Policy and Procedure

Policy Name: Assessment of Organizational Providers	**Policy#: CR305**	**Version#: 34**
Author Department: Credentialing	**Origination Date: 5/1/1998**	
Business Units Impacted: All	**Date Last Reviewed: 01/21/2025**	
Products/LOBs: All	**Date Approved by CPT: 01/23/2025**	

DEFINITIONS:

National Committee for Quality Assurance (NCQA) is a non-profit organization that evaluates and accredits managed care organizations. The NCQA's goal is to improve the quality of healthcare through evidence-based standards, programs, and accreditation.

SCOPE:

This policy applies to all contracted organizations in the scope of credentialing.

PURPOSE:

The purpose of this policy is to ensure that Colorado Access is compliant with NCQA credentialing standards.

STATEMENT OF POLICY:

To maintain a high-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 reassess organizational providers that are currently contracted at least every 3 years.

PROCEDURES:

1. **Scope of Credentialing/Assessment.** Colorado Access will conduct pre-contractual assessments and periodic reassessments of the following types of organizational providers:

Physical Health	Behavioral Health
Hospitals	Psychiatric Hospitals
Home Health Agencies	Substance Use Disorder Treatment Programs
Free-Standing Ambulatory Surgery Centers	Comprehensive Safety Net Provider
Skilled Nursing Facilities	Outpatient Mental Health Clinic
Nursing Homes	Recovery Support Services Organization
Hospices	Psychiatric Residential Treatment Facilities
Durable Medical Equipment (DME) Providers	Therapeutic Residential Child Care Facilities
Independent Diagnostic Testing Facilities	Qualified Residential Treatment Program

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Portable X-ray Suppliers	Acute Treatment Unit
Urgent Care Centers	Crisis Stabilization Unit

Individual practitioners who provide services exclusively in the organizational settings noted above are not required to be 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 corresponding verification requirements are listed below.

Verification Requirements	Required at Credentialing (C) or Recredentialing (R)	Verification Time Limit
Completed application, including signed and dated attestation and authorization	**C** **R**	Within 120 calendar days of decision
Enrolled and validated for Medicaid and/or CHP HMO	**C** **R**	Must be enrolled and validated prior to assessment and reassessment
State licensure: current copy of the Colorado license Must be in effect at the time of the decision date. See 5.D below for exceptions.	**C** **R**	Within 120 calendar days of decision
For health care institutions: current professional liability insurance – Minimum limits of liability of $500,000 per incident and $3 million aggregate, with the exception of public entities that have coverage through a Self-Insurance Trust, the Federal Tort Claims Act (FTCA) or have governmental immunity (must be in effect at the time of the decision date)	**C** **R**	Within 120 calendar days of decision

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For DME providers: current comprehensive general liability insurance – Minimum limits of liability of $1 million per incident and $3 million aggregate	**C** **R**	Within 120 calendar days of decision
CLIA Waiver and Certification - If applicable, current copy of the organization's CLIA certificate	**C** **R**	Within 120 calendar days of decision
State and federal regulatory status - In good standing.	**C** **R**	Within 120 calendar days of decision
Current accreditation by an acceptable accreditation body-A copy of the current certificate or letter from the acceptable accrediting body (see table below) that indicates the organizational provider is accredited, or a hardcopy printed from the accrediting body's website indicating the provider is accredited.	**C** **R**	Within 120 calendar days of decision
If not accredited by an approved entity, either: An acceptable federal (e.g., CMS) or state (e.g., Colorado Office of Behavioral Health) review or designation, including a quality assessment site review, within the past 3 years. OR Successful completion of a quality clinical review and site visit conducted by Colorado Access (See Section I.)	**C** **R**	Within 120 calendar days of decision
Colorado Secretary of State – in good standing	**C** **R**	Within 120 calendar days of decision

3. **Acceptable Accrediting Bodies and Alternative Site Visits:** The acceptable accrediting bodies and acceptable alternative site visits for each organizational provider type are listed in the table below. 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.

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Organizational Provider Type	**Acceptable Accrediting Body or Alternative Site Visit**
Hospital	The Joint Commission (general, psychiatric, children's and rehabilitation) CARF (Medical Rehab Program or Behavioral Health Program as applicable) CMS Site Survey or BHA 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
Hospice	The Joint Commission CARF CHAP ACHC CMS Site Survey

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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
Urgent Care Centers	Accreditation or equivalent quality review/site visit not required
Comprehensive Safety Net Provider Outpatient Mental Health Clinic Acute Treatment Unit Crisis Stabilization Unit Recovery Support Services Organization Qualified Residential Treatment Program Psychiatric Residential Treatment Facility Therapeutic Residential Child Care Facility Substance Use Disorder Treatment Centers	The Joint Commission CMS Review or BHA Site Review CARF COA Review NCQA, JTC, or AAAHC PCMH certification CDPHE Site Review

4. **Application Process.** Colorado Access requires all organizational providers to complete the Organizational Provider Application or Reapplication.

    A. **Initial Application**. Provider Contracting Manager sends the Credentialing Coordinator a request to assess new organizations. One application is required for each taxpayer identification number (TIN). If the organization has multiple locations under one TIN, then only one application is required, with multiple address records.

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B. **Reassessment Application**. Credentialing Coordinators will prompt currently contracted organizational providers to submit reassessment applications approximately 90 calendar days prior to the scheduled reassessment date and will follow-up if there is lack of provider response.

C. **Application Receipt**. Upon receipt of the application, the documents are saved electronically by the Credentialing Coordinator, and data is verified and entered into the credentialing database. The application is reviewed for completeness and the Credentialing Coordinator 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.**

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, Colorado Access 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 may not participate in Colorado Access's network. Verification is performed by the Provider Contracting team at initial assessment and then monthly thereafter using https://app.streamlineverify.com/.

C. **Colorado Medicaid/CHP HMO Enrollment**. Colorado Access's provider enrollment database is used to verify validation status.

D. **Colorado Secretary of State verification.** The organization must be in good standing. https://www.sos.state.co.us/biz/BusinessEntityCriteriaExt.do?resetTransTyp=Y

E. **Current Valid Colorado License**. Organizational providers included in the scope of this policy are required to have a current Colorado license, except for facilities that are not licensed or not required to be licensed by the State. These include Durable Medical Equipment suppliers and Urgent Care Centers. The Behavioral Health Administration issues Behavioral Health Entity (BHE) licenses to the behavioral health organizations. BHE licensure can have Full status or Provisional status at the time of credentialing.

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

F. **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 a 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 an organizational provider has cancelled its insurance coverage, Colorado Access will notify the HCPF within two (2) business days.

G. **CLIA Waiver and Certification**. If the organization provides in-house laboratory services, a current copy of the organization's CLIA certificate must be submitted.

Online verification can also be performed on https://wwwn.cdc.gov/CLIA/Resources/Lab-Search.aspx.

H. **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 not eligible for Colorado Access network participation. If sanctions are present, the Credentialing staff obtains the applicable documentation.

I. **Accreditation or Quality Review/Site Visit:**

a. **Accreditation by an acceptable accrediting body**: Accreditation is verified through the accrediting body website and receipt of a copy of the most recent accreditation report, certificate, or a decision cover letter sent by the accrediting body indicating the organizational provider is accredited.

b. **State or federal quality review/site visit:** A copy of the report (survey), or a letter sent to the organizational provider from CMS or BHA/CDPHE that shows that the organization was reviewed within the past three years is required, including a site visit. The findings of the review must indicate that the organization complies and has completed all the corrective action items. The CMS and State quality reviews must include criteria and standards consistent with those in this policy. If the report indicates remedies were imposed within the last three (3) years, credentialing staff will obtain the supporting documentation. Colorado Access may choose to conduct its own quality review/site visit if the documentation provided during the assessment or reassessment process indicated potential areas of non-compliance with its criteria. Colorado Access is not required to conduct a site visit if the provider organization is in a rural area, as defined by the US Census Bureau, and the state or CMS has not conducted a site review as part of its approval process.

c. **Participating Provider Quality Monitoring**. Quality monitoring occurs continually during the credentialing cycle. The Quality Management

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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 act as described in policy CR301.

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. Level 1: Organizations that meet all the requirements, which are reviewed and approved by the Medical Director.
    B. Level 3: Files that have an NPDB finding less than ten (10) years old, or 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 reviewed by committee. If, after Colorado Access performs a clinical review and site visit, there is a file that is determined to not meet full criteria, will require Credentialing Committee review.

7. **Credentialing Determination Notification.** Organizations undergoing initial assessment are notified in writing within ten (10) 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 application has been denied. The organization will be notified in writing within ten (10) business days.

8. **File Maintenance and Confidentiality**

    A. Information obtained during the credentialing/recredentialing process and Credentials Committee meeting minutes are treated confidentially. Colorado law protects quality

issues addressed under peer review. Files are maintained on a secured server.

B. Credentialing documents are maintained in either a secure electronic folder, or in the credentialing application via web crawlers. The checklist in the application documents the verifier's name, the date the information was verified, and the verification source.

C. Annually, participants of the Credentials Committee sign a confidentiality agreement that addresses the confidential nature of the information reviewed, subsequent decisions, and conflict of interest.

9. **Provider Directories.** Organizational providers will be added to Colorado Access's provider directory upon successful completion of the credentialing and contracting processes.

   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 required time frame, or the provider withdraws from 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).

10. **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 are saved in the credentialing software (web crawlers) or in a shared drive folder (internet). All data are tracked in a checklist as part of the credentialing software.

    B. Modified data are tracked and dated in the electronic checklists that are generated in the credentialing applications. 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 were incorrect.

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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 are one or more findings in an audit, the rest of the staff's files will be audited for the applicable element(s).
3. Regular auditing is conducted using the logic below:
   95%– 100% accuracy - audit 25% of all files
   90% – 94.9% accuracy - audit 50% of all files
   85% – 89.9% accuracy - audit 75% of all files
   below 85% accuracy - audit 100% of all files

REFERENCES:

ATTACHMENTS: None

POLICY HISTORY:

SUMMARY OF REVIEW/REVISION/APPROVAL DATES:
Version 1: 5/1/1998, Version 2: 6/1/2000, Version 3: 10/1/2003, Version 4: 4/1/2004, Version 5: 1/1/2005, Version 6: 5/1/2005, Version 7: 12/1/2005, Version 8: 7/1/2006, Version 9: 11/1/2006, Version 10: 8/1/2007, Version 11: 6/1/2008, Version 12: 2/1/2009, Version 13: 2/1/2010. Version 14: 1/1/2011, Version 15: 5/1/2012, Version 16: 9/1/2012, Version 17: 1/1/2013,

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APPROVAL BODY: COA Core Policy Team **APPROVAL DATE: 1/23/2025**