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Short Title: Provider Credentials/Insurer/Provider Contrac. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE CREDENTIALING OF HEALTH CARE PROVIDERS UNDER HEALTH BENEFIT PLANS; ADDING A DEFINITION, AND AMENDING NOTICE AND CONTRACT NEGOTIATION PROVISIONS FOR HEALTH BENEFIT PLAN AND PROVIDER CONTRACTING; CLARIFYING A CON EXEMPTION CRITERION; AND MODIFYING INSPECTION PRACTICES OF CERTAIN HOSPITAL OUTPATIENT LOCATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-230 reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care practitioner within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. If the insurer has not approved or denied the provider credentialing application form within 60 days of receipt of the completed application, upon receipt of a written request from the applicant and within five business days of its receipt, the insurer shall issue a temporary credential to the applicant if the applicant has a valid North Carolina professional or occupational license to provide the health care services to which the credential would apply. The insurer shall not issue a temporary credential if the applicant has reported on the application a history of medical malpractice claims, a history of substance abuse or mental health issues, or a history of Medical Board disciplinary action. The temporary credential shall be effective upon issuance and shall remain in effect until the provider's credentialing application is approved or denied by the insurer. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide health benefit plans with the information necessary to adequately assess and verify the qualifications of an applicant. The Commissioner may update the uniform provider credentialing application form, as necessary. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

(c) As used in this section, the terms "health benefit plan" and "insurer" shall have the meaning provided under G.S. 58-3-167."

SECTION 2.(a) G.S. 58-50-270, as enacted by S.L. 2009-352, is amended by adding a new subdivision to read:

"(3a) 'Health care provider' – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients."

SECTION 2.(b) G.S. 58-50-271(b), as enacted by S.L. 2009-352, reads as rewritten:

"(b) ~~Date of receipt for~~ Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States ~~mail.~~ mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an amendment if agreed to by the insurer and the provider."

SECTION 2.(c) G.S. 58-50-272, as enacted by S.L. 2009-352, is amended by adding a new subsection to read:

"(d) Nothing in this Part prohibits a health care provider and insurer from negotiating contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts."

SECTION 3. G.S. 131E-184(e), as enacted by Session Law 2009-145, reads as rewritten:

"(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the two million dollar ($2,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The proposed capital expenditure would:
   a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:
      1. Nursing home facility,
      2. Adult care home facility, or
      3. Intermediate care facility for the mentally retarded; and
   b. Not result in a change in bed capacity, as defined in G.S. 131E-176(5), or the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation that demonstrates that the proposed capital expenditure would be used for ~~only~~ one or more of the following purposes:
   a. Conversion of semiprivate resident rooms to private rooms.
   b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.
   c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents."

SECTION 4.(a) G.S. 131E-76(3) reads as rewritten:

"(3) "Hospital" means any facility which has an organized medical staff and which is designed, used, and operated to provide health care, diagnostic and

therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes, nursing homes licensed under G.S. 131E-102, ~~and~~ adult care homes licensed under G.S. ~~131D-2.~~131D-2, and any outpatient department including a portion of a hospital operated as an outpatient department, on or off of the hospital's main campus, that is operated under the hospital's control or ownership and is classified as Business Occupancy by the Life Safety Code of the National Fire Protection Association as referenced under 42 C.F.R. § 482.41. Provided, however, if the Business Occupancy outpatient location is to be operated within 30 feet of any hospital facility, or any portion thereof, which is classified as Health Care Occupancy or Ambulatory Health Care Occupancy under the Life Safety Code of the National Fire Protection Association, the hospital shall provide plans and specifications to the Department for review and approval as required for hospital construction or renovations in a manner described by the Department."

SECTION 4.(b) G.S. 131E-80(a) reads as rewritten:

"(a) The Department shall make or cause to be made inspections as it may deem necessary. Any hospital licensed under this Part shall at all times be subject to inspections by the Department according to the rules of the Commission. Except as provided under G.S. 131E-77(b) of this Part, after the hospital's initial licensing, any location included or added to the hospital's accreditation through an accrediting body approved pursuant to section 1865(a) of the Social Security Act, shall be deemed to be part of the hospital's license; provided, however, that all locations may be subject to inspections which the Department deems necessary to validate compliance with the requirements set forth in this Part."

SECTION 5. G.S. 122C-55(a1) reads as rewritten:

"(a1) Any facility may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with a facility when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment or habilitation of the client. For purposes of this subsection and subsection (a6) of this section, the purposes or activities for which confidential information may be disclosed include, but are not limited to, case management and care coordination, disease management, outcomes evaluation, the development of clinical guidelines and protocols, the development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and related services. As used in this section, "facility" includes an LME and "Secretary" includes the Department's Community Care of North Carolina Program or other primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services."

SECTION 6. Section 1 of this act becomes effective January 1, 2010. Sections 2(a), 2(b), and 2(c) of this act become effective January 1, 2010, and apply to health benefit plan contracts between health care providers and health benefit plans or insurers delivered, amended, or renewed on or after that date. The remainder of this act is effective when it becomes law.