Government Business Division
Policies and Procedures

Section (Primary Department) **Operations/Provider Solutions**	**SUBJECT (Document Title)** **Network Provider Credentialing and Re-Credentialing Policy - Healthy Blue**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
11/1/2019	11/20/2019	12/26/2019	10/9/2019
Department Approval/Signature : Lisa Thomas, Dir. II Medicaid Ops			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products	**Market**
☒ **Medicaid**	☒ **North Carolina**

PURPOSE

To establish a policy ("Policy") outlining the Medicaid Provider Enrollment file process utilized by the Prepaid Health Plan ("Medicaid Provider Enrollment File"), as required pursuant to the State of North Carolina Department of Health and Human Services, Division of Health Benefits, Revised and Restated for Proposal #: 30-190029-DHB, Prepaid Health Plan Services ("State Contract") to determine whether to allow a Provider to be included in the Blue Cross Blue Shield of North Carolina ("BCBS NC") network.

DEFINITIONS

Healthy Blue: The Medicaid product name being offered by BCBS NC.

Health Delivery Organization (HDO): Means a facility, institution or entity that is licensed, in accordance with all applicable state and/or federal laws, that provides or delivers health care services.

North Carolina Health Choice ("NC Health Choice"): The Health Insurance Program for Children authorized by N.C. Gen. Stat. § 108A-70.25 and as set forth in the North Carolina State Plan of the Health Insurance Program for Children.

Prepaid Health Plan ("PHP"): Has the same meaning as Prepaid Health Plan, as defined in North Carolina Session Law 2015-245: The Medicaid Transformation and Reorganization Act enacted on September 23, 2015, authorizing the transition of the North Carolina Medicaid and NC Health Choice Fee-for-Service programs to a Medicaid Managed Care delivery system Section 4. (2) of Session Law 2015-245, as amended by Session Law 2018-48. A PHP is a Managed Care Organization ("MCO"). As used in this Policy, PHP shall mean BCBS NC.

Provider: An individual person who is licensed or certified (as applicable) in accordance with all applicable state and federal laws to deliver health care services or any licensed or certified (as

applicable) person or institution that provides health care services, including practitioners and HDOs.

State: Means the State of North Carolina.

The Department: State of North Carolina, Department of Health and Human Services ("DHHS") that oversees the Medicaid Prepaid Health Plan Services contract.

Any capitalized terms that are not included in this Definitions section shall have the meaning set forth in the State Contract.

SCOPE

This Policy applies to all types of Providers, including but not limited to acute, primary, behavioral health, substance use disorders, and long-term services and support. Healthy Blue will rely on the enrollment/credentialing of the Department as indicated on the Medicaid Provider Enrollment File.

PROCEDURES

Initial Enrollment

Each Provider must first enroll with the Department's Medicaid and NC Health Choice programs. The Department will ensure that the applicants meet all program requirements and qualifications:

Based on state and federal requirements:

- Federal and state application fee
- Training
- Fingerprinting
- Site visits
- Criminal background checks
- Federal database checks
- Verification of provider certification, license and accreditation

PHP's role and responsibility:

- Accept the Medicaid Provider Enrollment File enrollment effective date provided by the Department when a NC Medicaid/NC Health Choice Provider is active in the NC Medicaid program.

- May collect other information for contracting purposes only. See Appendix A to this Policy for information that may be requested from Providers for contracting purposes only.
- Shall not request any additional credentialing information from a Provider without the Department's written prior approval.
- Shall not be permitted to delegate any part of the centralized credentialing approach to a Provider entity during the credentialing transition period.
- Shall not solicit or accept provider credentialing or verified information from any other source except as permitted by the Department.
- The PHP may execute a network provider contract, pending the outcome of Department screening, enrollment, and revalidation, of up to one hundred twenty (120) days, but must terminate a network Provider immediately upon notification from the State that the network Provider cannot be enrolled, or the expiration of one (1) one hundred twenty (120) day period without enrollment of the Provider, and notify affected members. 42 C.F.R. § 438.602(b)(2).
- The PHP shall meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing and network contracting process.

Nondiscrimination Statement

BCBS NC will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, BCBS NC will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the contracting process. Decisions are based on issues of professional conduct and competence as reported and verified through the contracting process.

BCBS NC policies and processes will not discriminate against any Provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification with regards to participation, reimbursement or indemnification.

The PHP will accept provider credentialing and verified information from the Department and will not request any additional credentialing information without the Department's approval. The PHP will be able to demonstrate that its network providers are credentialed in accordance with 42 C.F.R. § 438.206(b)(6) by review of policy, process, accreditation status and file review.

Disclosure Requirement
The PHP is prohibited from using, disclosing or sharing provider enrollment/credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the Provider and the Department.

Policy Publication
PHP will publish its approved policy, including all previous versions, on the PHP's website and include the effective date of each policy.

Recredentialing Timelines
All applicable Providers in the BCBS NC network within the scope of the BCBS NC credentialing program are required to be recredentialed every three (3) years unless otherwise required by the State Contract or State regulations.

BCBS NC shall re-credential Providers as follows:

1. During the provider credentialing transition period, no less frequently than every five (5) years.
2. After the provider credentialing transition period, no less frequently than every three (3) years.

Provider Disenrollment and Termination
Payment Suspension at Re-Credentialing:

1. The PHP will suspend claims payment to any Provider for dates of services after the effective date provided by the Department in its network within one (1) business day of receipt of a notice from the Department that provider payment has been suspended for failing to submit re-credentialing documentation to the Department or otherwise failing to meet Department requirements.
2. The PHP will reinstate payment to the Provider upon notice that the Department has received the requested information from the Provider. If the Provider does not provide the information with fifty (50) days of suspension, the Department will terminate the Provider from Medicaid.
3. The PHP is not liable for interest or penalties for payment suspension at recredentialing.

Termination as a Medicaid Provider by the Department:

1. The PHP will remove any Provider from the PHP network, claims payment system, and terminate its contract consistent with the effective date provided by the Department with the Provider within one (1) business day of receipt of a notice from the Department

that the Provider is terminated as a Medicaid Provider. This applies to all Providers regardless of the Provider's network status.

2. If the PHP suspended the provider payment, then upon notice by the Department that the Provider is terminated from Medicaid, the PHP will release applicable claims and deny payment.

PHP Provider Termination:

1. The PHP may terminate a Provider from its network with cause. Any decision to terminate will comply with the requirements of the State Contract.
2. The PHP will comply with the Program Integrity Provider Termination Requirements outlined in Section V.J.2. Program Integrity of the State Contract.
3. The PHP will provide written notice to the Provider of the decision to terminate the Provider. At a minimum, the notice will include:
   a. The reason for the PHP's decision;
   b. The effective date of termination;
   c. The Provider's right to appeal the decision; and
   d. How to request an appeal.
4. The PHP will report data to the Department on the number of Providers terminated by provider type in a format dictated by the Department for the Network Access Report identified in Section VII. First Restated and Revised Attachment J. Table 1: Reporting Requirements of the State Contract.

Process Requirements:

1. The PHP will have a method of allowing Providers to submit appeals through the PHP provider portal.
2. The PHP will accept a written request for an appeal from the Provider within thirty (30) calendar days from the date on which:
   a. Provider receives written notice from the PHP of the decision giving rise to the right to appeal; or
   b. PHP should have taken a required action and failed to take such actions.
3. The PHP will acknowledge receipt of each appeal request within five (5) calendar days of receipt of the request.
4. The PHP will extend the timeframe by thirty (30) calendar days for Providers to request an appeal for good-cause shown as determined by the PHP.
   a. PHP will document in its grievance and appeal policy the policy and procedure for extending the timeframe for submission of an appeal request.

b. PHP will include voluminous nature of required evidence/supporting documentation, and appeal of an adverse quality decision as good-cause reasons to extend the timeframe.

5. The PHP will provide information regarding provider appeals to Department upon request.

Resolution of Appeal:

1. The PHP will establish a committee to review and make decisions on provider appeals. The committee will consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal
2. The PHP will provide written notice of decision of the appeal within thirty (30) calendar days of receiving a complete appeal request, or if an extension is granted to the Provider to submit additional evidence, the date on which all the evidence is submitted to the PHP.

REFERENCES

Revised and Restated Request for Proposal #: 30-190029-DHB – Sections V.D.2.g; V.D.2.i-j; V.D.2.i.iv; V.D.5.

RESPONSIBLE DEPARTMENTS

Primary Department- Operations; Provider Solutions

EXCEPTIONS

The PHP will submit this Policy to the Department for review and approval thirty (30) days after award of the State Contract.

Appendix A

Information collected from the provider for contracting purposes to support claim payment, directories, and data management.

Additional Contracting Data
Office:
Provider's Office Handicap Accessibility Status
Provider's Office Hours
Provider's Website
Fax Number of Service Address
Provider 24 Hours status
After Hours Telephone Number

Financial:
Tax (W9) Name
Tax (W9) Address
Remittance Address
Practitioner:
PCP or Specialist Status
Is the provider accepting new patients?
Identification of any member age restrictions
Provider's Hospital Affiliations and or Admitting Privileges
Languages spoken by the provider and office staff other than English
Has provider completed Cultural Competency training?

REVISION HISTORY

Review Date	Changes
4/18/2019	*New, revised as requested by State*
10/9/2019	*Revised and approved by State*