



centipede
..... HEALTH NETWORK

PROVIDER MANUAL

Centipede Health Network
“Connecting the Dots”

April 2014 v1.1

TABLE of Contents

	<u>Page</u>
Welcome to CENTIPEDE NATION <i>from CentEO Nancy C Everitt!</i>	2
SECTION 1 – Overview of CENTIPEDE Health	3
SECTION 2 – Here for You – Key Contacts and Resources	5
SECTION 3 – Key Terms and Concepts	5
SECTION 4 – Understanding the Credentialing Process	5
SECTION 5 – How to Update/Change Your Provider File	8
SECTION 6 – Getting Paid – Reimbursement and Billing	8
SECTION 7 – Processes for Complaint & Dispute Resolution	9
SECTION 8 – Working together on Quality Programs	10
SECTION 9 – HIPAA Understanding Privacy & Security Health Insurance Portability & Accountability Act of 1996 (HIPAA)	10
SECTION 10 – Frequently Asked Questions	11
EXHIBIT A – Resources	13



WELCOME to CENTIPEDE NATION!

Thank you for joining CENTIPEDE and choosing to make a difference in the lives of others.

By joining CENTIPEDE and becoming a “credentialed” provider you are making a difference in the lives of Americans who wish to remain independent and live their best life at home surrounded by family and friends. “CENTIPEDE NATION” is the term we use to describe this exciting collaborative effort and community of providers, thought leaders, quality programs and home care access for ALL Americans.

Connecting the Dots...An Audacious Goal!

CENTIPEDE connects the dots within today’s fragmented home and community based service (HCBS) environment by connecting high quality providers like you, local community resources such as the Area Agencies on Aging and volunteer and faith based organizations to name just a few. Collaboratively we bring individuals and their care back to the local community.

CENTIPEDE is an audacious undertaking, one in which we challenge the status quo and create an infrastructure for home care services for ALL Americans. CENTIPEDE moves beyond the current model of HCBS for Medicaid and seeks to provide these valuable services to all. We know that this is not an easy undertaking and will be twice as hard and take longer than forecasted, however together we can make this dream a reality.

Based upon the individual needs and goals of each member and their unique life circumstances, CENTIPEDE providers deliver those services needed to facilitate independence such as personal care services, respite, home maker, home delivered meals, home modifications, transportation, adult day health and assisted living.

The Provider Manual...an Operational Road Map.

The attached document is the CENTIPEDE Participating Provider Manual. The Provider Manual is a road map to define and explain how key contractual covenants work, provide documentation of administrative guidelines and an overview of current and emerging quality programs. The Provider Manual is a living document and will change based upon your feedback and the evolution of the network and programs. We are looking for a true partnership with you and are open to your ideas and suggestions.

Growing Your Pie...our Support

“You are the core of CENTIPEDE”.

We share your commitment to providing the highest standards of SERVICE and CARE and recognize that the quality of your services is the most defining characteristic of CENTIPEDE.

We will walk with you to help you grow your business beyond Medicaid or Private Pay, to help you grow the pie with new business.

The CENTIPEDE team will provide you with:

- Managed Care expertise
- Training on Quality Measures and Metrics
- Opportunities to implement new programs and revenue sources for financial sustainability.

Here’s to you and here’s to CENTIPEDE... let’s change the way healthcare is delivered!

Sincerely,

Nancy C. Everitt, PMP
CentEO
CENTIPEDE Health Network

SECTION 1: Overview of CENTIPEDE Health Network

Overview: CENTIPEDE Health Network is an all Payor network for home and community based services.

Today, networks of home and community based service Providers generally exist as part of Medicaid Waiver Programs or are emerging as part of Dual Eligible Demonstrations and Managed Long Term Services and Supports networks. The primary challenge is that these current networks are specific to one payor which means network duplication and the need for Providers to contract multiple times with multiple Payors. This becomes challenging for many providers from an administrative perspective.

CENTIPEDE simplifies the process by contracting with Providers like you to create one quality network, then CENTIPEDE contracts with multiple PAYORS to create more business opportunities for your organization.

ALL PAYOR:

The term “all payor” means that the network is designed for all types of Payors and has several different levels of payment. You as a provider select those payor categories in the contract that you wish to serve; you can do this by “opting out” and declining Payor categories in Attachment A of the Provider Agreement.

You can also change your service categories at any time but no more than one time annually. The reason for minimizing changes to Payor categories is consistency. Payors are contracting based upon the network provider configuration and need for the network to remain as consistent as possible after open enrollment.

Figure 1 illustrates many of the types of Payors that access the CENTIPEDE Health network and your services.



REFERRALS TO YOUR ORGANIZATION:

Unlike paid referral services, organizations cannot “buy” referrals from CENTIPEDE. Referrals will come to your organization in several ways based upon the types of Payors that you accept, the member’s service need and the covered benefits of the member’s health plan.

Below is a chart illustrating several ways members and their families find out about your organization and how referrals are made to your organization by CENTIPEDE Care Advisors and/or Payor Care Managers.

GROWING the PIE: How CENTIPEDE Referrals Are Sent to Providers

SELF PAY-PRIVATE PAY → →

Self Pay-Private Pay members and families access services through a CENTIPEDE CARE ADVISOR or on their own via the Provider Directory.

REFERRALS: CENTIPEDE

Referrals will come via phone, fax or email from the CENTIPEDE CARE ADVISOR.



REFERRALS: MEMBER

Members and Caregivers may also call you directly.



PAYORS → →

Other Payors may send authorize referrals through one of the following:
 * PAYOR CARE MANAGER
 * CENTIPEDE CARE ADVISOR
 * PROVIDER DIRECTORY for Members.

REFERRALS: CENTIPEDE or PAYOR

Referrals will come via phone, fax or email from the PAYOR CARE MANAGER or CENTIPEDE CARE ADVISOR.



REFERRALS: MEMBER

Members and Caregivers may also call you directly.



IDENTIFYING MEMBERS:

CENTIPEDE Members will be issued electronic ID cards by CENTIPEDE for SELF PAY (Private Pay) access subscriptions and Payors will include the CENTIPEDE logo on the back of their ID cards.

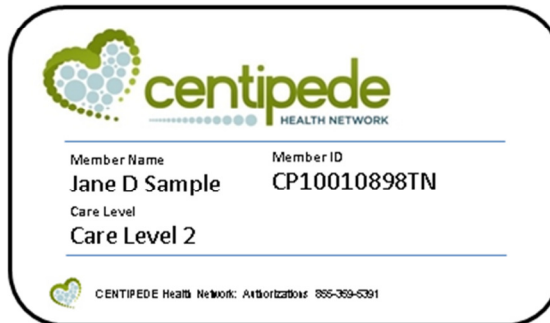
Below are two Sample ID Cards. Note each Payor has their own design, so look for CENTIPEDE service marks or name on the back of a card. The CENTIPEDE heart is your mark of excellence!



Q: How will I identify SELF PAY (Private Pay) CENTIPEDE Members?

A: All CENTIPEDE Self Pay members will be issued an electronic ID card and their membership information will be on file for 24/7 validation.

SAMPLE CENTIPEDE ID Card

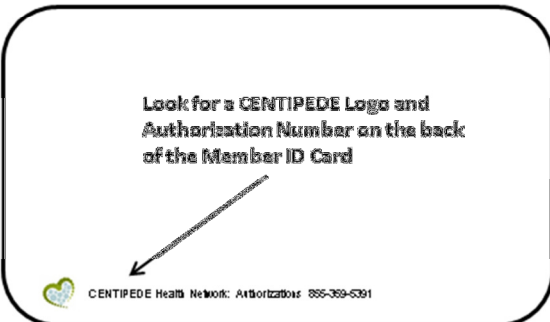


SAMPLE PAYOR ID Card: Look at Back of Card



Q: How will I identify a member on a Payor ID Card?

A: Look for the CENTIPEDE Logo on the back of the member's card.



SECTION 2: Key Contacts and Resources

Guidance: Contact the CENTIPEDE Provider team from 7:00amCST to 6:00pm CST Monday- Friday. You can also access the web portal for certain 24/7 services such as member look up, claims filing etc.

Phone: 1-855-359-5391

Fax: 1- 866-421-4135

Mail:

CENTIPEDE Health Network
PO Box 291707
Nashville, TN 37229

Overnight Mail:

CENTIPEDE Health Network
325 Seaboard Lane, Ste 100
Franklin, TN 37067

Email: joincentipede@heops.com

Website: www.centipedehealth.com

SECTION 3: Key Terms and Concepts

Overview: Below are a few terms and concepts with further detail. This section will grow based upon areas of clarification required to better help you understand and operationalize your agreement.

Clean Claim: A “Clean” claim means a claim that can be paid without additional information, or is a claim that may adhere to a state definition of a clean claim. The key to remember is if the claim is not in the correct format requested by the Payor, is incorrect or requires supporting information to be paid, the claim is not clean. Claims that are not clean will be denied or delayed for payment.

Note: Providers that are considered non traditional and some non licensed Providers may be requested to utilize alternate billing processes for simplification.

PPO: The term PPO stands for Preferred Provider Organization. The CENTIPEDE Network is a PPO network that can be accessed by other Payors that are contracted with CENTIPEDE. CENTIPEDE Providers will have access to Contracted Providers. These Payors are required to identify CENTIPEDE on their ID Cards as the network for services to direct care. Payors that are not contracted with CENTIPEDE may not access the network. CENTIPEDE does not engage in Silent PPO activities which is simply the brokerage of the network discount for non directed patients.

Prompt Payment: Prompt payment refers to a timeline that the Provider claim is paid within. The prompt payment goal is 30 days or less for claims payment from the date a “clean” claim is received. CENTIPEDE will be working on additional ways to help expedite the payment cycle for Providers.

SECTION 4: Understanding the Credentialing Process

Overview: Quality Providers are critical to the success of CENTIPEDE and for good outcomes for members. Credentialing is the process utilized to validate provider information against participation requirements. CENTIPEDE follows standards established by the National Committee for Quality Assurance (NCQA) to create best practices for the credentialing of home and community based Providers.

Credentialing Process:

Turnaround and Timing: CENTIPEDE strives for a rapid turnaround on your Participation materials. You will be contacted after receipt of your materials and our team will work with you on resolution of any missing information or materials needed to credential your organization.

- Our goal for credentialing is 7 days! *Note: However based upon your state's requirements and process for primary source verification this can extend the timeline to 30 days or greater.*

Validation and Verification: Credentialing validation is conducted through primary and secondary source verification of various pieces of information from your Provider Application. This means that CENTIPEDE contacts certain sources directly (primary source verification) to validate key information and will accept other source information for validation of other items (secondary source verification).

A provider receives one of the following levels of credentialing:

- **Provisionally Credentialed:** Initial elements validated, full credentialing incomplete.
- **Fully Credentialed:** All requirements met. *Your organization will be recredentialed in 3 years.*
- **Fully Credentialed with Exception:** All requirements met with an open exception. The file will be monitored for Quality at specified intervals. *Your organization will be recredentialed in 3 years.*

Credentialing Requirements will vary by specialty and by state; however baseline requirements exist for all.

Below is a chart of basic Core Credentialing Requirements for all Providers.

***Where licensure and/or certification is unavailable in a state, a current Business License will be validated.

CENTIPEDE Core Credentialing

PROVIDER DOCUMENTATION	CORE REQUIREMENTS
1. Signed Agreement	✓
2. Application/Attestation (180 days)	✓
3. Correct and Current W-9	✓
4. Validation of Licensure/Cert	✓
5. Validation of Complaints	✓
6. Validation of Exclusions - OIG	✓
7. Background Check Verification	✓
8. Prof/Gen Liability Insurance	✓
9. Malpractice/Legal Disclosure	✓

CENTIPEDE National Credentials Committee (NCC): The National Credentials Committee (NCC) reviews all applications for network participation and also includes provider representatives as subject matter experts.

- Credentialing of non exception files occurs daily with periodic review of exception files by the full Credentialing Committee. All files are de-identified before Credential Committee review to remove bias.
- All credentialing activities are held in the strictest confidence, and are appropriately safeguarded.
- Once approved by the Credentialing Committee, Providers who meet credentialing criteria are notified in writing via mail or electronically.
- Providers whose initial or recredentialing applications do not meet CENTIPEDE Credentialing Criteria for Participation are mailed a certified letter that outlines the rationale for the determination.

Provider Rights in Credentialing:

At CENTIPEDE this is about partnership. It's a two way street. Providers have rights in the Credentialing Process and we've listed these below for you:

- **You may review** any information received in support of their credentialing packet at any time during their application process and/or participation with CENTIPEDE. This includes information submitted by any outside primary source, including but not limited to: malpractice insurance carriers, state licensing boards and/or other entities. Requests to review information must be received in writing from the Provider.
- **You may correct** erroneous information submitted by another party or correct your own information that you may have submitted incorrectly. Corrections may include information regarding actions on a license, malpractice claims history, other disclosures or statements.

Reconsideration/Appeal Process:

Unfortunately, sometimes things don't work out.

If there is a quality concern that the NCC cannot overcome or your organization does not meet base credentialing requirements; there is a possibility that your organization may not be accepted into the network. The CENTIPEDE NCC will be forthright and share with you the rationale in writing. If you disagree with NCC determination and have additional information that may influence the NCC to change the participation decision, follow the processes below to re-open the discussion.

- **Reconsideration:** Any provider or organization declined for participation by the CENTIPEDE NCC may request a reconsideration. All requests and additional information in support of the applicant must be submitted, in writing, to the Credentials Committee Chairman within thirty (30) days of the provider or organization's receipt of the declination letter, unless otherwise mandated by state law.
- **Final Decision:** The provider or organization is notified of the CENTIPEDE NCC's Final Decision within sixty (60) days of CENTIPEDE's receipt of the provider or organization's appeal request, unless otherwise mandated by state law. Determinations by the Credentialing Committee after Reconsideration/Appeal are considered final.

SECTION 5: **Updating and/or Changing your Provider File**

Overview: Ensuring that your organizational information is accurate is critical to referrals and reimbursement. Take the time to review the list below on the type of information to update and how to update your organizational information.

Below are the types of changes that should be reported as soon as possible to CENTIPEDE via FAX, email or mail on organizational letterhead or via your online provider file.

***The CENTIPEDE Team cannot change these items via a phone call.

- New Tax Identification Number (with effective date and copy of the W-9 form)
- New or changed services
- New or changed service locations/counties for referrals
- New address
- New telephone or facsimile number
- Additional office location
- Closed location
- New ownership
- Deceased owner or provider
- New copies of Licensure and Insurance Face Sheet
- Change in Licensure (New, Cancelled)
- Change in Quality Certification Status
- Change in liability coverage
- Reported Complaints or Suspension

SECTION 6: **Getting Paid – Reimbursement and Billing**

Overview: Utilize the guidance below for Reimbursement and Billing guidance.



Claims Submission Process: Questions and Answers

Who Pays You and When?

The Patient or Payor will pay you for services directly. CENTIPEDE is NOT a Payor of services.

- Payors and Patients are contracted to pay Providers within 30 days of a “clean” claim.
- A clean claim means a claim requiring no further documentation and is in the correct format.
- The Patient or Payor will always be your source of payment and not CENTIPEDE.

Private Pay/Self Pay:

For Private Pay/Self Pay claims Providers will submit standard billing codes for payment. Payment will occur via Credit Card, electronic check or ACH which has been pre-verified by CENTIPEDE for payment by the patient. Providers will send billings to CENTIPEDE and the Patient; CENTIPEDE will review accuracy of the claim and approve the claim for payments by the patient.

Service estimates and agreements should be uploaded to the member account for documentation and electronic signature.

Payor Claims:

When submitting claims to Payors you may submit claims electronically or use industry standard forms such as a CMS-1500 form or other standard industry forms if paper claims are accepted by the Payor, within ninety (90) days after providing services.

Through your CENTIPEDE provider account you will have access to claims submission capabilities in the event you do not have these capabilities today. If you do have electronic claims capabilities today, you may continue to utilize your current process.

As appropriate, you should utilize the most recent versions of CPT-4 procedure codes (AMA Current Procedural Terminology), HCPCS codes, Revenue codes, DRGs, ICD-9 procedure codes or ICD-9 diagnostic codes.

Please use the address for claims submission listed on the patient's ID card or for self pay submit electronically to CENTIPEDE.

Billed Charges:

Billed charges must be the provider's own published fees in effect for all patients and cannot be an inflated or optimized set of billed charges. *Provider agrees upon request of CENTIPEDE to provide their current and prior "chargemaster" list of billed charges which may be evaluated against other bills for similar patients by the provider.*

Non Listed and Custom Codes:

These are codes that may occur related to custom services and new services without an established procedure code and or established fee.

Discount Off of Materials:

Materials utilized in Home Modifications and other services are not subject to discounting per the Self Pay Fee schedule provided that such materials are not marked up in an attempt to offset the network discount. *In situations including but not limited to suspected fraud and abuse, purchase invoices may be requested.*

Balance Billing:

According to CENTIPEDE's Provider Agreement, patients cannot be billed for the difference between the Provider's normal billed charges and the CENTIPEDE contracted rate.

Check the Explanation of Benefits (EOB) or Explanation of Payment (EOP which may also be referred to as a Remittance Advice RA) sent by the Payor to determine the amount billable to the patient. Any questions regarding the EOB or EOP should first be directed to the Payor. In addition to collecting the co-payment or the co-insurance or deductible amount, Providers may bill for services not covered by the patient's benefit plan if the patient has agreed to pay prior to the non-covered service.

If you have questions, you may contact CENTIPEDE with any questions 1-855-359-5391.

SECTION 7: Processes for Complaint & Dispute Resolution

Overview: CENTIPEDE focuses on a collaborative approach for Complaint and Dispute Resolution. When or if a contractual complaint or disagreement occurs the first step is to reach out to CENTIPEDE and work with us. We will assist you if this involves a Payor or directly from a Self Pay member.

At CENTIPEDE we use a **3 Step Process**: 1) Initial informal discussions with Provider Relations 2) Mediation and 3) Legal Remedies.

- **Step 1:** Call CENTIPEDE at 1-855-359-5391 and we will provide you with assistance.
- **Step 2:** If the issue cannot be resolved informally we will utilize Mediation as our dispute resolution process
- **Step 3:** If informal discussion and Mediation do not result in resolution then your organization or CENTIPEDE may resort to legal remedies.

SECTION 8: Working together on Quality Programs

Overview: Quality is the cornerstone to the success of CENTIPEDE.

Today quality metrics and measures for home and community based services are not standardized and or are lacking.

CENTIPEDE requires that all Participating Providers participate in and cooperate with our Quality Management Program. The CENTIPEDE Quality Management Program is evolving along with the standards in the industry. We ask you to join us in proactively shaping the future.

CENTIPEDE has initiated a provider driven CENTIPEDE Quality Council to assist in creating relevant standards by specialty. As these Quality Standards are being created, CENTIPEDE will bring forth these recommendations and standards for input as part of a provider driven quality process. The CENTIPEDE Quality Council will also be using guidance from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), HEDIS and other relevant quality sources.

More will be shared with you as the CENTIPEDE Quality Program evolves. We recognize the fragmentation and lack of industry standards in Home and Community Based Services and will be striving with our provider partners to assist in creating a relevant and valuable quality program.

Members of the CENTIPEDE Quality Council will be posted on the CENTIPEDE Website and will include representatives from all specialties.

SECTION 9: HIPAA – Understanding Privacy & Security

Overview: CENTIPEDE adheres to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and you as a contracted provider must be aware of and familiar with your responsibilities under HIPAA.

Final Rules have been issued for:

- Electronic data transactions used in the administration of healthcare data
- The privacy of individually identifiable health information
- Unique identifiers for employers
- The security of electronic identifiable health information by health plans, healthcare clearinghouses and certain Providers

What this means is that:

- CENTIPEDE and our Provider Network must secure and ensure member Protected Health Information (PHI) is safeguarded.
- CENTIPEDE and our Provider Network must limit communication about members and the detail regarding their care to a “minimum necessary” basis only.
- CENTIPEDE and our Provider Network will utilize standard health transaction sets and unique identifiers for Providers and employers.

If you as a provider do not have a National Provider Identifier (NPI), you are encouraged to apply for an NPI and share this number CENTIPEDE. An NPI is free and is issued by the National Plan and Provider Enumeration System (NPPES) <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

HIPAA Education:

CENTIPEDE will post links for HIPAA Education and Training on our website, please utilize as needed for staff training.

SECTION 10: Frequently Asked Questions

Overview: Below are several Frequently Asked Questions and where you can locate the answer in the Provider Manual.

How will we be paid?

The Patient or Payor will pay you for services directly. CENTIPEDE is NOT a Payor of services. More detail is available in SECTION 6.

What is the fee schedule?

The fee schedule is based upon the type of services by Payor. Methodologies are consistent with current methodologies for simplicity.

Medicaid is reimbursed according to current Medicaid reimbursement and methodology by state.

Medicare and Commercial are reimbursed according to current Medicare reimbursement methodology and regional reimbursement schedules based upon where the service is provided.

Self Pay/Private Pay is reimbursed on a discount off of your organization’s billed charges.

What if we have an existing contract with a Payor?

When you have a direct contract with a Payor, the direct contract with the Payor prevails.

How will you help me “grow” the pie (my business)?

CENTIPEDE helps you grow your business by creating new business opportunities through relationships with Payors and through the creation of new programs and services that you may participate within. We believe that the services you provide are the key to helping people live their best lives at home and we are looking for ways to bring in new business for you through the network.

Also CENTIPEDE will be working with our providers on best business and quality practices. Our team is additionally negotiating business support services with large buying power to bring down your costs on a variety of services from clinical and business supplies to marketing and support services.

How will referrals work?

Referrals will be sent to you by one of three sources 1) the CENTIPEDE Care Advisor 2) the Payor Care Manager or the 3) the Patient or Caregiver.

GROWING the PIE: How CENTIPEDE Referrals Are Sent to Providers

SELF PAY-PRIVATE PAY → →

Self Pay-Private Pay members and families access services through a CENTIPEDE CARE ADVISOR or on their own via the Provider Directory.

REFERRALS: CENTIPEDE

Referrals will come via phone, fax or email from the CENTIPEDE CARE ADVISOR.



REFERRALS: MEMBER

Members and Caregivers may also call you directly.



PAYORS → →

Other Payors may send authorize referrals through one of the following:

- * PAYOR CARE MANAGER
- * CENTIPEDE CARE ADVISOR
- * PROVIDER DIRECTORY for Members.

REFERRALS: CENTIPEDE or PAYOR

Referrals will come via phone, fax or email from the PAYOR CARE MANAGER or CENTIPEDE CARE ADVISOR.



REFERRALS: MEMBER

Members and Caregivers may also call you directly.



How will I know if a patient is part of the CENTIPEDE Health Network?

CENTIPEDE Members will be issued electronic ID cards by CENTIPEDE for SELF PAY (Private Pay) Memberships and Payors will include the CENTIPEDE logo on the back of their cards.

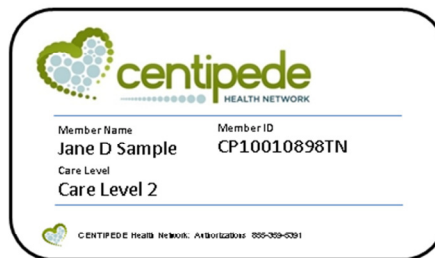
See below for a sample of the ID Cards. Note each Payor has their own design, so look for CENTIPEDE service marks or name on the back of a card. The CENTIPEDE heart is your mark of excellence!



Q: How will I identify SELF PAY (Private Pay) CENTIPEDE Members?

A: All CENTIPEDE Self Pay members will be issued an electronic ID card and their membership information will be on file for 24/7 validation.

SAMPLE CENTIPEDE ID Card



Q: How will I identify a member on a Payor ID Card?

A: Look for the CENTIPEDE Logo on the back of the member's card.

SAMPLE PAYOR ID Card: Look at Back of Card

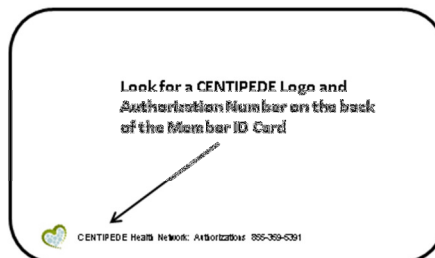


Exhibit A: Resources and Links

Overview: Below are key resources and links.

CARF (Commission on Accreditation of Rehabilitation Facilities): <http://www.carf.org/home/>

Founded in 1966 as the Commission on Accreditation of Rehabilitation Facilities, CARF International is an independent, nonprofit accreditor of health and human services in the following areas:

Aging Services, Behavioral Health (Opioid Treatment Programs), Business and Services Management Networks, Child and Youth Services, Employment and Community Services, Vision Rehabilitation, Medical Rehabilitation, DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies).

The CARF family of organizations currently accredits more than 50,000 programs and services at 23,000 locations. More than 8 million persons of all ages are served annually by 6,700 CARF-accredited service Providers. CARF accreditation extends to countries in North and South America, Europe, Asia, and Africa.

CHAP (Community Health Accreditation Program): <http://www.chapinc.org/>

CHAP is an independent, nonprofit, accrediting body for community-based health care organizations, which accredits nine programs and services. As the oldest national community-based accrediting body with more than 8,300 sites currently accredited, our purpose is to define and advance the highest quality of community-based care.

Through “deeming authority” granted by the Centers for Medicare and Medicaid Services (CMS), CHAP has the regulatory authority to survey agencies providing home health, hospice and home medical equipment services to determine if they meet the Medicare Conditions of Participation and CMS Quality Standards.

CMS (The Centers for Medicare & Medicaid Services): <http://www.cms.gov/>

The Centers for Medicare & Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments, and oversight of HealthCare.gov.

JCAHO (Joint Commission on Accreditation of Healthcare Organizations): <http://www.jointcommission.org/>

An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 20,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

N4A (National Association of Area Agencies on Aging): <http://www.n4a.org/>

The National Association of Area Agencies on Aging (n4a) is the leading voice on aging issues for Area Agencies on Aging and a champion for Title VI Native American aging programs. Through advocacy, training and technical assistance, N4A supports the national network of 618 AAAs and 246 Title VI programs.

NASUAD (National Association of States United for Aging and Disabilities): <http://www.nasuad.org/>

The National Association of States United for Aging and Disabilities (NASUAD) was founded in 1964 under the name National Association of State Units on Aging (NASUA). In 2010, the organization changed its name to NASUAD in an effort to formally recognize the work that the state agencies were undertaking in the field of disability policy and advocacy. Today, NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community based services for older adults and individuals with disabilities.

NCQA (National Committee for Quality Assurance): www.ncqa.org/

The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. The NCQA seal is a widely recognized symbol of quality. Organizations incorporating the seal into advertising and marketing materials must first pass a rigorous, comprehensive review and must annually report on their performance.

NCQA's programs and services reflect a straightforward formula for improvement: Measure. Analyze. Improve. Repeat. NCQA makes this process possible in health care by developing quality standards and performance measures for a broad range of health care entities.

OIG (Office of Inspector General): <http://oig.hhs.gov/>

The Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries. The OIG publishes an excluded provider list that CENTIPEDE and other organization's monitor related to Providers that are excluded from participating in the Medicare and Medicaid Programs.

HHS OIG is the largest inspector general's office in the Federal Government, with approximately 1,600 dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs. A majority of OIG's resources goes toward the oversight of Medicare and Medicaid — programs that represent a significant part of the Federal budget and that affect this country's most vulnerable citizens. OIG's oversight extends to programs under other HHS institutions, including the Centers for Disease Control and Prevention, National Institutes of Health, and the Food and Drug Administration.