Children's Hospital and Health System
Children's Community Health Plan
Policy and Procedure

This policy applies to the following entity(s):

☐ CHW – Milwaukee	☐ CHW - Fox Valley
☐ CHHS Foundation	☐ CHW - Surgicenter
☐ CHW – Community Services Division	☒ Children's Community Health Plan
☐ Children's Medical Group - Primary Care	☐ Children's Specialty Group
☐ Children's Medical Group - Urgent Care	☐ CHHS Corporate Departments

Organizational Assessment and Ongoing Assessment Policy

SUBJECT: Assessment and Ongoing Assessment of Organizational Providers

INCLUDED PRODUCT(S):

Medicaid	Commercial	Marketplace
☒ BadgerCare Plus	☒ Together with CCHP	☒ Together with CCHP
☒ Care4Kids Program		

PURPOSE:

Children's Community Health Plan (CCHP) shall conduct an initial assessment of each organizational provider before it contracts with that provider and an ongoing assessment thereafter, at least every three years. These assessments shall verify that the providers have met all state and federal; licensing and regulatory requirements, verifies whether a recognized accrediting body has been reviewed and approved the provider, may conduct an onsite quality assessment if there is no accreditation status, and determines whether the organizational provider meets or continues to meet the standards of participation, including but not limited to, accreditation, relevant licensure and good standing with appropriate agencies.

Definitions

- *Applicant* – the Organizational Provider seeking participation in CCHP's network
- *Initial Assessment* – the process of assessing and validating the applicable criteria and qualifications of an Organizational Provider for participation in the CCHP network
- *Credentialing Authority* – the National Committee for Quality Assurance (NCQA); the Centers for Medicare and Medicaid Services (CMS) as applicable, and any other federal or state authority
- *Material Restrictions* – any limitation or limiting condition imposed on a Practitioner's ability to practice medicine
- *Behavioral Health Organizational Providers* – inpatient, residential, and ambulatory facilities, which provide Behavioral Health services to Covered Persons
- *Organizational Providers* – refers to facilities providing services to members and where members are directed for services rather than being directed to a specific practitioner. Such as hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, and Behavioral health facilities that provide Behavioral Health and/or substance abuse treatment in an inpatient, residential or ambulatory setting (CCHP only organizationally credentials County ambulatory agencies and medication assisted treatment centers)
- *Primary Source Verification* – verification of credentialing information directly from the entity (e.g. state licensing board) that conferred or issued the original credential
- *Ongoing Assessment* – the process of re-assessing and validating the applicable qualifications of a Practitioner or Organizational Provider to allow for participation in CCHP's network

POLICY:

The initial assessment process assists CCHP in determining whether or not to grant network membership to an organizational provider. CCHP will collect, review and verify specific information regarding these organizational providers to determine whether the organizational provider meets established CCHP criteria.
Ongoing assessment is the process through which CHCP will update and verify pertinent information regarding network organizational providers. It is CCHP's policy to reassess these providers at least every 3 years.

A. Application Process

1. The Assessment and ongoing assessment Process applies to the following organizational providers seeking membership into the CCHP network:
   - Hospitals
   - Skilled nursing facilities
   - Home Health Agencies
   - Free standing surgical centers
   - Behavioral health facilities that provide behavioral health and/or substance abuse treatment in an inpatient, residential or ambulatory setting

2. Organizational provider applicants must submit a completed standardized application for review when applying for initial participation in CCHP's network. An organization must fulfill all criteria for participation in the CCHP provider network. CCHP may offer a contract only if the provider satisfactorily meets the specified criteria.
3. Organizational providers in the CCHP network must continuously fulfil the criteria, CCHP will determine whether each provider continues to satisfy the criteria by reassessing each provider from time to time, which will include, without limitation, review of information regarding good standing with the state and federal regulatory bodies, accreditation status, and quality assessment if the provider is not accredited.

B. Criteria

1. Accredited organizational providers must provide proof of current accreditation status conducted during the previous three year period and active federal or state licensure as applicable(accreditation report, certificate or decision letter). CCHP will accept accreditation results from:
   - AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities
   - AAAHC – Accreditation Association for Ambulatory Health Care
   - ACHC – Accreditation Commission for Health Care
   - BCBA – Board Certified Behavior Analyst
   - CARF– Commission on Accreditation of Rehabilitation Facilities
   - CHAP – Community Health Accreditation Program
   - CCAC - Continuing Care Accreditation Commission
   - CIHQ – Center for Improvement in Healthcare Quality
   - COA – Council on Accreditation for Children/Family Services
   - COLA – Commission on Office Accreditation
   - HFAP – Healthcare Facilities Accreditation Program
   - NCQA – National Committee for Quality Assurance
   - NIAHO/DNV – GL – National Integrated Accreditation for Healthcare/Det Norske Veritas and Germanischer Lloyd
   - TJC/JCAHO – Joint Commission on Accreditation of Health Care Organizations
2. CCHP contracts only with accredited providers. In absence of such accreditation, CCHP may evaluate the most recent site survey by Medicare or applicable Wisconsin oversight agency performed within the past 36 months for a given organizational provider, unless the provider is in a rural area as defined by the U.S. Census Bureau. During the reassessment process, CCHP will review the criteria unless otherwise required by applicable regulatory or accrediting bodies.

- Organizational providers must attest that they credential and re-credential their practitioners.

3. Valid, current and unrestricted license or certification to operate in Wisconsin. Must be in good standing with state and federal regulatory bodies, as applicable
4. Good standing under the Medicare and Medicaid programs. As part of our ongoing commitment to a quality network, we would like to remind you of your obligation to notify CCHP of any actions or remedied imposed by any accrediting body and/or state and federal regulatory bodies, including but not limited to Medicare and Medicaid programs, at the time of action. Failure to notify CCHP at the time of any such action could result in termination of your contract.
5. General/comprehensive liability insurance as well as errors and omissions (malpractice) of not less than $1,000,000 per occurrence and $3,000,000 in the general aggregate with an insurer licensed to provide medical malpractice insurance in Wisconsin, or show similar financial commitments made through an appropriate Wisconsin approved alternative, as determined by CCHP and appropriate secondary coverage by the Wisconsin Injured Patients and Families Compensation Fund. The pertinent network agreement may require coverage that exceeds the minimum level described above.
6. An absence of history of involvement in a malpractice suit, arbitration, or settlement that has resulted in limitations, restrictions, or actions against Accreditation or CMS standings. Organizations shall provide documentation relative to any fact or circumstance, whether or not relating to the organizational criteria, which potentially may affect the organizations ability to deliver appropriate care to CCHP members. Organizations shall not be admitted to the CCHP network to the extent any such facts or circumstances are determined to bear negatively upon the organization.
7. An absence of a history of denial or cancellation of professional liability insurance, or in the case of a provider with such a history, providers shall provide complete documentation relative to any denial or cancellation of professional liability insurance. Providers shall not be admitted to the CCHP network to the extent any such denial or cancellation of professional liability insurance, together with other factors in this policy, is determined to bear negatively upon professional competence or conduct, or ability to successfully participate in the network.
8. An absence of a history indicating (in the sole discretion of CCHP) a tendency toward inappropriate utilization management of medical records.
9. An absence of history of indictment or criminal conviction; or in the case of a provider with this history, evidence must be provided, in the form of comprehensive narrative, to include all information relevant to the action taken and its satisfactory resolution. Provider shall not be admitted to CCHP network to the extent any indictment or criminal conviction, together with other factors in this policy are determined to bear negatively upon professional competence or conduct, or ability to successfully participate in the network.

C. The Assessment and Ongoing Assessment Processes

1. Throughout the assessment and ongoing assessment processes, the provider is responsible for:
    i. Responding to requests for information
    ii. Keeping CCHP informed of any changes in its status relative to the criteria such as:
        1. Preclusion and/or exclusion from the Medicare or Medicaid programs including but not limited to any actions taken for non-compliance
        2. Cancellation of professional liability coverage
        3. Loss of Wisconsin licensure
        4. Loss of accreditation from recognized accrediting body
2. Prior to contracting with an organizational provider, CCHP will confirm or obtain information relating to the provider applicant with various sources, including but not limited to:
    i. Document current status of malpractice insurance with provider
    ii. Verify that the provider has met all state and federal licensing and regulatory requirements
    iii. Verify whether a recognized accrediting body has approved the provider **OR**
    iv. If not accredited provider has passed a CMS or state survey or meets rural exception
    v. Verify status with Medicaid/Medicare sanctions, preclusions and exclusions

3. CCHP will review the information collected at initial assessment and verify that the organization meets criteria listed in Criteria section
4. Non-accredited organizational providers are subject to individual review by the Executive Director of Clinical Services and will be considered for access need, only when the Executive Director of Clinical Services review indicates compliance with CCHP standards and there are no federal or state level deficiencies or sanctions that would adversely affect quality of care or patient safety.
5. In the case of reassessment, CCHP will review any information regarding effectiveness and efficiency of the provider since the initial or most recent assessment including but not limited to:
    i. Confirming that the provider continues to be in good standing with state and federal regulatory bodies and is reviewed and approved by an accrediting body OR
    ii. If not accredited provider has passed a CMS or state survey
6. The Credentialing department may terminate the organizational provider from participation in CCHP network, if criteria within this policy is not met. The credentialing department shall give the provider notice of any termination as defined in the provider's contract.

APPENDICES:

Appendix A
Organizational Provider Assessment/Reassessment Application

CITATIONS AND REFERENCES:

NCQA requirements: CR7 A,B,C
CCHP Practitioner and Organizational Provider Suspension, Termination and Appeal Rights
U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html)

Appendix A

Organizational Assessment/Reassessment Application

Instructions

This form should be printed in black or blue ink. If more space is needed than provided on the original, please attach additional sheets and reference the question(s) being answered. Any modifications to the wording or format of this application will invalidate the application.

- Please complete the application in its entirety
- Please sign and date the application
- Please attach the following, as applicable:

  ☐ Completed Facility Self-Evaluation Form *(enclosed, if applicable; *applies to non-accredited facilities only)*

  ☐ Copy of the organization's licensure issued by the State *(if applicable)*

  ☐ Copy of the organization's malpractice face sheet, showing dates and amounts of coverage

  ☐ Copy(s) of all accreditation certificates and survey results *(if applicable)*

  ☐ *(If not accredited)* Copy of most recent State Survey/Inspection Report, including Corrective Action Plan letter

Return application and attachments to:

Children's Community Health Plan
Attn: Credentialing MS 6280
PO Box 1997
Milwaukee, WI 53201
Email: cchp-credentialing@chw.org
Fax: (414) 266-5797

IMPORTANT

In order to remain in compliance with CCHP, each organization must be recredentialed every three (3) years. To allow CCHP adequate time to process your application, please return all requested materials by their due date. Failure to provide credentialing information to CCHP will delay the credentialing process and may affect your status as a plan provider.

Organization Information

Organization Type

Please check all boxes that apply: ☐ Ambulatory Surgical Center ☐ Home Health Agency ☐ Hospice Care ☐ Hospital – Number of beds: _____ ☐ Skilled Nursing Facility ☐ Other (explain):	☐ Behavioral Health Facility/Agency ☐ Mental Health: ☐ Substance Abuse: ☐ Day Treatment ☐ Day Treatment ☐ Inpatient ☐ Inpatient

Scope of Services

Please check all boxes that apply: ☐ Acute Care ☐ Ambulatory Surgery ☐ Home Health ☐ Hospice	☐ Mental Health ☐ Skilled Nursing ☐ Substance Abuse, Alcohol and Drug Treatment ☐ Other:

Corporate Information:

Legal Name of Organization (as reported to IRS):				
DBA (doing business as) Name of Organization:				
Address:			Tax ID (TIN):	
Mailing Address:			Phone:	Fax:
City:	State:	Zip:	Email:	
Contact Name:			Contact Title:	
Billing Address:			Phone:	Fax:
City:	State:	Zip:	Email:	
Credentialing Contact:			Phone:	Fax:
Address:			Email:	
Medicaid Number:			NPI(s):	

Facility Information:

Facility Location Name (*primary location*):

Facility Location Address (*primary location*): Contact Name and Title:

City: State: Zip:

Email: Phone:

Fax:

Medicaid Number: NPI(s):

If no Medicaid number, please explain:

Facility Administrator: Phone: ( ) Date facility opened and started operating (MM/YY):

Facility Location Name (*branch location, if applicable*):

Facility Location Address (*branch location*): Contact Name and Title:

City: State: Zip:

Email: Phone:

Fax:

Medicaid Number: NPI(s):

If no Medicaid number, please explain:

Facility Administrator: Phone: ( ) Date facility opened and started operating (MM/YY):

Facility Location Name (*branch location, if applicable*):

Facility Location Address (*branch location)*: Contact Name and Title:

City: State: Zip:

Email: Phone:

Fax:

Medicaid Number: NPI(s):

If no Medicaid number, please explain:

Facility Administrator: Phone: ( ) Date facility opened and started operating (MM/YY):

Accreditation

(Attach a copy of the most recent accreditation certificate for each accrediting body):

Is this facility accredited by a national accreditation organization? ☐ Yes ☐ No ☐ Pending

Select all that apply:

☐ AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities

☐ AAAHC – Accreditation Association for Ambulatory Health Care

☐ ACHC – Accreditation Commission for Health Care

☐ CARF/CCAC – Commission on Accreditation of Rehabilitation Facilities/Continuing Care Accreditation Commission

☐ CHAP – Community Health Accreditation Program

☐ CIHQ – Center for Improvement in Healthcare Quality

☐ COA – Council on Accreditation

☐ COLA – Commission on Office Laboratory Accreditation

☐ HFAP – Healthcare Facilities Accreditation Program

☐ NCQA – National Committee for Quality Assurance

☐ NIAHO/DNV GL - National Integrated Accreditation for Healthcare/Det Norske Veritas and Germanischer Lloyd

☐ TJC – The Joint Commission

Other:

Date of last survey (MM/DD/YYYY):

Has the accreditation organization been granted deeming authority by CMS for this provider type?

☐ Yes ☐ No

Has this provider ever been denied accreditation? ☐ Yes ☐ No *If yes, please provide explanation on separate sheet.*

Non-Accredited Facilities

Casper Report:

☐ Section N/A – Facility is accredited by a national accreditation organization (If N/A box is checked, please skip to section B: Accreditation Information)

CCHP will request a copy of your facility's most recent Casper report from the Wisconsin Department of Health Services (DHS). In addition to CCHP's request from the DHS, your facility is responsible for submitting documentation so that we may fully verify compliance status (as applicable). All applicable documents must be returned to CCHP with your completed application. Failure to provide credentialing information may delay the process and may affect your status as a plan provider*.

- Casper report documentation must be from a visit performed in the last three (3) years.
- Areas that were identified as requiring follow-up, improvements, corrections and/or identified deficiencies – please provide a letter of acknowledgement from the Wisconsin DHS indicating that the necessary corrections have been made and were deemed acceptable in each identified area.
- Substantiated complaints: please provide a listing of substantiated complaints, along with notification from the DHS of accepted Plan of Correction for each substantiated complaint.

*It is not necessary to submit your Plan of Correction in its entirety. State notification of accepted correction(s) or accepted plan of correction for each substantiated complaint is acceptable.

1. Current Compliance Status:
   ☐ Provider meets requirements
   ☐ Provider meets requirements based on an acceptable plan of correction
   ☐ Provider does not meet program requirements
- Were any deficiencies identified during the last full CMS/State survey? ☐ Yes ☐ No
- If yes, have all deficiencies been corrected?
   ☐ Yes – Accepted Plan of Correction letter (please attach letter from State documenting acceptance)
   ☐ No – Please attach written explanation of outstanding issues and how each issue is being addressed

2. Quality Issues:
   Substandard quality of care citations (Life Safety and Health citations): _____
   (Total number)

3. Complaints:
   Substantiated complaints in the last 36 months: _____
   (Total number)

**Note: if your facility does not meet program requirements and you are unable to provide documentation that the facility is in compliance with CMS, an on-site visit will be conducted by a Children's Community Health Plan credentialing staff member. You will be contacted to arrange a date and time for the visit.*

Licensure and Certificates

1. Is this facility participating in the Medicaid program? ☐ Yes ☐ No ☐ Pending (If Yes, please complete below)

2. Date of last full CMS survey (MM/DD/YYYY)*: _____

3. Date of most recent survey report (MM/DD/YYYY)**: _____

*If the facility is accredited by a national accreditation organization that has been granted deeming authority by CMS, the site survey performed by the accredited organization meets this requirement.

** Survey and report must be completed within the last three (3) years to be applicable.

License Type:	State:	Number:
Issue Date:	Expiration Date:	
Most Recent Survey Date:		
License Type:	State:	Number:
Issue Date:	Expiration Date:	
Most Recent Survey Date:		
License Type:	State:	Number:
Issue Date:	Expiration Date:	
Most Recent Survey Date:		

Has your licensure ever been revoked or otherwise limited? ☐ Yes ☐ No

If yes, please explain:

Registrations and Certificates (Attach a copy of all that apply):

DEA Number:	Issue Date:	Expiration Date:
CS/CDS Number:	Issue Date:	Expiration Date:

☐ CLIA – Clinical Laboratory Improvement Amendments **Please note: Certification required*

CLIA Number: Issue Date: Expiration Date:

Insurance Coverage
(Attach a copy of current liability insurance face sheet):

Coverage Type: ☐Claims Based ☐Occurrence Based ☐Tail Coverage ☐Umbrella

Carrier Name:	Policy Number:
Carrier Address:	
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

Credentialing Program
1. Do you verify the credentials of all licensed staff that you employ? ☐ Yes ☐ No For YES: How frequently is this verified? For YES: Please check method(s) of verification for licensed staff: ☐ Online directly with the appropriate State Board ☐ Obtaining a current copy of the license ☐ Other _____ For YES: Please check method(s) of verification for non-licensed staff: ☐ Background check agency ☐ Previous employer(s) ☐ Other
2. Do you ensure that each of the LICENSED staff practicing at your facility renews his/her State License before it expires? ☐ Yes ☐ No
3. Do you perform background checks on all staff before hiring? ☐ Yes ☐ No For YES: Please check all method(s) utilized: ☐ Federal and/or State Criminal Background Check(s) ☐ Background Check agency ☐ Search a State 'Misconduct Registry' or equivalent ☐ Other:
4. When a licensed professional is hired at this facility, who ensures they are licensed upon hire and that their license stays current?
5. What other screening activities are done to ensure the person is competent for the position they hold?
6. Are subcontractors required to carry individual medical malpractice/professional liability insurance? ☐ Yes ☐ No For YES: What amounts?
7. If you use Telemedicine, do you verify licensure of the individual providers? ☐ Yes ☐ No For YES: How often?
8. Is there 24 hour health provider coverage in the facility? ☐ Yes ☐ No For YES: What type of provider?
9. Are inpatient services available? (non-hospital only) ☐ Yes ☐ No ☐ N/A For NO: Do you have written agreements with local hospitals for immediate acceptance of patients that require care? ☐ Yes ☐ No For YES: List hospital(s)
10. Does the facility have a licensed Anesthesiologist or CRNA? ☐ Yes ☐ No ☐ N/A
11. Is a physician and Anesthesiologist/CRNA required to remain present during surgical procedures? ☐ Yes ☐ No ☐ N/A
12. Are RN's available for patient care at all times in the operating and recovery rooms? ☐ Yes ☐ No ☐ N/A

Attachments

(Documents, if applicable, must be submitted with the completed application)

Please place a check next to each document that is being included with the completed application:

☐ Completed Facility Self-Evaluation Form (enclosed, if applicable; *applies to non-accredited facilities only)

☐ Copy of the organization's licensure issued by the State (if applicable)

☐ Copy of the organization's malpractice face sheet, showing amounts of coverage and coverage dates

☐ Copy(s) of all accreditation certificates and survey results (if applicable) (If not accredited)

Action History Questions

(Pertaining to the last 5 years)

*Please respond to the following questions YES or NO. If your answer to any of the following questions is YES provide a detailed explanation, as specified in each question, on a separate sheet. Sign and date each additional sheet. **Modification to the wording or format will invalidate the application.*

1. Has this facility, under any current or former name or business identity, ever had any felony convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?

   ☐ Yes ☐ No

2. Has this facility, under any current or former name or business identity, ever had any felony convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?

   ☐ Yes ☐ No

3. Has this facility, under any current or former name or business identity, ever had any felony convictions under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR Section 1001.101 or 1001.201?

   ☐ Yes ☐ No

4. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?

   ☐ Yes ☐ No

5. Has this facility ever had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

   ☐ Yes ☐ No

6. Has any settlement been paid on behalf of the facility and/or any of its employees?
   ☐ Yes ☐ No

7. Has this facility, under any current or former name or business identity, ever had accreditation revoked or suspended?
   ☐ Yes ☐ No

8. Has this facility, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program?
   ☐ Yes ☐ No

9. Is this facility, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?
   ☐ Yes ☐ No

10. Has this facility, under any current or former name or business identity, ever had the malpractice insurance terminated or revoked except by request or consent?
    ☐ Yes ☐ No

11. Has this facility, under any current or former name or business identity, ever had or currently have pending, any legal actions excluding medical malpractice?
    ☐ Yes ☐ No

Compliance

1. Does this facility currently meet all State and Federal requirements? ☐☐Yes ☐☐No

2. Does this facility currently meet requirements set forth by the Centers for Medicare and Medicaid Services? ☐☐Yes ☐☐No

AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this application, it is agreed and understood that:

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as a CCHP Participating Provider or cause for summary dismissal from CCHP or be subject to applicable state or federal penalties for perjury.

I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with CCHP.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with CCHP and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by CCHP.

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

**This provider complies with all Federal, State and local handicapped access requirements as well as the standards required by the Federal Americans with Disabilities Act (ADA).

_____	_____
Printed Name of Authorized Representative	Signature of Authorized Representative
_____	_____
Authorized Representative's Title	Date Signed