BlueCross BlueShield of North Carolina | HealthyBlue

Section (Primary Department) Provider Solutions, Credentialing	SUBJECT (Document Title) Provider Credentialing and Re-credentialing Process - Healthy Blue

Effective Date	Date of Last Review	Date of Last Revision	Dept. Approval Date
11/1/2019	10/9/2019	10/9/2019	10/9/2019
Department Approval/Signature :			

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 Centralized Provider Enrollment and Credentialing process utilized by the Prepaid Health Plan, 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 using objective quality standards in making a Quality Determination, subject to certain Department requirements.

DEFINITIONS

Centralized Credentialing and Re-credentialing Process ("CCRP"): Processes implemented by the Department with a designated vendor who will collect information and verify credentials, through a centralized credentialing process for all Providers currently enrolled or seeking to enroll in the State Medicaid program. The information will be collected, verified, and maintained as required to participate in the Medicaid program. The process and information requirements will meet the most current data and processing standards for a credentialing process for an accredited health plan with accreditation from the selected, nationally recognized accrediting organization, and shall also meet the standards found in 42 C.F.R. Part 455 Subparts B and E. The Department has selected the National Committee for Quality Assurance as the Plan accrediting organization. Providers will use a single, electronic application to submit information to be verified and screened to become a Medicaid enrolled Provider, with the application serving for enrollment as a Medicaid fee-for-service Provider as well as a Medicaid managed care Provider.

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

Health Delivery Organziation (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.

Healthy Blue is a Medicaid plan offered by Blue Cross and Blue Shield of North Carolina. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association. ® Marks of the Blue Cross and Blue Shield Association.
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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.

Provider Data Contractor (PDC): The vendor contracted with the Department to supplement the Department's existing provider enrollment and credentialing data to support the PHP's ability to make Quality Determinations during the provider Medicaid Managed Care network contracting activities.

Provider Network Participation Committee: The committee responsible for determining whether a Provider has met objective quality standards.

Quality Determination: A PHP's decision, made by its quality Provider Network Participation Committee in accordance with its provider retention and selection policies, as to whether a Provider has met objective quality standards. Making a Quality Determination is one step in the contracting process between the Provider and the PHP.

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.

PROCEDURES

State Contract Credentialing Requirements:
Please note: PHP acknowledges that compliance with the following State Contract Credentialing Requirements is in accordance with Section V.D. Providers 2. Provider Network Management g.

Credentialing and Re-credentialing Process of the State Contract as amended per Amendment Number 1 to the State Contract.

Initial Enrollment/Credentialing

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

The Department will contract with a PDC to supplement the existing provider enrollment and credentialing data to support the PHP ability to make Quality Determinations during the provider Medicaid Managed Care network contracting activities.

Through the uniform credentialing process, the Department will screen and enroll, and periodically revalidate all PHP network providers as Medicaid providers. 42 C.F.R. § 438.602(b)(1).

PDC's role and responsibility:

- Obtain the primary source-verified credentialing data for NC Medicaid and NC Health Choice enrolled Providers.
- Not permit outreach to Providers to update the provider information. Providers are encouraged to keep their credentialing file up to date with NCTracks.
- Ensure that the PHP has access to information from a credentialing process that is held to consistent, current standards. Publish the NC Medicaid credentialed file in a secure FTP site daily or make available through a PDC platform where the PHP and the Department will access and download the file.

PHP's role and responsibility:

- Accept verified information from the PDC; is not permitted to require additional credentialing information from a Provider to make their Quality Determination.
- May collect other information, but information cannot be used for Quality Determinations. 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.

The Department or its designee will primary source verify the following data on individual Providers when available without outreach to the Provider:

- Current license
- Current DEA/CDS certification
- Current board certification status
- Highest level of education and training

Last five (5) years of:

- State licensing board sanctions
- Medicare/Medicaid sanctions
- Malpractice history
- Work history including gaps

The Department or its designee will primary source verify the following data on facility Providers with accrediting bodies when available without outreach to the Provider:

- Liability insurance
- Evidence of accreditation from the Joint Commission or other appropriate accrediting body.

The Department or its designee will primary source verify the following data on facility Providers without accrediting bodies when available without outreach to the Provider:

- Information on quality management program
- Reports on disciplinary action from the last five (5) years
- Letters of recommendation attesting to quality or cost effectiveness of care.
- Documented policies for coverage arrangements or onsite quality assessment on the quality management program.

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.
PHP will make a Quality Determination based solely upon the credentialing information provided by the Department.

1. PHP will not require a Provider to submit any additional information to be used in the Quality Determination.
2. PHP will follow this Policy when making a Quality Determination and contracting decision for in-state, border (i.e., Providers that reside within forty (40) miles of the North Carolina state line), and out-of-state network Providers.
3. PHP will have discretion to make Quality Determinations consistent with this Policy.

If an adverse finding is noted on the NC Medicaid credentialed file ("PDC File"), the source for that adverse finding may be queried to supplement the PDC File data for the Quality Determination process.

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.

Criteria for Selecting and Maintaining Practitioners' Credentialing Status
This information may be identified either from the PDC File or as a result of an adverse event or as a result of ongoing monitoring. Outreach for this information will not be made to the Provider.

A. New Applicants (Credentialing)
    1. Must possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Healthy Blue members, unless:
        a. The applicant's licensure action was related to substance abuse, physical impairment or mental illness and the applicant demonstrated a minimum of two (2) years of successful participation in a treatment and/or monitoring program

with no evidence of recidivism, recurrence or relapse since the institution of the treatment/monitoring.

2. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or Federal Employee Health Benefit Program; and
3. Malpractice judgements and settlements history will be reviewed:
   Providers with **one (1) or more** of the following malpractice case history will be individually reviewed and considered by the Provider Network Participation Committee:
   - Any case in which a settlement or award greater than or equal to $100,000 was made AND death was the patient outcome; or
   - Two (2) cases each of which had a settlement or award equal to or greater than $300,000; or
   - Any case history of unusual concern – example: one pended case where practitioner removed the wrong organ or operated on the wrong limb.

B. Currently Participating Applicants (Recredentialing)
   1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a Provider participates in BCBS NC's programs or provider network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the Provider will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as BCBS NC's other credentialed provider network(s);
   2. Must possess a current, valid license to practice in each state in which the practitioner provides care to PHP members; and
   3. The Provider's malpractice case history will be reviewed following the approval cycle. If no new cases are identified since the last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.

Facility (HDOs) Eligibility Criteria

A. General Criteria for Facilities:
   1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP.

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.

Ongoing Sanction Monitoring
To support certain credentialing standards between the recredentialing cycles, BCBS NC has established an ongoing monitoring program. The PHP performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the PHP will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General ("OIG")
2. Federal Medicare/Medicaid reports
2. State licensing boards/agencies
3. Any other information received from sources deemed reliable by the PHP

When a Provider within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Provider Network Participation Committee
Providers who meet all Objective Quality Standards for initial or continued participation (including off-cycle review) and whose credentials have been satisfactorily verified by the PDC may be approved by the Healthy Blue Medical Director.

Processing Timeframes
The PHP will make Quality Determinations within the following timeframes:
1. For ninety percent (90%) of Providers within thirty (30) calendar days of the Provider Network Participation Committee's receipt of complete credentialing and verified information for consideration; and
2. For one hundred percent (100%) of Providers within forty-five (45) calendar days of the Provider Network Participation Committee's receipt of complete credentialing and verified information for consideration.

The PHP will provide written notice of Quality Determinations to providers within five (5) business days of the Provider Network Participation Committee's determination.

Provider Disenrollment and Termination
<u>Payment Suspension at Re-Credentialing:</u>
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.

Appeals Process

For Network Providers:

A network Provider has the right to appeal certain actions taken by the PHP. Appeals to the PHP will be available to a network Provider for the following reason:

1. Termination of, or determination not to renew, an existing contract based solely on the PHP's Objective Quality Standards.

For Out-of-Network Providers:

An out-of-network Provider may appeal certain actions taken by the PHP. Appeals to the PHP will be available to an out-of-network Provider for the following reason:

1. A determination to not initially credential and contract with a Provider based on the PHP's Objective Quality Standards.

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. The committee will include an external peer reviewer when the issue on appeal involves whether the Provider met Objective Quality Standards.
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- Provider Solutions; Credentialing

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*