Section (Primary Department) **Provider Services Organization**	**SUBJECT (Document Title)** **Healthy Blue Good Faith Contracting - NC**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
02/04/2019	05/07/21	05/07/2021	05/11/21
Department Approval/Signature:			

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

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

POLICY:

This policy applies to activities executed by the health plan and their subcontracted vendors related to network development activities for the Healthy Blue Network under North Carolina's Medicaid Managed Care Program, effective July 1, 2021.

Healthy Blue is a Medicaid plan offered by Blue Cross and Blue Shield of North Carolina ("Blue Cross NC"). Certain administrative services for Healthy Blue are provided by Amerigroup Partnership Plan, LLC. ("Amerigroup") pursuant to a strategic alliance with Blue Cross NC. Blue Cross NC and/or Amerigroup are hereinafter referred to as Health Plan.

DEFINITIONS:

Prepaid Health Plan (PHP) - A PHP is a Managed Care Organization (MCO).

Indian Health Care Provider (IHCP) - An IHCP as defined by 42 C.F.R. § 438.14(a)

Provider - Individual practitioners and facilities, entities, organizations, atypical organizations/providers, and institutions, including Essential Providers and IHCPs, unless otherwise noted.

Advanced Medical Home (AMH) - Refers to an initiative under which PHPs delegate care management responsibilities and functions to State-designated AMH practices to provide local care management services.

Primary Care Physician (PCP) - The participating physician, physician extender (e.g., physician assistant, nurse practitioner, certified nurse midwife), or group practice/center selected by or assigned to the Member to provide and coordinate all the Member's health care needs and to initiate and monitor referrals for specialized services, when required.

Salesforce - The health plan provider relationship management system

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PROCEDURE:

1. The health plan will offer to contract with a provider in writing and will consider all facts and circumstances surrounding a Provider's willingness to contract before determining that the Provider has refused the health plan's "good faith" contracting effort.
2. The health plan will follow Department guidance during the Provider Credentialing Transition Period and utilize the Medicaid enrolled provider information gathered by the Department for network contracting purposes.
3. The health plan will accept provider credentialing and verified information from the Department, or designated Department vendor, and shall not request any additional credentialing information from a provider without the Department's written prior approval. We may collect other information from providers as necessary for the contracting process.
4. The health plan will make timely network contracting decisions using the process outlined in the Credentialing and Re-credentialing Policy
5. The health plan shall not solicit or accept provider credentialing or verified information from any source other than the Department, or designated Department vendor, except as expressly permitted by the Department in Section V.D. Providers.
    a. The health plan is prohibited from using, disclosing, or sharing provider credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the Department.
    b. During the Provider Credentialing Transition Period, as a provider is re-credentialed through the Provider Enrollment process, the health plan shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. The health plan's process shall occur no less frequently than every five (5) years consistent with the Department policy and procedure.
    c. After the Provider Credentialing Transition Period, the health plan shall evaluate a contracted provider's continued eligibility for contracting by confirming the appearance of the provider on the daily Provider Enrollment File. The health plan's process shall occur every three (3) years consistent with Department policy and procedure, unless otherwise notified by the Department.
6. The health plan will reimburse out-of-network Providers who provide services to a Member in accordance with the Transition of Care requirements of the North Carolina's Medicaid Managed Care Program at 100% of the Medicaid Fee-for-Service rate.
7. The health plan will reimburse an out-of-network Provider who is not excluded for quality reasons or refused a "good faith" contract at either 90 or 100 percent as follows:

Situations in which the health plan will pay no more than 90% of FFS to OON providers

- A "good faith" effort to contract with a provider was made, but the provider has refused that contract
- The provider was excluded from our network for failure to meet objective quality standards

Situations in which the health plan will pay 100% of FFS to OON providers

- The provider has not been offered a contract or is still engaged in good faith negotiations
- All family planning providers
- Out of state providers that deliver emergency and post-stabilization services
- In state providers that deliver emergency and post-stabilization services
- OON providers will receive 100% of Medicaid reimbursement during transition in coverage, ninety (90) days after-go-live

8. The provider will have (30) calendar days to accept the contract. The 30-day period begins upon provider's receipt of a version of the contract which is consistent with that approved by the Department. If within thirty (30) calendar days the potential network provider rejects the request or fails to respond either verbally or in writing, the health plan may consider the request for inclusion in the Medicaid Managed Care Provider Network rejected by the provider. If discussions are ongoing, or the contract is under legal review, the health plan will not consider the request rejected.
9. The health plan will not require individual practitioners, as a condition of contracting with us, to agree to participate or accept other products offered by the health plan nor will we automatically enroll the provider in any other product offered by the health plan. This requirement will not apply to facility providers.
10. All offers will include the standard provisions for provider contracts found in Attachment G. Required Standard Provisions of PHP and Provider Contracts, including the prescribed provisions located therein.

Contracting and Negotiating in Good Faith

The Network will meet availability, accessibility, and quality goals and requirements. In developing the Network, we will negotiate with any willing Provider in good faith regardless of Provider or our affiliation. The health plan or subcontractor to the extent that the subcontractor is delegated responsibility by the health plan for coverage of services and payment of claims under the Contract, will not include exclusivity or non-compete provisions in contracts with providers, including non-medical service providers (e.g. non-emergency medical transportation

drivers), require a provider to participate in the governance of a PLE, or otherwise prohibit a provider from providing services for or contracting with any other PHP.

The health plan has a strong monitoring program that ensures Providers meet Members' needs and program requirements.

The health plan will perform ongoing activities to recruit new Providers including Behavioral Health Providers to retain Providers currently participating in our Provider Network. The health plan will not enact any recruitment or retention activity that is or could potentially be discriminatory of Providers that serve high-risk populations or specialize in complex conditions that require costly treatment. The health plan will not discourage its Network Providers from contracting with other Managed Care Organizations.

The health plan will conduct a good faith effort to contract with North Carolina or contiguous county Providers, who are enrolled Medicaid Providers within the state of North Carolina, using contract mailing, ongoing negotiations, and continuing communications with the Providers to receive a completed Network agreement. If the Provider chooses not to contract or does not meet the qualifications to participate in the Network, all communications are documented in Salesforce.

Ongoing Responsibilities

- The health plan will maintain a Provider relations department committed to maintaining and improving the Network through recruitment, contracting, and servicing licensed, board-certified or board-eligible Providers.
- Provider relations continuously monitors the Network to identify any opportunities to improve network access.
    - Data points including geo access, Member complaints, single case agreements, and competitor data are used to identify Network needs.
    - Provider relations focuses its recruitment efforts on specialties and geographies where Member choice or access needs improvement.
- Provider relations retains the Network through a multifaceted approach, including:
    - Servicing Providers' issues,
    - Offering competitive and attractive collaboration opportunities,
    - Responding to annual Provider satisfaction surveys, and
    - Reviewing Provider termination data to identify and address any trends in reasons for termination.

Tribal Member Services and Indian Health Care Providers

Indian means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual:

- Is a member of a Federally recognized Indian tribe;
- Resides in an urban center and meets one or more of the four criteria:
    - Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
    - Is an Eskimo or Aleut or other Alaska Native;
    - Is considered by the Secretary of the Interior to be an Indian for any purpose; or
    - Is determined to be an Indian under regulations issued by the Secretary of Health and Human Services;
    - Is considered by the Secretary of the Interior to be an Indian for any purpose; or Indian Healthcare Provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

The health plan will:

- Demonstrate that there are sufficient IHCPs that are Network Providers to ensure timely access to services available under the Contract from such Providers for tribal populations who are eligible to receive services.
    - Pay IHCPs, whether participating or not, for covered services provided to Indian members who are eligible to receive services without prior authorization or referral from a contract provider as follows:
        - At a rate negotiated between Healthy Blue and the IHCP; or
        - In the absence of a negotiated rate, at a rate not less than the level and amount of payment that Healthy Blue would make for the services to a Network Provider which is not an IHCP; and
        - Pay claims from the IHCP in accordance Section 1932(h)(2) of the Act and 42 C.F.R. §§ 438.14(c)(2) and 457.1209, and pay at either the rate provided under the State plan in a Fee-for-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.
    - Make prompt payment to all in-network IHCPs in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. §§ 447.45 and 447.46.

- Permit any Indian member to receive services from an IHCP PCP participating as a Network Provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services.
- Permit Indian members to obtain services covered under the Contract from out-of- network IHCPs from whom the member is otherwise eligible to receive such services.
- If at any point in time access to covered services cannot be ensured in the Agency due to few or no IHCPs, Contractor will be considered to have met the requirement in paragraph 1) of this section if:
  - Indian members are permitted by Healthy Blue to access out-of-state and/or out-of-network IHCPs; or
  - Healthy Blue must permit an out-of-state and/or out-of-network IHCP to refer an Indian member to a Network Provider.

Monitoring

The health plan's Chief Network Officer will conduct random audits of Provider records in Salesforce to validate compliance with the Good Faith Provider Contracting Policy.

Procedures

The health plan's provider relations department will make reasonable attempts to contract in good faith with any out-of-network Providers rendering ongoing care to an enrolled Member. When the out-of-network Provider is serving as a Member's PCP, the provider relations department contacts the Provider and encourages them to join the Network.

The health plan will make a minimum of three attempts (or any number required by state) at outreach to Providers to solicit their Network participation. The provider will have (30) calendar days to respond with their intent to join the network either verbally or in writing. During the 30 days, three outreach attempts will be telephonic and/or electronic and attempts will be tracked in salesforce which includes task and reminders to ensure all three attempts have been made. This procedure applies to all Provider types in North Carolina and those Providers in contiguous counties needed to meet the adequacy needs of North Carolina Members. The health plan will give written notice to any provider with whom we decline to contract within five (5) business days after our final decision. The notice will include the reason for the decision, the Provider's right to appeal that decision, and how to request an appeal.

Please note: If discussions are ongoing, or the contract is under legal review, the health plan will not consider the request rejected.

We will submit the Good Faith Contracting policy to the Department for review 90 days after Contract Award.

REFERENCES:

Blue Cross NC Provider Network Contract
The Blue Book℠ Provider Manual
Revised and Restated RFP 30-190029-DHB – Section V.D.4.r.ii
Provider Transition of Care Policy

RESPONSIBLE DEPARTMENTS:

Primary Department: Provider Services Organization

Secondary Department(s): Healthy Blue Network Development

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
4/1/2019	• New Policy created
6/5/2019	• Revised per state review
7/30/2019	• Revised per state review
8/15/2019	• Revised per state review
5/7/2021	• Revised per Amendment #3