurance entity is a participating organization with CAQH, it's required to accept either the electronic application or a paper application. (TN Code Ann.56-7-1009)
3. Required to respond within 90 days to providers who submit "clean" CAQH application. A "clean" CAQH application means there is no defect, misstatement of facts, improprieties, lack of required substantiating documentation or particular circumstance requiring special treatment that impedes prompt credentialing. (TN Code Ann. 56-7-1001).
4. Unless otherwise required by a national accrediting body, a health insurance entity shall accept and begin processing a completed credentialing application as early as ninety (90) calendar days before the anticipated employment start date of the health care provider. (TN Code Ann. 56-7-1009(b).)
5. Cannot require activation of malpractice coverage prior to effective date of participation. (TN Code Ann. 56-7-1001(c)).
6. For HMOs only: recredentialing procedure to include data from quality improvement activities. (Tenn. Comp R & Regs. R. 1200-8-33-06(12))
7. For HMOs only: required to monitor and evaluate delegated credentialing activities on an ongoing basis. (Tenn Comp. R & Regs. R. 1200-8-33-06(12)).
8. For HMOs only: the attestation must not be older than 180 calendar days at the time of the credentialing decision. (Tenn. Comp. R. & Regs. R. 1200-8-33-.06(2).
9. For new provider applicants joining a participating medical group,:
   - **a)** Provide group with list of all information and supporting documentation required for credentialing application of a new provider applicant to be considered complete.
   - **b)** Notify new provider applicant in writing of status of credentialing application no later than five (5) business days of receipt of the application. Notice shall indicate if application is complete or incomplete, and if incomplete, shall indicate information or documentation needed to complete the application.
   - **c)** If application is incomplete and new provider applicant submits additional information or documentation to complete the application, health insurance entity shall notify the new provider applicant in writing of the status of the credentialing application no later than five (5) business days of receipt of the additional information or documentation.
   - **d)** Notify new provider applicant of the results of the credentialing application within ninety (90) days after notification from the health insurance entity that the application is complete.
   - **e)** If the new provider applicant fails to submit a complete credentialing application within thirty (30) calendar days of notice of an incomplete application, then the application is deemed incomplete and credentialing is discontinued. (TN Code Ann. 56-7-1001(f).)
10. A health insurance entity shall not require the disclosure of a physician's participation in a physician wellness program, as defined in TN Code Ann. 63-1-173, as a condition of credentialing, contracting, or network participation with the health insurance entity. (TN Code Ann. 56-7-1001(g)(1)).

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## Tennessee UnitedHealthcare Community Plan Requirements[31]

1. The Contractor shall completely process credentialing applications within (30) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. Completely process shall mean that the Contractor shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not used by the Contractor.
2. Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES) prior to credentialing/recredentialing decision.
3. Additional query of TennCare Terminated Provider List is required for Practitioners and Facilities: **https://www.tn.gov/content/dam/tn/tenncare/documents/terminatedproviderlist.pdf**
4. An agency that provides nursing services only to children may not be able to attain Medicare certification (due to a lack of sufficient patients who are Medicare eligible). Only in this instance (i.e., the agency provides nursing services only to children), TennCare will consider alternative certifications or accreditations that if attained, demonstrate the agency would meet the requirements for participation in Medicare.
5. At a time to be determined by TennCare, TennCare will implement centralized data collection processes for credentialing and recredentialing of providers. Providers must enroll with TennCare and provide supporting documentation through the electronic application process. TennCare will utilize a Centralized Credentials Verification Organization to provide standardized primary source verified data sets to the CONTRACTOR. The CONTRACTOR shall maintain its Credentialing Committee for determination of eligibility to participate in the CONTRACTOR's network. The CONTRACTOR shall not directly require providers to submit supplemental or additional information for purposes of making credentialing decisions unless approved by TennCare. Requests for additional provider information must be made to TennCare. TennCare will then request additional information from the provider and provide to the CONTRACTOR utilizing standardized data sets.

31 Requirements of the State Medicaid Contract.

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# Texas

The standards set out in section four of the National Credentialing Plan set the baseline credentialing standards for licensed independent practitioners (LIP) and components in all markets. In addition to these national standards, in Texas, compliance is also required with the following state laws/regulations:

- **Standardized Credentialing Form:** Physicians, Advance Practice Nurses and Physician Assistants. Hospitals and Health Maintenance Organizations (HMOs) are required to use the form. (TX Ins. Code 1452.052, 28 TX Adm. Code 21.3201).
- **HMO Credentialing Files:** Credentialing files are included in the list of documents required to be available at the HMO offices in TX. (28 TX Adm. Code 11.303 (c)(11))
- **HMO Quality Improvement Program:** HMOs are required to implement a documented process for selection and retention of contracted physicians and providers. The HMO's credentialing process, and that of the HMO's delegate where credentialing is delegated, must comply with National Committee for Quality Assurance (NCQA) standards to the extent the NCQA standards do not conflict with TX state requirements. (28 TAC section 11.1902(4) and (7)).

"The HMO is required to have procedures for detecting deficiencies **subsequent to the initial site visit…**" (Emphasis added. 28 TAC section 11.1902(5)(A)).

**HMO Delegation Agreement Filing:** HMOs must file the executed delegation agreement and any subsequently executed amendments to the agreement with the Department of Insurance. (28 TX Adm. Code 11.2611)

**HMO Reporting Requirements:** HMOs that become aware of information that suggests the delegated entity is not operating in compliance with its written agreement must immediately:

1. notify the delegated entity in writing of those findings;
2. request in writing a written explanation with supporting documentation of the delegated entity's apparent noncompliance with the written agreement. TX Adm Code 11.2606(b).

The delegated entity must respond to the request within 30 days after receipt of the request and must provide a corrective action plan. TX Adm Code 11.2606(c). A copy of all communications required between the HMO and delegated entity must be sent to TDI simultaneously with transmission. TX Adm Code 11.2606(d).

The HMO Medical Director [28 TAC 11.1606] is required to:

- Be licensed in Texas (§11.1606 (c)(1)
- Reside in Texas (§11.1606 ( c)(2)
- Demonstrate active involvement in all quality management activities (§11.1606 (c)(4)
- Be subject to HMO's credentialing requirements (§11.1606 (c)(5)

HMOs are required, during the annual application period only, to respond to physician and provider applications for participation within 90 days of receipt of the application for participation. (28 TX Adm. Code 11.1402(c)). Notification to physician or provider will be given in writing.

## Preferred Provider Organizations (PPOs) Provider Contracting Requirements

(28 TX Adm. Code 3.3706):

- All LIPs and components must be eligible to apply and be afforded a fair, reasonable and equitable opportunity to become a preferred provider.
- Notify annually all LIPs in the service area of the opportunity to apply to participate. The notice may be made by publication or individual writings to all affected LIPs.
- Designation as a preferred provider may not be unreasonably withheld, but the PPO may reject an application on the basis of sufficient qualified providers already in the network.

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- Provide the specific reason for denials to LIPs and components.
- All denials of LIP initial credentialing applications must offer the right to a review of the denial by an advisory review panel.
  - The advisory review panel shall be composed of three or more participating LIPs in the service area, at least one of whom is an LIP in the same or similar specialty as the applicant.
  - The PPO may make a determination that is contrary to the recommendation of the advisory review panel.
  - The PPO is required to provide a written explanation of denied applications.
  - Upon request of the LIP, the advisory panel recommendation must be provided.
- Notices of terminations of agreements with LIPs and components must include the reason for the termination.
- For terminations of LIP agreements, the PPO is required to offer review by an advisory review panel, following the same procedure noted above, except in cases of:
  - Imminent harm to patient health, or
  - Action by any state licensing board which impairs an LIP's ability to practice, or
  - Fraud or malfeasance.

**HMOS and PPOs** (TX Ins. Code 1452.103 – effective September 2007)

When an applicant physician who joins a medical group, medical school or teaching hospital that already participates in the managed care plan's network, the applicant physician is considered eligible for "expedited credentialing" when the managed care plan has:

- Verified that the applicant physician is licensed in good standing with the Texas Medical Board, and
- Determined that all credentialing information necessary to initiate the credentialing process for the applicant physician has been submitted.

During expedited credentialing:

- The managed care plan is not obligated to list the applicant physician in the provider directory, and
- The applicant physician is not considered to be a primary care physician for selection by HMO members until the full credentialing process is completed.

Upon completion of the managed care plan's standard credentialing process:

- The plan may reject the applicant physician's application if they do not meet standard credentialing requirements, and
- Managed care plans are explicitly protected from liability for damages based on the expedited credentialing process of applicant physicians.

## Texas UnitedHealthcare Community Plan Requirements[32]

1. The MCO must use the Texas Association of Health Plans' (TAHP's) contracted Credentialing Verification Organization (CVO) as part of its credentialing and recredentialing process, regardless of membership with the TAHP. The CVO is responsible for receiving completed applications, attestations, and primary source verification documents. The MCO retains the sole responsibility for credentialing the Provider. Credentialing documentation must be submitted to HHSC upon request.
2. The MCO may subcontract with another entity to which it delegates credentialing activities, if the delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and requirements defined by HHSC.
3. Inclusion of data from quality improvement activities at the time of recredentialing.

32 Requirements of the State Medicaid Contract.



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4. Additional requirements for verification of sanctions on Practitioners and Facilities including but not limited to the Office of the Inspector General List of Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System (EPLS)) and the Texas Office of the Inspector General List of Medicaid Exclusions:Texas HHSC OIG > Exclusions - Download Exclusions File (state.tx.us).
5. The MCO must complete the credentialing process for a new provider and its claims system must be able to recognize the provider as a Network Provider no later than 90 calendar days after receipt of a completed application.
6. If an application does not include all required information, the MCO must provide the provider with written notice of all missing information no later than 5 Business Days after receipt.
7. If a provider qualifies for expedited credentialing the claims system must be able to recognize the provider as a Network Provider no later than 30 calendar days after receipt of a completed application even if the MCO has not yet completed the credentialing process. (The MCO must comply with requirements of Texas Chapter 1452 Sub-chapter C, D, and E regarding expedited credentialing and payment of physicians, podiatrists and therapeutic optometrists who have joined established medical groups or professional practices that are already contracted with the MCO.)
8. The MCO must also establish and implement an expedited Credentialing process, as required by Tex. Gov't Code §540.0656, that allows applicant providers to provide Covered Services to Members on a provisional basis for the following provider types:
    - Dentists;
    - Dental specialists, including dentists and physicians providing dental specialty care;
    - Licensed Clinical Social Workers (LCSWs);
    - Licensed Professional Counselors (LPCs);
    - Licensed Marriage and Family Therapists (LMFTs);
    - Psychologists; and Federally Qualified Health Center (FQHC) or a health care provider for a FQHC.

    The MCO must allow applicant providers to qualify for expedited Credentialing if the provider:
    - Has a current contract with a Medicaid MCO or is a member of or a health care provider for an established health care Provider group or a FQHC as defined by 42 U.S.C. Section 1396d(1)(2)(B) that has a current contract in place with an MCO;
    - Is a Medicaid enrolled provider;
    - Agrees to comply with the terms of the contract between the MCO and the health care provider group or FQHC; and
    - Submits all documentation and information required by the MCO in a timely manner as necessary for the MCO to begin the Credentialing process.

    The MCO must also establish and implement an expedited Credentialing process for NF Providers that successfully underwent a change of ownership. The MCO's expedited Credentialing requirements for such NFs must only include requirements in bullet 2 and 4 above in the preceding paragraph. An applicant provider must also agree to comply with the terms of the contract between the MCO and the NF.
9. Professional Liability Insurance or General Liability Insurance requirements do not apply to Nursing Facility Providers (Nursing Home or Skilled Nursing Facility).
10. The MCO must ensure that an adequate number of participating physicians have admitting privileges at one or more participating hospitals in the MCO's network to ensure necessary admissions are made. Verification of element by Applicant attestation.

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# Utah

Pursuant to Utah Code Annotated section 31A-45-304, managed care plans are:

1. Required to establish credentialing criteria for participating providers, which must be filed with the state and made available to any provider upon request.
2. Required to make a decision on the provider application within 120 days of receipt of the application and all necessary information.
3. Prohibited from rejecting applicants, or terminating participation, based solely on the provider's staff privileges at a general acute care hospital not under contract with the managed care organization.

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# Vermont

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

(Code of VT Rules 21-040-010 (5.2)

- The Medical Director, required to be licensed in VT, is responsible for and required to participate in provider credentialing verification process.

1. Primary source verification is required for the following elements for initial credentialing: Professional Liability Insurance certificate from the carrier, status of hospital privileges, DEA Certificate or State Controlled Dangerous Substances Certificate require primary source verification, work history.[33]
2. Primary source verification of Drug Enforcement Administration (DEA) Certificate or State Controlled Dangerous Substances Certificate from the carrier for recredentialing.
3. Recredentialing process needs to include performance appraisal of provider, review of data from member complaints, and results of quality reviews, utilization management reviews and member satisfaction surveys.

Vermont adopted the Council on Affordability and Quality Healthcare (CAQH) credentialing form as its Uniform Credentialing Application. (18 VT Statutes Annotated 9408(a); 192 VT Government Register 43).

1. Health care insurers and HMOs are required to notify providers of deficiencies on completed applications within 30 business days of receipt of the application by the insurer.
2. Health care insurers and HMOs are required to act upon and finish the credentialing process within 60 calendar days of receipt of a completed application. An application is considered complete once the insurer has received all information and documentation necessary to make its credentialing decision. (18 VT Statutes Annotated 9408(a).)

33 A copy of professional liability declaration sheet will serve as evidence of primary source verification. A review of the attested credentialing application will serve as primary source verification of work history.



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# Virgin Islands (U.S.)

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# Virginia

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to:

1. Continue the credentialed status of a fully-credentialed practitioner who changes their place of employment or their non-health plan employer, as long as the practitioner provides specified information within 60 calendar days of the change, if practicing within the same specialty. The information includes:
   - **a)** The effective date of the change;
   - **b)** The new tax ID number and copy of W-9, as applicable;
   - **c)** The name of the new practice, contact person, address, telephone and fax numbers; and
   - **d)** Other such information as may materially differ from the most recently completed credentialing application submitted by the provider to the health plan.

   This provision does not apply if the provider's prior place of employment or employer had been delegated credentialing responsibility by the health plan. Nothing in this section shall be construed to require a health plan to contract or re- contract with a provider. (12 Virginia Administrative Code 5-408-170(E)) .
2. Include data from quality improvement activities at recredentialing. (12 Virginia Administrative Code 5-408-170(F)(5)).
3. Active medical staff privileges or admitting privileges are waived for podiatrists provided that the podiatrist has a delineation of privileges that enables such podiatrist to perform the type of services that are covered by the PPO or HMO at a designated hospital or hospitals. (Va. Code Ann. § 38.2-3407.6).
4. When a contractual relationship exists between the carrier and the new provider applicant or entity for whom the new provider applicant is employed or engaged. Establish protocols and procedures for processing new provider credentialing applications and reimbursing new provider applicants, after being credentialed by the health plan, for health care services provided to covered persons during the period in which an approved applicant's completed credentialing application was pending. At a minimum, the protocols and procedures shall require the following:
   - **a)** A health insurance carrier that accepts applications through an on-line credentialing system shall notify a new provider applicant through the on-line credentialing system that the provider has submitted and attested to the application as notice by the carrier that the application is received. If the carrier does not accept applications through an on-line credentialing system, the carrier shall within 10 days of receiving an application provide notification to the new provider applicant either by mail or electronic mail, as selected by the applicant, that the application was received;
   - **b)** Beginning January 1, 2024, a new provider applicant's application is deemed complete within 30 days of the carrier receiving the application, unless the carrier has provided notice that the application is not complete. Notice shall be provided by electronic mail unless the provider applicant has selected notification by mail;
   - **c)** The carrier shall approve or deny new provider applicant credentialing applications within 60 days of receiving a completed application;
   - **d)** Claims submitted according to carrier claims submittal policies for services rendered during the period of a pending application shall be adjudicated and paid no later than 40 days after the new provider applicant is credentialed and contracted;
   - **e)** The protocols and procedures shall apply only if a contractual relationship exists between the health plan and the new provider applicant or entity for whom the new provider applicant is employed or engaged; and
   - **f)** Any reimbursement shall be paid at the in-network rate that the new provider applicant would have received had he been, at the time the covered health care services were provided, a credentialed participating provider in the network for the applicable health benefit plan. (Va . Code Ann . § 38 .2-3407 .10:1(B)).

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5. When a contractual relationship does not exist between the carrier and the new provider applicant or entity for whom the new provider applicant is employed or engaged:
   a) Notify applicant within 60 calendar days of receipt of the credentialing application if information is missing rendering the application incomplete.
   b) Complete credentialing process within 90 calendar days of receipt of additional information.
   c) Complete credentialing process within 120 calendar days for clean applications. (12 Virginia Administrative Code 5-408-170(D)(6)).
6. Not refuse to initially credential or refuse to reverify the credentials of a health care provider solely because the provider treats a substantial number of patients who require expensive or uncompensated care. (12 Virginia Administrative Code 5-408-170(I)).

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## Virginia UnitedHealthcare Community Plan Requirements

Inclusion of data from quality improvement activities at the time of recredentialing.

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

Database query of the National Practitioner Data Bank (NPDB) during credentialing and recredentialing

The Contractor and its network providers shall comply with all applicable Federal and State laws assuring accessibility to all services by individuals with disabilities pursuant to the Americans with Disabilities Act (ADA) (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Members.

Any physician who provides inpatient services to the Contractor's members shall have admitting and treatment privileges in a minimum of one general acute care hospital. Verification of element by Applicant attestation.

In accordance with Va. Code § 38.2-3407.10:1, the Contractor must establish reasonable protocols and procedures for reimbursing new provider applicants, within thirty (30) calendar days of being credentialed by the carrier, for health care services or mental health services provided to covered persons during the period in which the applicant's completed credentialing application is pending. At a minimum, the protocols and procedures must:

- Apply only if the new provider applicant's credentialing application is approved by the Contractor
- Permit reimbursement to a new provider applicant for services rendered from the date the new provider applicant's completed credentialing application is received for consideration by the Contractor
- Apply only if a contractual relationship exists between the Contractor and the new provider applicant or entity for whom the new provider applicant is employed or engaged; and
- Require that any reimbursement be paid at the in-network rate that the new provider applicant would have received had he been, at the time the covered health care services were provided, a credentialed participating provider in the network for the applicable health benefit plan

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# Washington D.C.

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).are required to accept the district's uniform credentialing form for credentialing and recredentialing.
(D.C. Code sections 31-3252 and 31-3251; Code of D.C. Municipal Regulations sections 26-4201 and 26-4299.)

## Washington D.C. UnitedHealthcare Community Plan Requirements

UnitedHealthcare recredentials every three (3) years in accordance with NCQA standards.

Physician Providers, Home Health Agencies, and other licensed and certified professional Providers, including Behavioral Health Providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to obtain Continuing Medical Education (CME) credits or Continuing Education Units (CEUs) and participate in other training opportunities, as required for Provider's respective licensure and/or certification.

Inclusion of data from quality improvement activities at the time of recredentialing.

The Contractor shall maintain Provider credentialing files. Provider credentialing files can be maintained electronically; however, the Contractor must have the capability to print out a paper file upon DHCF request.

The Contractor shall ensure that the Provider credentialing process is completed within one hundred eighty (180) days upon the Contractor's receipt of all required documents. The Contractor's failure to credential or re-credential Providers in a timely manner may result in corrective action.

The Contractor's Provider credentialing files shall include but not be limited to: Licensure status; Specialty or sub-specialty; Professional affiliations; Hospital admitting privileges; Education and training; Board eligibility/ certification; Professional credentials and/or certifications; Basic demographic information; Hours of operations; Office locations; Languages spoken by office staff; Status of panel (open, closed); Malpractice coverage; Reported incidents; Documentation that the Provider has not been suspended, excluded or debarred from participation in any District, state, and/or Federal health care benefit programs. Documentation that Providers have completed all training modules required by DHCF or the Contractor and Satisfaction Survey responses are conducted by the network and operations area.

Additional query of DC Excluded Parties List is required for Practitioners and Facilities:
**https://ocp.dc.gov/page/excluded-parties-list**

The Contractor shall ensure, in accordance with 42 C.F.R. § 438.602(b), each of its Network Providers are screened and enrolled as a Medicaid Provider by DHCF. Validation will be conducted by the Provider Operations area as being enrolled.

The Contractor must demonstrate that all hospitals are accredited by The Joint Commission and verifies to the District that the hospital has met all state licensing and certification requirements.

The Health Plan shall submit such written policies and procedures annually to DHCF, if amended.

The Contractor shall ensure that all Providers are credentialed prior to becoming Network Providers and that the Contractor conducts a site visit for all nursing facilities, assisted living facilities, and behavioral services providers before they provide services to Enrollees.

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# Washington

(Rev. Code WA 48.43.750, 48.43.757, 48.165.035, 48.43.094)

1. Health carriers must use the database selected pursuant to RCW 48.165.035 to accept and manage credentialing applications from health care providers. A health carrier may not require a health care provider to submit credentialing information in any format other than through the database selected pursuant to RCW 48.165.035. (RCW 48.43.750, RCW 48.165.035.)
   - **a)** Determinations to approve or deny a credentialing application shall be made no later than 90 days after receiving a completed credentialing application.
   - **b)** Effective June 1, 2020, a health carrier shall make a determination approving or denying a credentialing application no later than 90 days after receiving a completed application. All determinations made by the health carrier in approving or denying must average no more than 60 days.
   - **c)** Requirements noted above (number 1, (a) and (b) does not apply to health care entities that utilize credentialing delegation arrangements in the credentialing of their health care providers with health carriers.
2. If a carrier approves a health care provider's credentialing application, upon completion of the credentialing process, the carrier must reimburse a health care provider under the following circumstances (RCW 48.43.757):
   - **a)** When credentialing a new health care provider through a new provider contract, the carrier must reimburse the health care provider for covered services provided to the carrier's enrollee retroactively to the date of contract effectiveness if the credentialing process extends beyond the effective date of the new contract.
   - **b)** When credentialing a provider to be added to an approved and in-use provider contract where a relationship existed between the carrier and the health care provider or the entity for whom the health care provider is employed or engaged at the time the health care provider submitted the completed credentialing application, the carrier must reimburse the health care provider for covered health care services provided to the carrier's enrollees during the credentialing process beginning when the health care provider submitted a completed credentialing application to the carrier.
   - **c)** Nothing in this section requires a health carrier to pay reimbursement for any covered medical services provided by a health care provider applicant if the health care provider's credentialing application is not approved or if the carrier and health care provider do not enter into a contractual relationship.
3. For health plans issued or renewed on or after Jan. 1, 2016 but before Jan. 1, 2017, health plans that delegate credentialing agreements to contracted health care facilities must accept credentialing for pharmacists employed or contracted by those facilities.
   (RCW 48.43.094.)

## Washington UnitedHealthcare Community Plan[34]

UnitedHealthcare credentials providers for all lines of business the provider will be serving simultaneously (i.e. Commercial, Medicare, and/or Medicaid). Verification of the provider's enrollment with the State of Washington Health Care Authority (HCA) as a Medicaid provider is conducted after the credentialing process, but prior to the provider being loaded to UnitedHealthcare's systems, when the provider will be serving Washington's Integrated Managed Care (IMC), Apple Health Expansion (AHE), or Behavioral Health Services (BHSO) members. Verification of the provider's enrollment with the HCA is conducted by UnitedHealthcare's Provider Operations Team.

Federal database checks on Practitioners and Facilities of the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General List of Excluded Individuals/Entities (OIG/LEIE) and the General Services Administration's System for Awards Management (GSA/SAM) (the successor to the Excluded Parties List System (EPLS)) prior to credentialing/recredentialing decision.

34 Requirements of the State Medicaid Contract.

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Additional query of WA Provider Termination and Exclusion List is required for Practitioners and Facilities: **http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/provider-termination-and-exclusion-list**

Contractor must notify providers within fifteen (15) calendar days of the credentialing committee decision.

The UnitedHealthcare Credentialing Plan and Addendum applies to the Washington Apple Health IMC, AHE and BHSO members.

The Contractor is not responsible for credentialing providers and facilities for the Medicaid product that are part of the Indian health system. Indian health system providers will still need to be credentialed if participating in UnitedHealthcare's other product lines, excluding Medicaid.

Practitioners and Facilities credentialing and recredentialing to be completed within one hundred twenty (120) calendar days on receipt of the credentialing application when the provider application is complete upon submission.

A credentialing application is considered complete when all required information has been obtained from the Provider, and a license has been issued. It is not possible for an application to be considered complete prior to the issuing of a license.

A re-credentialing application is considered complete when all required information has been obtained from the Provider. It is not possible for a recredentialing application to be complete if the Provider does not have a current issued license. NCQA and CMS require the quality performance review prior to recredentialing, therefore the application is not complete until the quality performance review has been completed.

Use and promotion of one of the following as the Contractor's single credentialing portal: the credentialing solution from the state's lead organization for administrative simplification, (Foundation for Health Care Quality (FHCQ), the Council for Affordable Quality Healthcare (CAQH) or an HCA-approved equivalent (RCW 48.43.750 (1)(a)).

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# West Virginia

W. VA. CSR § 114-53-4 Requirements of a Quality Assurance Program:

1. A Health Maintenance Organization (HMO) shall develop a quality assurance program which adheres to all applicable state and federal laws, federal regulations and state rules.
2. An HMO that has obtained full accreditation or equal status from a nationally recognized accreditation and review organization approved by the commissioner pursuant to West Virginia Code §33-25A-17a is deemed to be in compliance with this rule.
3. Complete initial credentialing of any new provider and accept or reject the provider within 120 days following the receipt of a completed application. That time frame may be extended for an additional 90 days because of delays in primary source verification. The insurer shall make available to providers a list of all information required to be included in the application. (W. Va. CSR 33-45-2.11)
4. "Credentialing entity" means any health care facility, payor or network that requires credentialing of health care practitioners; "credentialing entity" has the same meaning ascribed to "health care entity" in W. Va. Code of St. Rules 64, 114CSR3.4. (W. VA. CSR 64-89B-2.4)
5. "Health Care Practitioner" or "practitioner" means a health care provider who is licensed, certified, or otherwise authorized to provide health care services, as designated by the Secretary and Commissioner to be subject to the uniform credentialing and recredentialing forms. (W. VA. CSR 64-89B-2.6)
6. Shall use the uniform credentialing form developed by the committee for credentialing health care practitioners and the uniform recredentialing form developed by the committee for recredentialing health care practitioners. (W. Va. CSR § 64-89-4) Applications can be found at **https://www.wvinsurance.gov/Uniform-Credentialing**
7. A health care entity may request information in addition to the information provided in the uniform credentialing or uniform recredentialing forms. A request for additional information may not require repetition of the information required in, or substitute another form for, the uniform credentialing or uniform recredentialing forms. Additional information shall be requested by the health care entity on supplemental sheets attached to the uniform forms. (W. Va. CSR § 64-89-4.4)
8. When the uniform credentialing form or uniform recredentialing form is amended as provided in Section 5 of this rule, all health care entities shall use the amended uniform forms to credential or recredential health care practitioners. (W. VA. CSR 64-89-4.5)
9. Any credentials data collected or obtained by a health care entity during the credentialing or recredentialing process shall constitute confidential peer review information, as provided by W. Va. Code §30-3C-3, and shall not be disclosed by the health care entity except as provided by law. ( W VA CSR § 64-89-6).
10. When a contract with a statewide CVO has been executed by the state of WV, the following paragraph will apply. As of March 2018, the WV Department of Insurance has advised that the state-wide CVO has not yet been established.
11. Except as provided in subsection 8.3 of this section, during the third year after the completion of a practitioner's initial credentialing, each practitioner is subject to recredentialing by the last day of the practitioner's birth month and by the same date every third year thereafter. ( W. Va. CSR § 64-89B-8.1) The CVO shall be responsible for notifying each practitioner of their recredentialing date in a timely manner. ( W. Va. CSR § 64-89B-8.2)
12. Nothing in this rule may be construed to prohibit a health care entity from delegating credentialing or recredentialing activities to another entity, such as a certified verification organization, as long as the entity to whom the activities have been delegated follows the requirements of this rule. (W. Va. CSR § 64-89-7 )

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# Wisconsin

No additional credentialing requirements.

## Wisconsin UnitedHealthcare Community Plan Requirements[35]

Inclusion of data from quality improvement activities at the time of recredentialing.

The HMO must complete the initial credentialing process on practitioner and facility providers within 90 days after receipt of all necessary documents required by provider.

May not employ or contract with debarred or excluded Practitioner and Facility providers from the Office of the Inspector General List or Excluded Individuals and Entities (OIG-LEIE) and the General Services Administration System for Awards Management (GSA-SAM) (the successor to the Excluded Parties List System) (EPLS)).

35 Requirements of the State Medicaid Contract.

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# Wyoming

Health Maintenance Organizations (HMOs) are required to credential licensed individual practitioners and hospitals, but no specific credentialing requirements identified. (Wyoming Statutes Annotated sections 26-34-108(b)(ii)(G)).

Wyoming Statutes 26-56-102. Health care provider credentialing; requirements (Effective July 1, 2025)

1. Within seven (7) calendar days after a health carrier receives an application for credentialing, the health carrier shall provide the applicant notice of receipt of the application in written or electronic form and contact information for the person reviewing the application.
2. After receiving an application, a health carrier shall determine whether the application is complete. If the health carrier determines that the application is incomplete, the health carrier shall notify the applicant in writing or by electronic means that the application is incomplete within thirty (30) calendar days after the date the health carrier received the application. The notice shall describe the items that are required to complete the application.
3. The health care provider shall submit a completed credentialing application within thirty (30) calendar days of receiving the notice. Failure of the health care provider to submit a completed credentialing application within thirty (30) days of receiving the notice shall restart the timelines in this subsection.
4. A health carrier shall conclude the process of credentialing an applicant within sixty (60) calendar days after the health carrier receives the applicant's application. The sixty (60) calendar day period shall pause if a health care provider receives notification that their application is incomplete and shall resume after the health carrier verifies that the health care provider has resubmitted a completed credentialing application.
5. A health carrier shall provide each applicant written or electronic notice of the outcome of the applicant's credentialing at the conclusion of the credentialing process.
6. If an applicant becomes credentialed as a participating health care provider in a health carrier's network and a fully executed contract between the health care provider and the health carrier is in effect prior to covered services being provided, the health carrier shall reimburse the applicant for all covered reimbursable health care services provided by the applicant beginning with the date the health carrier received a completed credentialing application from the applicant, unless otherwise preempted by federal law.
7. A health carrier shall not be required to approve any application for credentialing, except as provided by W.S. 26-22-503
8. The department of insurance shall promulgate rules providing for a uniform credentialing application.

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# Federal Requirements for Medicare Participation[36]

UnitedHealthcare's Credentialing plan for Medicare and Medicaid managed care plans adheres to managed care standards at 42 CFR §438.214 and 42 CFR §422.204. This addendum outlines only those additional requirements that are not already covered within the body of the Credentialing plan.

1. The information collected and verified must be no more than 180 calendar days old at the time of the Credentialing Committee decision.
2. The provider must not be excluded or debarred from participation in Medicare via a query of the General Services Administration/SAM database.
3. Delegation agreements must address Medicare Advantage (MA) contracting and delegation requirements, including but not limited to a requirement to comply with all applicable MA credentialing requirements. (See 42 CFR 422.504(i) and Medicare Managed Care Manual, Chapter 11, Sections 100.5 & 110).
4. Verification that licensed individual practitioners have not opted out of participation with Medicare, with the exception that dental providers who are providing services under supplemental benefits (not medical) do not require verification that the practitioners have not opted out of participation in Medicare. (42 CFR § 422.220)
5. Credentialing required for additional facility types as outlined in the Credentialing Plan (Attachment C), including but not limited to credentialing Federally Qualified Health and Rural Health Clinics as facilities.
6. Those facilities listed in Attachment C of the Credentialing Plan must have a provider agreement with CMS (e.g., Medicare CMS certification). See also Medicare Managed Care Manual, Chapter 6.

Additional information available at:
**cms.gov/Manuals/IOM/list.asp**

- Medicare Managed Care Manual, Chapter 6.
- Medicare Program Integrity Manual, Chapter 15
- Medicare Benefit Policy Manual, Chapter 15, Section 40

**http://www.npdb.hrsa.gov/**

36 42 CFR 422.204 and 42 CFR 438.214 applies to all Medicare and Medicare/Medicaid dual eligible products

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