Assessment of Organizational Providers— CR305

Subject: Assessment of Organizational Providers	**Revised Effective:** May 6, 2021
Policy #: CR305	**Review Schedule:** Annual or as needed

Applicability: All programs requiring credentialed providers

Policy: To maintain a quality organizational provider network, Colorado Access will establish criteria and processes for the pre-contractual assessment of organizational providers with whom it intends to contract and for the ongoing assessment, at least every three years, of organizational providers that are currently contracted.

Procedures:

1. **Scope of Credentialing/Assessment.** Colorado Access will conduct a pre-contractual assessment of the following types of organizational providers for all lines of business:

Physical Health	**Behavioral Health**
Hospitals	Psychiatric Hospitals
Home Health Agencies	Community Mental Health Centers
Free-Standing Ambulatory Surgery Centers	Community Mental Health Clinics
Skilled Nursing Facilities	Psychiatric Residential Treatment Facilities
Nursing Homes	Therapeutic Residential Child Care Facilities
Federally Qualified Health Centers - (Exception: Colorado Access made an organizational decision to credential individual practitioners at FQHC's)	Mental Health Specialty Clinics that maintain a current license or designation from the Colorado Office of Behavioral Health
School Based Health Centers - (Exception: Colorado Access made an organizational decision to credential individual practitioners at SBHC's)	Substance Use Disorder Treatment Centers
Rural Health Clinics - (Exception: Colorado Access made an organizational decision to credential individual practitioners at RHC's)	
Hospices	
Durable Medical Equipment (DME)	
Independent Diagnostic Testing Facilities	
Portable X-ray Suppliers	
Urgent Care Centers	

Providers who provide services exclusively in the settings noted in this Section above and provide care only as a result of members/consumers being directed to the organization are not individually credentialed or recredentialed by Colorado Access.

2. **Criteria and Verification Requirements.** The criteria used to evaluate organizational providers during initial assessment and reassessment and the verification requirements associated with each follow below. Ongoing monitoring of organizational providers is accomplished through the

Configuration team and is therefore outside the scope of this policy and procedure (see policy and procedure CMP206 Sanction, Exclusion, Prohibited Affiliation and Opt-out screening and ADM301 Adverse Actions and Hearing and Appeal Process for Practitioners).

Verification Requirements	Required at Credentialing (C) or Recredentialing (R)	Verification Time Limit
Completed Application, including signed and dated attestation and authorization	**C** **R**	Within 180 calendar days of decision
Enrolled and validated for Medicaid	**C** **R**	Must be enrolled and validated by Health First Colorado prior to credentialing and reassessment
Licensure - current copy of the Colorado license or if not subject to State licensure, appropriate state or federal agency certification and/or OBH full designation (Licensure must be in effect at the time of the decision date)	**C** **R**	Within 180 calendar days of decision
For health care institutions current professional liability insurance – Minimum limits of liability of $500,000.00 per incident and $3 million aggregate with the exception of public entities who have coverage through the Self-Insurance Trust, the Federal Tory Claims Act (FTCA) or have governmental immunity (Must be in effect at the time of the decision date)	**C** **R**	Within 180 calendar days of decision
For DME providers current comprehensive general liability insurance – Minimum limits of liability of $1 million per incident and $3 million aggregate	**C** **R**	Within 180 calendar days of decision
CLIA Waiver and Certification - If applicable, obtains a current copy of the organization's CLIA certificate	**C** **R**	Within 180 calendar days of decision
State and federal regulatory status - In good standing. A screen print displaying the query results from the Office of Inspector General (OIG) Federal Program Exclusions Databasehttps://exclusions.oig.hhs.gov	**C** **R**	Within 180 calendar days of decision

Current accreditation by an acceptable accreditation body - A copy of the most recent accreditation certificate, a copy of a letter from the accrediting body that indicates the organizational provider is accredited, or a hardcopy print from the accrediting body's website indicating the provider is accredited.	**C** **R**	Within 180 calendar days of decision
If not accredited, the completion of a CMS, or OBH Quality Review, or the completion of a Colorado Access Site Visit with a copy of the entity's credentialing policies - If the organization is not accredited or is accredited by a non-approved entity, a copy of the most recent site survey or letter from the reviewing entity indicating the results of the review and that the organization passed inspection. If the State or federal review is greater than 3 years old, the results of a site visit conducted by Colorado Access, with a copy of the organization's credentialing or Human Resources policies for screening and verification of staff training is required.	**C** **R**	Within 180 calendar days of decision

3. **Accreditation or Site Visit by CMS, OBH or Colorado Access**. In the case of non-accredited organizational provider(s), Colorado Access will utilize a quality review from the Centers for Medicare and Medicaid Services (CMS), or the Office of Behavioral Health (OBH). The site review results, and outstanding Corrective Action Plans will be examined to ensure that the organization was reviewed and passed inspection. If the organizational provider has not undergone a site visit by one of the above, or the last visit was greater than 3 years old, Colorado Access will perform a site visit. Urgent care centers do not require a site visit or accreditation.

   Following are the organizational providers and their associated accrediting bodies or in lieu of accreditation, the applicable CMS or OBH site review. The organizational provider must provide evidence of one of the following or have a site visit performed by Colorado Access to be considered for participation or ongoing participation.

Organizational Provider Type	**Accrediting Body, CMS, or OBH Site Review**
Hospital	The Joint Commission (general, psychiatric, children's and rehabilitation) CARF (Medical Rehab Program or Behavioral Health Program as applicable) CMS Site Survey or OBH Survey of psychiatric hospitals

Home Health Agency	The Joint Commission CARF URAC CHAP ACHC CMS Site Survey
Free-Standing Ambulatory Surgical Center	The Joint Commission AAAASF AAAHC CMS Site Survey
Skilled Nursing Facility	The Joint Commission URAC CARF (Medical Rehab Program or Behavioral Health Program as applicable) CMS Site Survey
Nursing Home	The Joint Commission URAC CMS Site Survey
Community Mental Health Center/Clinic or Mental Health Specialty Clinic	The Joint Commission COA CARF CMS Review or OBH Site Review
Psychiatric Residential Treatment Facility	The Joint Commission COA CARF OBH Site Review
Therapeutic Residential Child Care Facility	The Joint Commission COA CARF OBH Site Review
Substance Use Disorder Treatment Centers	The Joint Commission COA CARF OBH Site Inspection
Hospice	The Joint Commission CARF CHAP ACHC CMS Site Survey
Federally Qualified Health Centers and Rural Health Clinics	The Joint Commission CMS Site Survey NCQA

Durable Medical Equipment	DMEPOS The Joint Commission ACHC CHAP ABCOP CMS Site Survey
Portable X-ray Suppliers	CMS Site Survey
Independent Diagnostic Testing Facilities	The Joint Commission

4. **Application Process.** Colorado Access requires all organizational providers to complete the Organizational Provider (Re)Application.

    A. **Initial Application**. Credentialing staff enters the initial demographic data into the credentialing database and forwards the application to the organizational provider. One application is required for each tax identification number (TIN). If the organization has multiple locations under one TIN, then only one record is maintained, with multiple address records.

    B. **Reassessment Application**. Reassessment applications are distributed to currently contracted organizational providers based on the date of the last credentialing and after current participation status has been confirmed. Distribution occurs approximately 90 calendar days prior to the scheduled reassessment date.

    C. **Tracking Non-Receipt of Applications**. Emailed applications are tracked, and a series of follow-up requests are made if the completed application has not been received. If these attempts are unsuccessful, Provider Relations is contacted to assist with follow-up.

    D. **Application Receipt**. Upon receipt of the application, the documents are saved electronically, and key information is entered into the credentialing database. The application is reviewed for completeness and the credentialing staff ensures the requested documentation is present and current. Follow-up is conducted with the organizational provider if the application is incomplete.

5. **Documentation and Verification Process.** The following elements are researched and/or gathered in support of the assessment process:

    A. **Review of Application Questionnaire**. If there is an affirmative response to the application questionnaire regarding Medicare and Medicaid sanctions, remedies imposed by the State to include State monitoring, civil monetary penalty, denial of Medicaid payment for new admissions, temporary management and/or closure within the last three (3) years, the Credentialing staff will obtain supporting documentation from the Organizational Provider or from the Health Facilities Division website.

B. **SAM and OIG background checks**. Organizational providers that are excluded from participating in Medicare or Medicaid Programs would be not be included and/or terminated from the network.

C. **Validation**. Search the enrollment website to verify provider is approved https://colorado-hcp-portal.xco.dcs-usps.com/hcp/provider/Home/ProviderEnrollment/ProviderEnrollmentStatus/tabid/453/Default.aspx

D. **Current Valid Colorado License or State or Federal Certification**. Organizational providers included in the scope of this policy are required to have a current Colorado license with the exception of facilities that are not licensed or may not be licensed by the State. These facilities include Durable Medical Equipment, Rural Health Clinics, School Based Health Centers, and Federally Qualified Health Centers. Rural Health Clinics, School Based Health Centers, Federally Qualified Health Centers, Comprehensive Outpatient Rehabilitation Facilities are required to have Health Care Policy and Financing (HCPF) or Medicare Certification (CMS).

   A copy of the license, certification or report that is provided by the organizational provider meets the verification requirement. The license must be current at the time of the decision. OBH licensure must have Full status rather than Provisional status. A durable medical equipment supplier license is not required as a condition of enrollment as a provider in the medical assistance program.

   A screen print from the Colorado Department of Public Health and Environment (CDPHE) website indicating CMS meets the verification requirement for certification. https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities

   Urgent care centers are not required to be licensed in the state of Colorado and therefore licensure of the supervising physician is verified.

E. **Professional Liability Insurance Coverage**. Colorado Access requires health care institution organizational providers subject to this policy to carry minimum professional liability coverage of $500,000 per incident and $3 million aggregate.

   Comprehensive General Liability Insurance Coverage. Colorado Access requires Durable Medical Equipment providers subject to this policy to carry minimum comprehensive general liability coverage of $1 million per incident and $3 million aggregate.

   A copy of the insurance declaration sheet including the organizational provider's name, the effective and expiration dates and amounts of coverage meets the verification requirement. The policy must be in effect at the time of the decision.

   Organizational providers who have coverage through the Self-Insurance Trust, the Federal Tort Claims Act (FTCA) or have governmental immunity are exempt from carrying the minimum amounts of malpractice insurance of $500,000 and $3 million aggregate.

Should Colorado Access have knowledge that a provider has cancelled their insurance coverage, Colorado Access will notify the HCPF within two (2) business days.

F. **CLIA Waiver and Certification**. If the organization provides in-house laboratory services, obtains a current copy of the organization's CLIA certificate. Online verification can also be performed on https://wwwn.cdc.gov/CLIA/Resources/Lab-Search.aspx.

G. **State and Federal Regulatory Status.** Colorado Access requires that the status of an institution's standing with state and federal regulatory agencies be verified directly with the Office of Inspector General (OIG) and the National Practitioner Data Bank (NPDB). If an organizational provider is identified as being excluded, the provider is referred to Provider Contracting Department and the credentialing process is terminated. If sanctions are present, the Credentialing staff obtains the applicable documentation.

H. **Accreditation or Site Survey**. Colorado Access requires each organizational provider be accredited by one of the accreditation bodies listed in this policy, or in lieu of accreditation, Colorado Access will accept the CMS site survey or the OBH Site Inspection Report, as applicable. The CMS and State quality reviews used in lieu of Colorado Access site visits must include criteria and standards outlined in this policy. If the organizational provider is not accredited by an entity recognized by Colorado Access or not subject to site reviews conducted by CMS or OBH, Colorado Access will perform a site visit.

   Accreditation is verified through the accrediting body website and receipt of a copy of the most recent accreditation certificate or a copy of the cover letter sent by the accrediting body indicating the organizational provider is accredited. The accreditation must be in effect at the time of the decision.

   If the organizational provider is not accredited or is accredited by an entity not recognized by Colorado Access, receipt of a copy of the report (survey), or a letter sent to the organizational provider from CMS or OBH that shows that the organization was reviewed within the past three years is required. The findings of the review must indicate that the organization is in compliance and has completed all of the corrective action items. If the report indicates remedies were imposed within the last three (3) years, credentialing staff will obtain the supporting documentation.

   If the non-accredited organization has not had a site visit performed by one of the entities noted above, Colorado Access will contact the organization and perform a site visit. Colorado Access will not conduct a site visit if the State or CMS has not conducted a site review of the provider, and the provider is in a rural area, as defined by the U.S. Census Bureau. The organization site visit will include any of the following applicable areas, but is not limited to, an assessment of the physical environment, processes to ensure member rights, the provision of care, treatment and emergency services, medications management, quality improvement, staff hiring and credentialing processes, and medical records.

I. **Participating Provider Quality Monitoring**. Quality monitoring occurs continually during the credentialing cycle. The Quality Management Department forwards quality of care

concerns to the Credentialing department upon identification. The credentialing department forwards such concerns to the Credentials Committee. The Credentials Committee may further investigate quality of care concerns and/or take action as described in ADM301.

6. **Organizational Provider File Review Classification Process.** The Credentials Committee establishes the file review classification process. The file review classification process provides guidance to the credentialing staff for determining which files will be prepared for review.

   A. Files that meet all of the minimum criteria will be assigned a Level 1 and will be sent to the Medical Director to review and approve.

   B. Files that contain evidence of Medicare and Medicaid sanctions, remedies imposed by the State to include, State monitoring, civil monetary penalty, denial of Medicaid payment for new admissions, temporary management and/or closure that have occurred within the past three (3) years, will be assigned a Level 3 and will be reviewed by the Senior Medical Director and/or Credentials Committee who will render a decision regarding (continued) network participation.

7. **Credentialing Determination Notification.** Organizations undergoing initial assessment are notified in writing within ten (14) business days of the decision. If the organizational provider is denied participation, the Credentialing Manager, in writing, within ten (10) business days, will notify them and the documentation is filed in the organizational provider electronic file.

   Organizations undergoing reassessment will not be notified in writing unless the status of the organization has been altered or the organization has been denied. The organization will be notified in writing within ten (10) business days.

8. **Organizations Listings in the Directories.** The organizations will not be added to the provider directory until the Senior Medical Director or Credentials Committee has approved the organizations.

   If the organization ceases to comply with assessment criteria as determined through the processes of continuous compliance monitoring, reassessment does not take place within the time frame required by Colorado Access' standards and/or the provider chooses not to participate in the network, the organization will be removed from the provider directory within five (5) business days (see policy and procedure PNS201 Provider Manual, Directory and Communications Updates).

9. **Credentialing System Controls.** Colorado Access implements controls to ensure security and integrity of credentialing information.

   A. Colorado Access receives all primary source verified data electronically in the following ways: web crawlers and the internet. The data is saved in the credentialing software (web crawlers) or in a shared drive folder (internet). All data is tracked in a checklist as part of the credentialing software.

   B. Modified data is tracked and dated in the electronic checklists that are generated in the

credentialing application at every credentialing cycle. Upon completion of the verification process, a report is generated and saved in the provider's folder, which summarizes who and when each primary source verification was modified.

C. Credentialing Coordinators, Provider Data Analysts, and the Credentialing Manager are authorized to review, modify, and delete information in the credentialing software system. Deleting data is only necessary if the original data entered was incorrect.

D. Only the staff mentioned in 9.C. above are authorized to modify data in the credentialing software, which is password protected by the user's Windows log in information. The credentialing software system can only be accessed in the office or using the Colorado Access VPN. All other users are assigned to a user group with read-only access in the system. The electronic folders are only available to these staff and are not made available companywide.

E. Colorado Access audits initial and recredentialing files daily for compliance with NCQA standards. The auditors are members of the Business Support team and report to the Director of Member and Provider Data Integrity.

    1. For new credentialing staff, 100% of the files are audited until the audit score is at least 95%. Once a staff person reaches a score of 95%, the auditors review 25% of the staff's files.
    2. If there is one or more findings in an audit, the rest of the staff's files will be audited for the applicable element(s).
    3. If a staff falls below 95% total accuracy, 100% of their files will be audited until they return to 95% accuracy.

References:
N/A

Attachments:
N/A