
Facility Credentialing Policy

Purpose

Blue Cross and Blue Shield of Vermont (Blue Cross VT or Plan) requires hospitals, home health agencies, skilled nursing facilities, freestanding surgical centers, freestanding renal dialysis centers, designated agencies, freestanding birthing centers, portable X-ray suppliers and behavioral health care facilities (providing mental health or substance use disorder (MHSUD) services in inpatient, residential and facility based outpatient settings) meet the Plan's requirements for performance and delivery of high quality clinical care and service.

Scope

Eligible facilities requesting participation in the Blue Cross VT or Plan network must complete the facility credentialing application and meet the Plan's criteria for participation as set out in Exhibit A before entering into a contractual relationship with the Plan. At least every three years after the initial approval for participation, the Blue Cross VT or Plan credentialing verification committee formally reviews the credentials of the facility and makes decisions about continued participation in the Blue Cross VT or Plan network. The committee includes licensed providers and the Plan's medical director. Between recredentialing cycles, the Plan monitors sanctions, member complaints about the facilities, and quality issues. The committee takes appropriate action against facilities when it identifies occurrences of poor quality. Except as otherwise provided by law, Blue Cross VT or Plan confidentially maintains all information obtained in the credentialing process. Facilities may obtain a copy of this policy at any time at www.bluecrossvt.org.

Regulatory/Accreditation Links

2024 NCQA HPA Standards and Guidelines/Elements: CR 1-7

State of Vermont Rule H-2009-03 Standards: 5.2A – 5.2J

18 V.S.A. § 9408a

Vermont Agency of Human Services Department of Mental Health: *Designated Agency Provider Manual*
Medicare Managed Care Manual, Chapter 6 (Medicare Advantage)

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Last Approved: 12/2023 Accreditation Team

Department: Network Management, Quality Improvement

Reference: S:\P_REIM\Enrollment Information\Active Credentialing Info\Policies\Professional Credentialing Policy


Policy Links:

BCBSVT Practitioner Credentialing Policy

BCBSVT Ancillary Provider Enrollment Policy

BCBSVT Quality of Care Risk Investigations Policy

BCBSVT Provider Appeals from Adverse Contract Actions and Related Reporting Policy
BCBSVT Delegation and Oversight Policy


Signature: Tom Weigel, MD (Nov 30, 2023 14:39 EST)
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Policy

I. Eligibility

Facility applicants must provide evidence of the following information to be considered for network participation:

- A. An active, unencumbered state license to operate; AND
- B. Certificate of current malpractice insurance coverage with a minimum of \$1 million per occurrence and \$3 million in the aggregate, or evidence of federal or state tort immunity; AND
- C. A CMS or state survey less than three years old at the time of application. The report from the institution must show evidence of substantial compliance or an acceptable corrective action plan with current state regulatory requirements; OR;
- D. Accreditation by one of the following accrediting bodies¹:

Facility Type	Acceptable Accrediting Bodies
Hospital	TJC, HFAP, DNV, CMS Critical Access Hospital Designation
Home Health Agency	TJC, CHAP
Skilled Nursing Facility	CHAP
Ambulatory Surgical Center	TJC, AAAHC
Behavioral Health Care Facility	TJC, HFAP, CARF, COA, AAAHC
Renal Dialysis Center	CMS and TJC, AAAHC
Designated Agency	The Plan will credential designated agencies that are in good standing with the state as demonstrated by meeting the Agency Designation requirements set forth by the Department of Developmental and Mental Health Services.
Freestanding Birthing Center	TJC, AAAHC, CMS Critical Access Hospital Designation, CABC
Portable X-ray	The Plan will credential Portable X-ray suppliers that show evidence of substantial compliance or an acceptable corrective action plan with the current state regulatory requirements.

¹ This list of accrediting bodies is not exhaustive. To the extent an applicant is accredited by an entity not listed in this policy, Plan will consider approving the accreditation of that entity on a case-by-case basis. If an entity has both proof of accreditation and proof of a CMS/state survey, proof of accreditation is preferred.

*AAAH: Accreditation Association for Ambulatory Health Care
*TJC: The Joint Commission
* HFAP: Healthcare Facilities Accreditation Program
* DNV: Det Norske Veritas
* CHAP: Community Health Accreditation Program
* CARF: Commission on Accreditation of Rehabilitation Facilities
* COA: Council on Accreditation
*CABC: Commission for the Accreditation of Birthing Centers

For applicants wishing to participate in the Medicare Advantage network, Plan will expect the provision of proof of signed participation agreements with CMS.

The Plan does not credential facilities that do not meet the requirements outlined above.

Plan recognizes that CMS considers a number of other entities as facilities or institutional providers, but Plan contracts with these entities as professional providers and credentials the individual providers as noted in the Practitioner Credentialing Policy. Nevertheless, to participate in the Medicare Advantage network, the following groups must, during the enrollment process, confirm they have signed participation agreements with CMS, as required by Chapter 6 of the Medicare Managed Care Manual, §70:

- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Outpatient Physical Therapy and Speech Pathology Providers;
- Providers of outpatient diabetes self-management training; and
- Rural Health Clinic (RHCs) and Federally Qualified Health Center (FQHCs)

Clinical laboratories are covered under the separate **Blue Cross** VT or Plan Ancillary Provider Enrollment Policy.

II. Credentialing Application Requirements

Facilities, as outlined above, must complete a facility credentialing application and include the following information:

- A. Copy of current valid state license
- B. Copy of professional liability insurance coverage with a minimum of \$1 million per occurrence and \$3 million in the aggregate, or evidence of federal or state tort immunity current at the time of committee decision
- C. A copy of the most recent state survey by Medicare or the appropriate state oversight agency for that facility, or certificate of accreditation from one of the acceptable accrediting bodies noted above
- D. A signed and dated attestation/release to obtain primary source verification

The requirements for ancillary providers are outlined in Blue Cross VT or Plan's separate Ancillary Provider Enrollment Policy.

III. Credentialing Procedure

A. Receipt of Application

Once Plan receives a credentialing application, a Plan credentialing team leader or business analyst reviews the application for completeness. If the application is not complete, the credentialing team leader or business analyst will follow up with the applicant for further details. If the application is complete, it is submitted for primary source verification.

B. Verification Process

The Plan, its delegate, or its agent completes primary verification of credentials using recognized primary sources as identified in exhibit A in the areas below. The Plan delegates its primary source verification function (PSV) to a credentialing verification organization (CVO) certified by NCQA in credentialing. Annually, the CVO must provide the Plan with its current NCQA certification to qualify for continued delegation of PSV functions.

1. Current state license in the state where the facility provides care to Blue Cross VT or Plan members via the state's department of health and human services website or a current copy of the facility license as displayed to the public.
2. Copy of professional liability insurance coverage current at the time of committee decision, with a minimum of \$1 million per occurrence and \$3 million in the aggregate, or, evidence of federal or state tort immunity.
3. Verification of sanctions or exclusions from Medicare/Medicaid, or other Federal Healthcare Programs via query of the Office of Foreign Assets Control (OFAC) sanctions list, the Office of the Inspector General (OIG)/General Services Administration (GSA) list, as well as confirmation that the provider does not appear on the federal preclusion list.

C. Preliminary Review

Once primary source verification is complete, the credentialing team leader or business analyst reviews the application for compliance with the criteria listed below:

1. Accreditation or Compliance with CMS/State Survey.
 - a. Facilities relying on accreditation by one of the entities listed above must show the accreditation is current at the time of review and approval.
 - b. Facilities relying on CMS or state surveys must show substantial compliance with their most recent survey or evidence of a corrective action plan that is accepted by the state.
2. No adverse findings identified during primary source verification, or there is at least one finding but it meets these sub-criteria:
 - a. Adverse events that occurred more than 10 years from the next scheduled network quality and credentialing committee meeting, or
 - b. Adverse findings that have been dismissed, or
 - c. Adverse finding that has judgments or settlements within 10 years or less than \$10,000
3. If there are adverse findings other than those described in paragraph (2) above, the application must be sent to the network quality credentialing committee for review.

D. Plan Procedure Following Preliminary Review

1. If the application meets the requirements stated in (c)(1) and (c)(2) above, the application is considered “clean,” and is sent to Plan’s medical director for approval.
2. If the application remains incomplete despite outreach to the facility for more information, Plan may take any of the following actions:
 - a. Refuse to contract with the facility requesting initial credentialing
 - b. Terminate the contract of a facility due for re-credentialing
3. Plan will submit applications that do not meet the requirements set forth in (c)(1) and (c)(2) above to the network quality credentialing committee for further review.

E. Application Approval

1. Plan’s chief medical director (CMO) or practitioner designated by the CMO may approve clean applications that meet the requirements stated in (c)(1) and (c)(2), above. Plan’s CMO or practitioner designated by the CMO may choose to submit applications to the network quality credentialing committee for further review, however, even if the applications are complete.
2. The network quality credentialing committee, described more fully below, has the authority to approve or deny applications.

IV. Network Quality and Credentialing Committee

The Plan maintains a network quality and credentialing committee consisting of at least six Blue Cross VT or Plan -credentialed practitioners, including the Plan’s medical directors. These practitioners represent a variety of practice areas and provide the Plan with meaningful advice and expertise on credentialing decisions. Committee members meet monthly and require a quorum of four members, no more than two of whom must be Plan medical directors. The role of the network quality and credentialing committee is to conduct quality reviews of facilities to ensure ongoing member safety and quality care for Blue Cross VT or Plan members.

The network quality and credentialing committee reviews applications and supporting documentation referred by the Plan’s medical director. The network quality and credentialing committee makes credentialing, recredentialing and quality action decisions in a confidential, non-discriminatory manner. Annually, each member of the network quality and credentialing committee signs a confidentiality and affirmative statement attesting to review and provide thoughtful consideration to the credentials and quality information of each facility applying to participate in the Plan’s network.

The network quality and credentialing committee bases its recommendations on a quality review, of facility specific complaints and adverse events, recognizing that its recommendations apply for all Plan products. Blue Cross Vermont investigates all complaints and adverse events referencing the Quality of Care Risk Investigation Policy. A more detailed investigation occurs when the volume of complaints or adverse events within the reporting period exceeds our thresholds. Per the referenced policy, the thresholds are any quality of care complaint or issue/concern that ranks in the yellow or red categories,

OR the subject of three cases within 18 months ranking in the green or blue categories (See Quality of Care Risk Investigation Policy for breakdown of the risk categories). The biannual Complaint and Adverse Event Report is presented to the Credentialing Committee by the Clinical Quality Consultant every six months, and pending the thresholds mentioned above, facility intervention is implemented as needed. If complaints or adverse events involving facilities do not exceed the thresholds, the data is tracked and trended for future monitoring. It is not the role of the network quality and credentialing committee to deny a facility's request for participation based on anything except quality concerns. The network quality and credentialing committee may not recommend participation in one Plan product but not another.

Committee member responsibilities include:

- A. Review and thoughtfully consider the credentials and other quality-related information of each facility, making recommendations with regards to initial or continued participation in the Plan's networks.
- B. Request information not specifically described herein if the committee determines that such information would assist the committee in verifying the credentials of the facility.
- C. Interview facilities as appropriate.
- D. Recommend approval of credentialing or recredentialing of facilities for a period of up to three years. Alternatively, the committee may recommend, based on quality concerns, approval for a shorter period, with a follow-up review by the committee for later consideration.
- E. Recommend denial of credentialing or recredentialing, as appropriate, for reasons that may include:
 - 1. Failure to cooperate with the Plan's care management or quality improvement programs and policies
 - 2. Reasons found, by the sole discretion of the committee, that inclusion of the facility in the Plan's network might harm the Plan or Plan members.
- F. Review quality information (and recommend corrective action as appropriate, up to and including termination and any required reporting to authorities) related to a network facility outside of the regular credentialing cycle, including but not limited to:
 - 1. Adverse events or licensure restrictions identified through the Plan's ongoing sanction monitoring process
 - 2. If Plan receives three or more complaints about the facility within an eighteen-month period as identified in the Plan's routine complaint monitoring
 - 3. Any quality of care issues identified through the Plan's member complaint, chart review, claim denial process, or other activities
- G. Review quality information (and recommend corrective action as appropriate, up to and including termination) related to a network facility outside of the regular credentialing cycle including but not limited to:
 - 1. Adverse events or licensure restrictions identified through the Plan's ongoing sanction monitoring process
 - 2. Facilities having three or more complaints within an eighteen-month period as identified in the Plan's routine complaint monitoring
 - 3. Any quality-of-care issues identified through the Plan's member complaint, chart review, claim denial process, or other activities
 - 4. Failure to meet the Plan's requirements for specialty practice

The Plan does not make credentialing decisions based on the type of patients the applicant treats or because the applicant treats a substantial number of expensive or uncompensated care patients. The committee does not consider any of these factors when making a credentialing decision. All network quality and credentialing committee members sign a participation agreement pledging non-discrimination when making credentialing decisions. The credentialing analyst ensures this non-discriminatory policy by comparing the approval listing report against any denial and assessing for trends based on applicant's patient type. The Plan also monitors provider complaints to determine if there are complaints alleging discrimination in the credentialing process and acts on them as appropriate. Annually, the credentialing analyst will report on credentialing process outcomes, including denials and provider complaints, to quality council.

V. Acceptance into the Network

When a facility's application for credentialing has been approved, the effective date will be:

- A. The date Plan approved credentialing if the contract is completed prior to credentialing approval OR
- B. The date Plan receives the signed contract if the contract is NOT complete at the time of credentialing approval.

Upon initial credentialing approval, the credentialing team leader or business analyst forwards the approval to Plan's provider contracting department. Provider contracting coordinates execution of the contract and forwards the enrollment information to network management. Network management sets up the facility in the claims payment system and in the provider directory as a network facility.

Upon recredentialing approval, the credentialing team leader or business analyst forwards the approval to the enrollment team within network management who verifies setup in the provider directory and claims payment system as a network facility.

The Plan notifies facilities in writing of all initial credentialing decision and any recredentialing denials within sixty days of the decision date, to include, if applicable, the reason for denial and the right to appeal the decision. The Plan provides recredentialing approval notifications upon request.

Credentialing timeliness is reported annually to the accreditation team to ensure completion of the credentialing and recredentialing process and notifications in a timely manner and the credentialing analyst makes recommendations for process improvement when the Plan does not meet thresholds.

Facilities that do not meet the credentialing criteria outlined above, are deemed unqualified for network participation, or have been denied participation based on quality concerns validated by the network quality and credentialing committee may reapply for participation once the facility satisfies Plan's credentialing criteria or meets the network quality and credentialing committee's recommendations.

VI. Primary Source Verification

The Plan delegates its primary source verification (PSV) function to a credentialing verification organization (CVO) certified by NCQA in credentialing. Annually, the CVO must provide the Plan with its current NCQA certification to qualify for continued delegation of PSV functions.

VII. Ongoing Monitoring

In addition to checking sanctions for any new facilities during the initial credentialing process (including a review of the Office of Inspector General (OIG)/ General Services Administration (GSA) exclusion list, the Office of Foreign Assets Control (OFAC) sanctions list, the CMS preclusion list, and the Medicare Opt-Out list, the Plan also monitors all network facility sanctions, complaints about facilities, and quality issues on an ongoing basis between recredentialing cycles. The Plan's delegates (contracted physician-hospital organizations (PHOs) and CVO) query the Office of Inspector General (OIG)/General Services Administration (GSA) exclusion list, the Office of Foreign Assets Control (OFAC) sanctions list, and the CMS preclusion list monthly. The Plan receives any adverse events or licensure restrictions identified by the delegates within thirty (30) calendar days of release. Each delegate and CVO must inform the Plan of the date of the query, facility name, and sanction identified. The non-CVO delegate must include actions taken, follow up and corrective action plan if applicable.

The credentialing team leader or business analyst may request additional documentation as needed from the source pertaining to reported adverse events. The quality review and credentialing committee then reviews this information and acts on the information as outlined in the responsibilities section above.

To the extent a monitoring report shows that a facility has been excluded or terminated from Federally funded health care programs, including Medicare, or is otherwise unable to accept federal funds, Plan will initiate termination of that facilities contract immediately.

The network quality review and credentialing committee also reviews instances of possible poor quality and member safety issues identified by the Plan through its regular business activities. The committee takes appropriate action against practitioners when it identifies safety issues or occurrences of poor quality. The Blue Cross VT *Quality of Care and Risk Investigation Policy* describes this process. This applies to all facilities in the network independent of the credentialing entity.

The Plan monitors member complaints and implements appropriate interventions as outlined in the Blue Cross VT *Quality of Care and Risk Investigations Policy*. Plan delegates in the credentialing process do not perform this function.

The Plan reserves the right to terminate any Plan network facility based on the ongoing sanction monitoring reports or because of proven instances of poor quality of care to members, regardless of whether the Plan or the Plan's delegate made the initial or subsequent credentialing decision.

VIII. Confidentiality and Information Security

Blue Cross VT or Plan keeps all information obtained in the credentialing and review process confidential, except as otherwise provided by law. Electronic records are only accessible by approved user groups set up within the user application. All Plan employees and committee members sign a confidentiality statement as a condition of employment and participation on the committee. All materials and processes are subject to the standards outlined in the corporate confidentiality and security policies. The Plan retains all credentialing information, whether paper or electronic, for a

minimum of two credentialing cycles or for six years, whichever is longer. For providers enrolling in the Medicare Advantage network, Plan will follow retention requirements of CMS.

The minutes and records of the quality review and credentialing committee are confidential and privileged under 26 V.S.A. §1443, except as otherwise provided in Vermont Rule 09-03.

Credentialing system access: The network management (NM) manager is the only authorizing agent who can grant access to new users. The credentialing team lead will email the NM manager a request to submit a system access request to the CRM consultant for approval and appropriate access. Access to credentialing application and data are classified into a secure credentialing user group. User groups are defined based on the user's job function and level of authority to access, modify, or delete information. Access to the credentialing applications and secure credentialing database is limited to the CRM consultants, chief medical officer (or designee) and the credentialing team lead or business analyst. CRM consultants customize user groups by making appropriate information visible for a specific user group, the credentialing team lead or business analyst. CRM consultant will assign user role as requested by the NM manager to ensure an appropriate level of access. User roles within the groups are read, write and or modified capabilities. The chief medical officer (or designee), credentialing team lead, business analyst and CRM consultants have read, write and modification access to the credentialing records. CRM consultant is also responsible for terminating user credentials immediately upon notification of employee's departure from the organization.

Only the credentialing team lead or business analyst have access to download the completed primary source verification PDF report from the CVO's secure portal and upload it into the Plan's secure credentialing database. To maintain an accurate credentialing file, modifications to PSV documentation and recording of credentialing and recredentialing dates, may be required. The credentialing function of the CRM system has an audit log which tracks all historical additional, modifications, changes and deletions. The audit log feature includes the following elements:

- Table name (item or element being modified)
- Action taken (Insert, update, delete)
- User making the change
- Change date and time
- Reason for change
 - Staff documents reason for change in the credentialing system controls notes section of the providers credentialing record

The credentialing team leader or business analyst may have a need to request modifications to PSV reports when or the PSV report includes erroneous information such as a verification for a different practitioner than the one listed in the record, or if credentials expire before a decision is made. The credentialing team leader or business analyst records a description of the error in the notes section of the facilities credentialing record, and emails notification to the CVO with the error description and the course of action the CVO needs to take to fix the error. The credentialing team leader or business analyst downloads the corrected PSV report from the CVO's portal and retains both documents in the credentialing database, identifying the corrected document in the system. Credentialing and recredentialing dates are modified from the original recording when a data entry error or a system glitch occurs that creates erroneous dates. As noted above, the CRM system audit log records all entries,

including the change made, who made the change and when the change was made to the record. The credentialing team leader or business analyst records a description of the error in the notes section of the facilities credentialing record to explain the reason why the change was made. The chief medical officer (or designee), credentialing team leader or business analyst and CRM consultants have authority to delete records. Deletion of records only occur when they contain duplicate data entries.

Access to CRM is obtained through the network single sign on password. Users are required to change their network password every 90 days using complex standards of a minimum of 8 characters or when staff suspects their password is compromised:

- Uppercase characters (A-Z)
- Lowercase characters (a-z)
- Numbers (0-9)
- Non-alphanumeric characters (e.g. -, !, \$, #, %)

In addition to standard corporate security and system audits, the Plan will audit credentialing files annually. The credentialing team leader or business analyst will pull a report from CRM that identifies modifications made to credentialing reports from their original recording. The credentialing team leader will conduct an audit of a random sample of 5% or 50 files (whichever is less) of initial and recredential files approved in the previous year with modifications. The audit consists of assessing whether modifications in the credentialing files meets the requirements in this policy, including making the modification for an acceptable business reason by authorized individuals who documents the reason for the modification.

When the audit reveals modifications not allowed under this policy, that will trigger the credentialing team leader, along with the clinical quality consultant from quality improvement and the HIRM divisional portfolio manager to implement a quarterly monitoring process. They will conduct an audit of a random sample of credential files approved in the previous quarter. Sample will be minimum of 5% or 50 files (whichever is less) approved in the previous quarter that were modified. Results of these audits will be recorded internally and shared with the director of network management and the accreditation team. The quarterly monitoring process will remain in place for three consecutive quarters until findings demonstrate compliance.

IX. Annual Review

The accreditation team will review this policy annually ensure that it is consistent with current business practice and to incorporate the latest regulatory and accreditation standards.

Blue Cross and Blue Shield of Vermont
Primary Source Verification by Facility Type
Exhibit A

Facility Type: ALL				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Facility Credentialing Application	BCBSVT	N/A	BCBSVT facility credentialing application	
License to practice	<u>Rule H-2009-03</u> • 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u>	State's department of health and human services	Verification of licensure within each state the facility holds a license. Each licensing state must be queried. • Exception: Ambulatory Surgical Centers, Designated Agency & Renal Dialysis Centers (not licensed by State of Vermont)	
License sanctions	<u>Rule H-2009-03</u> • 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u>	https://iqrs.npdb.hrsa.gov/	Verification of license sanctions within each state the facility holds a license.	
Liability coverage	<u>VT Rule H-2009-03</u> • 5.2E4 <u>Current year NCQA HP Standards and Guidelines</u>	Copy of professional liability insurance coverage current at the time of committee decision.	Minimum of \$1 million per occurrence and \$3 million in the aggregate, or, evidence of federal or state tort immunity	
Accreditation	<u>Rule H-2009-03</u> • 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u>	See individual facility types	If the facility does not hold required accreditation, they may apply under the Report of Good Standing criteria below.	
Report of Good Standing	<u>Rule H-2009-03</u> • 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u>	• https://iqrs.npdb.hrsa.gov/	A CMS or state review less than three years old at the time of application. The report from the institution must show evidence of substantial compliance or an acceptable corrective action plan with current state regulatory requirements. This criteria is not required if the facility holds a required accreditation noted above.	
Medicare and Medicaid Sanctions	<u>Rule H-2009-03</u> • 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u>	• https://iqrs.npdb.hrsa.gov/ • https://oig.hhs.gov/	Verification of sanctions or exclusions from Medicare/Medicaid, or other Federal Healthcare Programs via query of the Office of Inspector General (OIG).	
Attestation and Release of Information	<u>Rule H-2009-03</u> • 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u>	• Application • Signed attestation	Attestation/release for BCBSVT to obtain primary source verification.	

Blue Cross and Blue Shield of Vermont
Primary Source Verification by Facility Type
Exhibit A

Facility Type: Hospital				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Accreditation	<u>Rule H-2009-03</u> <ul style="list-style-type: none"> 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u> 	<ul style="list-style-type: none"> The Joint Commission - https://www.jointcommission.org/ Healthcare Facilities Accreditation Program https://www.hfap.org/ DNV-GL https://dnvglhealthcare.com/ CMS Critical Access Designation https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs 	If the facility does not hold required accreditation, they may apply under the Report of Good Standing criteria.	

Facility Type: Home Health Agency				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Accreditation	<u>Rule H-2009-03</u> <ul style="list-style-type: none"> 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u> 	<ul style="list-style-type: none"> The Joint Commission - https://www.jointcommission.org/ Community Health Accreditation Program - https://chapinc.org/ 	If the facility does not hold required accreditation, they may apply under the Report of Good Standing criteria.	

Facility Type: Skilled Nursing Facility				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Accreditation	<u>Rule H-2009-03</u> <ul style="list-style-type: none"> 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u> 	<ul style="list-style-type: none"> Community Health Accreditation Program - https://chapinc.org/ 	If the facility does not hold required accreditation, they may apply under the Report of Good Standing criteria.	

Facility Type: Ambulatory Surgical Center				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Accreditation	<u>Rule H-2009-03</u> <ul style="list-style-type: none"> 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u> 	<ul style="list-style-type: none"> The Joint Commission - https://www.jointcommission.org/ Accreditation Association for Ambulatory Health Care, Inc. - https://www.aaahc.org/ 	If the facility does not hold required accreditation, they may apply under the Report of Good Standing criteria.	

Blue Cross and Blue Shield of Vermont
Primary Source Verification by Facility Type
Exhibit A

Facility Type: Behavioral Health Care Facility				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Accreditation	<u>Rule H-2009-03</u> <ul style="list-style-type: none"> 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u> 	<ul style="list-style-type: none"> The Joint Commission - https://www.jointcommission.org/ Accreditation Association for Ambulatory Health Care, Inc. https://www.aaahc.org/ Healthcare Facilities Accreditation Program - https://www.hfap.org/ CARF International - http://www.carf.org/home/ Council on Accreditation - http://coanet.org/ 	If the facility does not hold required accreditation, they may apply under the Report of Good Standing criteria.	Includes Youth Residential Treatment Facilities

Facility Type: Renal Dialysis Center				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Accreditation	<u>Rule H-2009-03</u> <ul style="list-style-type: none"> 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u> 	<ul style="list-style-type: none"> CMS Critical Access Designation https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs The Joint Commission https://www.jointcommission.org/ Accreditation Association for Ambulatory Health Care, Inc. https://www.aaahc.org/ 	If the facility does not hold required accreditation, they may apply under the Report of Good Standing criteria.	

Facility Type: Designated Agencies				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Accreditation	<u>Rule H-2009-03</u> <ul style="list-style-type: none"> 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u> 	<ul style="list-style-type: none"> https://mentalhealth.vermont.gov/individuals-and-families/designated-and-specialized-service-agencies 	The Plan will credential designated agencies that are in good standing with the state as demonstrated by meeting the Agency Designation requirements set forth by the Department of Developmental and Mental Health Services.	

Blue Cross and Blue Shield of Vermont
Primary Source Verification by Facility Type
Exhibit A

Facility Type: Free Standing Birthing Center				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Accreditation	<u>Rule H-2009-03</u> <ul style="list-style-type: none"> 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u> 	<ul style="list-style-type: none"> The Joint Commission - https://www.jointcommission.org/ Accreditation Association for Ambulatory Health Care, Inc. https://www.aaahc.org/ CMS Critical Access Designation https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs Commission for the Accreditation of Birthing Centers - https://www.birthcenteraccreditation.org/find-accredited-birth-centers/ 	If the facility does not hold required accreditation, they may apply under the Report of Good Standing criteria.	
Hospital Privileges	None	<ul style="list-style-type: none"> Application Signed attestation 	A copy of the policy and procedure for coverage arrangements with a participating practitioner and hospital, in the event of an emergency.	

Facility Type: Portable X-Ray				
Credentialing Requirement	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Report of Good Standing criteria with State in which they reside	<u>Rule H-2009-03</u> <ul style="list-style-type: none"> 5.2E6 <u>Current year NCQA HP Standards and Guidelines</u> 	<ul style="list-style-type: none"> https://dail.vermont.gov/ 	A CMS or state review less than three years old at the time of application. The report from the institution must show evidence of substantial compliance or an acceptable corrective action plan with current state regulatory requirements.	
Licensure	None	<ul style="list-style-type: none"> https://www.cms.gov/ 	A copy of CMS Medicare Approval form	