AMERIHEALTH CARITAS NORTH CAROLINA

POLICY AND PROCEDURE

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Page: 1 of 5

Subject: Good Faith Provider Contracting

Department: Provider Network Management

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Stakeholder(s): Legal Affairs, Medical Economics, Financial/Actuarial Services

Applicable Party(ies): Provider Network Management, Credentialing, Financial/Actuarial Services

Line(s) of Business: AmeriHealth Caritas North Carolina

Policy:

AmeriHealth Caritas North Carolina (ACNC) will manage its provider network to meet availability, accessibility, and quality goals and requirements. In developing its network, ACNC will negotiate in good faith with any qualified willing Provider, who is participating in the North Carolina Medicaid program, regardless of Provider or other affiliation with another prepaid health plan. A good faith effort is made to contract all qualified Providers credentialed by the North Carolina Department of Health and Human Services (NCDHHS) at Medicaid allowable rates.

ACNC shall have a strong monitoring program to help ensure that Providers are meeting Member needs and ACNC requirements; that all contracting efforts conform to NCDHHS requirements; and that the contracted/covered services to be provided to enrollees are considered, as well as the Provider's ability to be credentialed by NCDHHS.

ACNC does not deny or refuse participation in its network to any Provider requesting to participate in its network on the basis of age, gender, race, creed, religion, skin color, handicap, sexual orientation, political affiliation or beliefs, or national origin. In addition, ACNC shall not discriminate with respect to participation, as to any Provider who is acting within the scope of the Provider's license or certification under applicable state law, solely on the basis of such license or certification, in accordance with Section 1932(b) (7) of the Social Security Act (as enacted by section 4704(a) of the Balanced Budget Act of 1997). Further, ACNC shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatments.

Purpose:

To provide clear procedures to help ensure that ACNC is negotiating with any qualified willing Provider in good faith, regardless of the Provider, or the Provider's affiliation with another prepaid health plan.

Definitions:

ACNC: AmeriHealth Caritas North Carolina.

HIPDB: Health Care Integrity and Protection Data Bank. The purpose of the HIPDB was to help combat health care fraud and abuse. The HIPDB is no longer operational; however, information previously collected and disclosed by the HIPDB is now collected and disclosed by the National Practitioner Data Bank (NPDB).

Non-Routine Provider File: A file with malpractice cases, license sanctions, affirmative answers to disclosure questions, etc. that requires PNPC review and discussion.

NPDB: National Practitioner Data Bank is a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S.

OIG: Office of Inspector General.

Provider: The umbrella term used to refer to acute, primary care physicians, behavioral, substance abuse disorders, specialist, and allied health practitioners. As referred to in this policy document, a Provider includes hospitals, ancillaries, facilities, entities, organizations, atypical organizations, and institutions where the facility would be contracted with instead of the individual provider.

SAM: System for Award Management: The SAM database keeps its user community aware of administrative and statutory exclusions across the entire government, and individuals barred from entering the United States.

North Carolina Session Law 2015-245 is an act to transform and reorganize North Carolina's Medicaid and NC Health Choice programs. This act establishes failure to meet Objective Quality Standards or refusal to accept network rates as the only acceptable reasons to decline to contract with providers.

Procedures:

I. Good Faith Contracting

The following are processes ACNC follows to help ensure a good faith effort is made to contract all qualified, willing Providers at Medicaid allowable rates, including but not limited to PCPs, specialists, hospitals, behavioral health providers, Indian Health Care Providers and out of network Providers.

A. Contracting Process.

1. ACNC will offer to contract with a Provider using a NC DHHS approved provider agreement in writing, via letter, email or fax. As required in Section V.D.2.c.vii.a., of the PHP contract, the ACNC provider agreement will include the Required Standard Provisions for provider agreements. The Required Standard Provisions are found in Section VII. Attachment G of the PHP agreement.
2. An ACNC Account Executive will follow up the initial outreach to the Provider within 10 business days.
3. ACNC will not include exclusivity or non-compete provisions in contracts with Providers, including nonmedical service Providers (e.g. non-emergency medical transportation drivers), require a Provider to participate in the governance of a Provider-led entity (PLE), or otherwise prohibit a Provider from providing services for or contracting with any other prepaid health plan.
4. ACNC will not require individual Providers, as a condition of contracting with ACNC, to agree to participate or accept other ACNC products. ACNC does not offer any other products in North Carolina.
5. ACNC will not automatically enroll the Provider in any other product offered by ACNC. ACNC does not offer any other products in North Carolina.
6. Negotiations to contract will continue until both parties agree on contract terms, or until one or more parties decide to not move forward. The contracting timeframe formally begins when ACNC presents a NCDHHS-approved provider agreement to the provider. If within thirty (30) calendar days of receiving the NCDHHS-approved provider agreement, the potential network provider rejects the agreement or fails to respond either verbally or in writing, ACNC may consider the request for inclusion in the Medicaid Managed Care Provider Network rejected by the provider. If discussions are ongoing based on a response by the potential network provider to the proposed agreement, or the contract is under legal review, ACNC shall not consider the request rejected. ACNC will cease negotiations when it has determined, per Section I.B. below, that a Good Faith Provider contracting effort has been made.

B. ACNC will conclude that a good faith provider contracting effort has been made in contracting decisions if:

1. ACNC has considered all facts and circumstances surrounding a Provider's willingness to contract and has determined that the Provider has refused the plan's good faith contracting effort. For example, if a Provider and ACNC cannot agree to rates despite negotiations and ACNC has engaged the contract review committee as set forth in Section C. 1. below, ACNC will conclude that a good faith contracting effort has been made.

C. **Contract Review Committee**

1. To help ensure that ACNC is negotiating with any qualified willing Provider in good faith, ACNC has established a contract review committee to review a Provider's request for nonstandard contract language, reimbursement rates and/or methodology. In reviewing requests for nonstandard language, rates and/or reimbursement, the contract review committee considers:

a. exact contract language or reimbursement rates, methodology being proposed
b. summary of request and why it is being requested/value of arrangement
c. market intel available as to how competitor plans are reimbursing providers for this type/specialty, as appropriate
d. impact to network adequacy
e. impact to membership
f. financial impact and value of arrangement
g. operational impact

2. Recommendations are presented to executive leadership and a decision is reached and communicated to the Provider.
3. See CPNM.339.105 Contract Review Committee Policy

D. **Written Notice and Appeal Rights**
ACNC will give written notice to any Provider with whom it declines to contract within five (5) business days after ACNC's final decision. The notice shall include the reason for ACNC's decision; the Provider's right to appeal that decision or request to cure the issue identified in the adverse quality determination, and how to request an appeal in accordance with the provider appeal process set forth in ACNC's provider handbook.

E. **Payment to Providers**
With the exception of out of network emergency services, post-stabilization services and services provided during transitions in coverage, ACNC is prohibited from reimbursing an out of network provider more than ninety percent (90%) of the Medicaid Fee-for-Service rate if:

1. ACNC has made a good faith effort to contract with a provider but the provider has refused that contract.

F. ACNC Provider Network Management will notify the Provider Data Management department to create a provider record in the claims payment system for the Provider with whom good faith contracting efforts have failed, per Section I.B., and attach a ninety percent (90%) payment agreement to the Provider's record.

II. Monitoring Mechanisms

The Provider Network Management (PNM) Director and PNM Managers are responsible for overseeing the activities of the Account Executives (AEs), including validating that the AEs comply with this policy and negotiate with any qualified and willing Provider in accordance with the process set forth above.

A. ACNC will maintain file of Providers with whom we attempted but failed to contract by region.

1. Provider Network Management will develop and maintain a file of providers by region who we failed to contract with, listing the following:
    a. provider name and contact information
    b. Account Executive (AE) assigned,
    c. date of original outreach,
    d. reasons or reasons for the lack of success,

e. outstanding issues,

f. date of most recent outreach and comments.

B. On a quarterly basis, the PNM Director shall pull a random number of providers for whom each AE was not able to successfully contract with on behalf of the Plan, not to exceed **10** files.

1. The PNM Director and/or the PNM Managers will review the file and determine if the steps outlined in Section I.A., and I.B.1., above, were followed. As part of their review, PNM Managers will assess if the AEs have documentation sufficient to demonstrate that they complied with the contracting process outlined in Section I.A., above.
2. If the PNM Director and/or the PNM Managers identify an issue, he/she will work with the appropriate AE to further investigate the negotiation process for any provider at issue.
3. The AE will be retrained on the good faith contracting policy to reduce the probability of reoccurrence. Should the same AE be found to be out of compliance with the proper process on subsequent reports, they will be subject to corrective action.

C. Monitoring for discriminatory practices occurs throughout the contracting, credentialing and recredentialing processes.

1. Tracking and identifying discrimination in contracting, credentialing and recredentialing processes is done through:

a. Periodic audits of credentialing files (in process, denied and approved files) that suggest potential discriminatory practice in selecting Providers;

b. Annual audits of Provider complaints for evidence of alleged discrimination, in conjunction ACNC.