BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

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, urgent care centers 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 Network Quality and Credentialing Committee (NQCC) formally reviews the credentials of the facility and makes decisions about continued participation in the Blue Cross VT or Plan network. The NQCC 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 NQCC 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

2026 NCQA HPA Standards and Guidelines/Elements: CR 1-13
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)

Effective Date: 01/01/1998
Revision Date: 9/30/2026
Next Revision Date: 7/2027
Last Approved: 09/30/2026 Accreditation Team
Department: Network Management, Quality Improvement
Reference: S:\P_REIM\Enrollment Information\Active Credentialing Info\Policies\Facility Credentialing Policy
Policy Links:
BCBSVT Provider Appeals from Adverse Contract Actions and Related Reporting Policy
BCBSVT Practitioner Credentialing Policy

BCBSVT Ancillary Provider Enrollment Policy
BCBSVT Delegation and Oversight Policy
BCBSVT Quality of Care Risk Investigation Policy
BCBSVT Credentialing Information Integrity Policy

Policy

1. **Eligibility**

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

a) An active, unencumbered state license to operate1; 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 Centers for Medicare and Medicaid Services (CMS) or State review/survey fewer 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 requirements1; OR;
d) A copy of the Preferred Provider certificate1; OR;
e) Full accreditation by one of the following accrediting bodies in Table 1 [12]:

Table 1:

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.

*AAAHC: 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

[1] Exception for Urgent Care Centers
[2] This list of accrediting bodies is not exhaustive. To the extent an applicant is fully 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.

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, including those with temporary, provisional or limited accreditation.

The Plan recognizes that CMS considers several 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.

2. Credentialing Application Requirements

Facilities, in Table 1, must complete a facility credentialing application and include the following information:

a) A copy of current valid state license[3];
b) A 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 CMS or State survey in the last three years at the time of application; OR; a copy of the Preferred Provider certificate OR; certificate of full accreditation from one of the acceptable accrediting bodies in Table 1.[3]
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.

3. Credentialing Procedure

a) Receipt of Application.
b) The Plan delegates the Primary Source Verification (PSV) function to a credentialing verification organization (CVO) that is certified by the National Committee for Quality Assurance (NCQA) in credentialing. Once the CVO receives a credentialing application the CVO reviews the application for completeness. If the application is not complete, the CVO will follow up with the applicant for further details. If the application is complete, the CVO starts the PSV process.
c) Verification Process:

[3] Excludes Urgent Care Centers

The Plan, its delegate, or its agent completes PSV of credentials using recognized primary sources as identified in exhibit A in the areas below. 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 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[3].
2. Verification of CMS or State survey in the last three years at the time of application; OR; a verification of the Preferred Provider certificate OR; verification of full accreditation from an acceptable accredited body identified in Table 1[3].
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.

d) Preliminary Review

Once PSV is complete, the credentialing team lead, or credentialing analyst, reviews the PSV report, application and supporting documentation for compliance with the criteria below:

1. Accreditation or compliance with CMS/State survey.
    a. Facilities relying on accreditation by one of the entities in Table 1 must provide evidence that the accreditation is current at the time of review and approval.
    b. Facilities relying on inspection reports or residential treatment program licensing reports must provide evidence of a current Preferred Provider certificate.
    c. Facilities relying on CMS or State survey must show substantial compliance with their most recent survey.
        i. Facilities with deficiencies must provide evidence of a corrective action plan that is accepted by the state; or
        ii. Have no deficiencies denoted in the shaded cells in Table 2.

Table 2: Survey deficiency Score: SFF Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J - 50 points (75 points)	K - 100 points (125 points)	L - 150 points (175 points)
Actual harm that is not immediate jeopardy	G - 10 points	H - 20 points (25 points)	I - 30 points (35 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D - 2 points	E - 4 points	F - 6 points (10 points)
No actual harm with potential for minimal harm	A - 0 point	B - 0 points	C - 0 points

2. No adverse findings identified during PSV, or there is at least one finding but it meets

these sub-criteria:

a. Adverse events that occurred more than five years from the next scheduled NQCC meeting, or

b. Adverse findings that have been dismissed, or

c. Adverse findings that have judgments or settlements within five years or less than $200,000.00.

e) Plan Procedure Following Preliminary Review

1. Applications that meet the requirements outlined in (d)(1) and (d)(2) are considered "clean," and sent to Plan's medical director for approval.

2. Applications that do not meet the requirements outlined in (d)(1) and (d)(2) are considered “not clean” and sent to the NQCC for further review and determination.

3. If the application remains incomplete despite outreach to the facility for more information, Plan may take any of the following actions:

d. Refuse to contract with the facility requesting initial credentialing.

e. Terminate the contract of a facility due for re-credentialing.

f) Application Approval

1. Plan's chief medical officer (CMO) or practitioner designated by the CMO may approve clean applications that meet the requirements stated in (d)(1) and (d)(2). At the discretion of the Plan's CMO or practitioner designated by the CMO may choose to submit clean applications to the NQCC for further review..

2. The NQCC, described more fully below, has the authority to approve or deny applications.

4. Network Quality and Credentialing Committee

The Plan maintains an NQCC consisting of at least six Blue Cross VT 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 NQCC is to conduct quality reviews of facilities to ensure ongoing member safety and quality care for Blue Cross VT members.

The NQCC reviews applications and supporting documentation referred by the Plan's medical director that do not meet the clean credentialing criteria. The NQCC makes credentialing, recredentialing and quality action decisions in a confidential, non-discriminatory manner. Annually, each member of the NQCC 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 NQCC 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 VT investigates all complaints and adverse events relating to 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 threshold. 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 NQCC 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 NQCC to deny a facility's request for participation based on anything except quality concerns. The NQCC may not recommend participation in one Plan product but not another.

NQCC member responsibilities include:

a) Review and thoughtfully consider the credentials and other quality-related information of each facility, making recommendations with regard 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 18-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 18-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 NQCC members sign a participation agreement pledging non-discrimination when making credentialing decisions. The credentialing team lead 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 team lead will report on credentialing process outcomes, including denials and provider complaints, to quality council.

5. 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 lead, or credentialing analyst forwards the approval to Plan's provider contracting department. Provider contracting coordinates execution of the contract and forwards the contract to network management {NM). NM sets up the facility in the claims payment system and in the provider directory as a network facility.

Upon recredentialing approval, the credentialing team lead, or credentialing analyst makes the approval available to the NM enrollment team 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 30 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.

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 NQCC may reapply for participation once the facility satisfies Plan's credentialing criteria or meets the NQCC recommendations.

6. Ongoing Monitoring

The Plan checks sanctions for any new providers during the provisional and initial credentialing process using NPDB and FACIS Level 3 that screens through DHHS OIG, GSA SAM, OFAC SDN, Centers for Medicare & Medicaid Services - Opt Out List, plus State Medicaid sanctions and exclusions, 42 HEAT sources and 51 AG Notice and Release sources, state level procurement/contractor debarment sources, as well as State Board and State Agency issued sanctions and disciplinary actions. The search includes information on disciplinary actions ranging from exclusions and debarments to letters of reprimand and probation.

The Plan also monitors all network provider sanctions, complaints about providers and quality issues at

least monthly between recredentialing cycles, including Medicare and Medicaid exclusions and collecting and reviewing expiration of licensure from the state licensing or certificate agency. License limitation information is monitored for all states in which the provider practices, even if those states are outside the Plan's service area or not states where the provider provides care to the Plan's members.

The Plan identifies any adverse events, licensure restrictions and license expirations through FACIS Level 3 by the CVO within thirty (30) calendar days of release.

The credentialing team lead requests additional documentation from the licensing board pertaining to reported adverse events or licensing restrictions. The NQCC reviews this information and acts on the information as outlined in the responsibilities section above.

The credentialing team confirms the license expiration date by querying the licensing website. Facilities whose license renewed without a lapse are recorded in the credentialing database. Facilities whose license has lapsed or expired, the Plan will initiate termination of the facilities contract immediately.

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 NQCC reviews potential quality concerns and member safety issues identified through the Plan's regular business activities. The Quality of Care and Risk Investigation Policy outline the evaluation process, which includes investigating information from identified adverse events and all facility-specific member complaints upon receipt. If applicable, the facilities complaint history is also assessed. The Quality Improvement department conducts ongoing monitoring of all complaints for all facilities, and adverse events, reporting to the committee biannually for complaints and monthly for adverse events.

When safety concerns or quality deficiencies are identified, the NQCC recommends appropriate interventions. Once determined, these interventions are implemented as needed to address quality and safety issues. Ongoing monitoring and interventions apply to all network facilities, regardless of credentialing entity.

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.

7. Annual Review

The credentialing team will review this policy at least annually to ensure that it is consistent with current business practice and to incorporate the latest regulatory and accreditation standards. The internal NQCC members will review the policy before it is reviewed for approval by the Accreditation Team prior to signoff by the CMO.

Signature: Tom Weigel, MD

Tom Weigel, MD
Chief Medical Officer, Blue Cross VT or Plan

Revisions

Date of Change	Effective Date	Overview of Change
4/1/2025	7/1/2025	Add link to the new Blue Cross VT Credentialing Information Integrity Policy.
4/1/2025	7/1/2025	Removed confidential & security from policy; to be incorporated into the new Credentialing Information Integrity Policy.
4/1/2025	7/1/2025	Modified notifying practitioners of the credentialing and recredentialing decision from 60 to 30 calendar days from the credentialing committee's decision.
4/1/2025	7/1/2025	Added criteria for facility sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed by the credentialing committee.
4/1/2025	7/1/2025	Added Medicare exclusions language.
12/23/2025	12/18/2025	Added urgent care centers credentialing criteria.
4/25/2026	5/12/2026	Added language to support NCQA 2026 HPA Policy updates to CR 5A F3 to include monitoring sanctions and licensure limitation information for all states in which the practitioner practices, even if those states are outside the Plan's service area or are not states where the practitioner provides care to the Plan's members.
4/25/2026	5/12/2026	Added language to clarify annual review process.
8/5/2026	9/30/2026	Added language to clarify criteria for accreditation must be full. We do not credential facilities with temporary, provisional or limited accreditation.
8/5/2026	9/30/2026	Added and removed language to clarify our preliminary review process to determine clean or non-clean files.
8/5/2026	9/30/2026	Clarified the data elements our CVO verifies by removing malpractice insurance and replacing it with the Verification of CMS or State survey in the last three years at the time of application; OR; a verification of the Preferred Provider certificate OR; verification of full accreditation from an acceptable accredited body identified in Table 1[3].
9/16/2026	9/30/2026	Clarified policy will be updated at least annually.

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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	N/A	Image of license for each state the facility holds a license. Exception: Ambulatory Surgical Centers, Designated Agency, IOP's & Renal Dialysis Centers (not licensed by State of Vermont)	Exception: Urgent Care Centers
License sanctions	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	https:/ /iqrs.npdb.hrsa.gov/	Verification of license sanctions within each state the facility holds a license.	Exception: Urgent Care Centers
Liability coverage	VT Rule H-2009-03 • 5.2E4 Current year NCQA HP Standards and Guidelines	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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	See individual facility types	If the facility does not hold required accreditation, they may apply under the Report of Good Standing criteria below.	Exception: Urgent Care Centers
Report of Good Standing	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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, OR Facilities relying on inspection reports or residential treatment program licensing reports must provide evidence of a current Preferred Provider certificate. This criteria are not required if the facility holds the required accreditation noted above.	Exception: Urgent Care Centers
Medicare and Medicaid Sanctions	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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. Report of Good Standing criteria for facilities with inspection reports or residential treatment program licensing reports will meet this requirement with evidence of a current Preferred Provider certificate.	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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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. Evidence of good standing is an Agency Designation certificate.	

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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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.erg/find-accredited-birth-centers/	If the facility does not hold required accreditation, we will accept a copy of their annual inspection.	
Hospital Privileges	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	Rule H-2009-03 • 5.2E6 Current year NCQA HP Standards and Guidelines	• 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	• https://www.ems.gov/	A copy of CMS Medicare Approval form.	

Facility Type: Urgent Care Center

	Governing Entities	Acceptable sources for verification	BCBSVT requirements	Comments and Exception Criteria
Walk-In Treatment for Non-Emergent Conditions	None	• Application • Signed attestation	Attestation / release for BCBSVT to obtain primary source verification.	