Excellus

SUBJECT: CREDENTIALING/RECREDENTIALING OF HEALTH DELIVERY ORGANIZATIONS SECTION: CREDENTIALING POLICY NUMBER: CR-07	EFFECTIVE DATE: 1/01
Applies to all products administered by the Plan except when changed by contract	

The Plan is committed to providing quality care and services to its members. To support this goal, the Plan evaluates health delivery organizations with which it contracts through either an organizational assessment process or a credentialing process, as applicable to the provider type.

Health Delivery Organizations Subject to Organizational Assessment

Certain health delivery organizations are not credentialed by the Plan but are subject to an organizational assessment prior to contracting and at least every thirty-six (36) months thereafter.

The assessment includes verification that the organization:

- Holds a valid license to operate and complies with applicable state and federal requirements;
- Is accredited by a recognized accrediting body (e.g., TJC, CHAP) or meets standards established by the Medicare Advantage (MA) organization;
- Maintains Medicare approval and, where applicable, a signed participation agreement with CMS and meets CMS conditions for coverage.

Organizations subject to organizational assessment include:

- Durable Medical Equipment (DME) suppliers;
- Clinical laboratories holding a CMS-issued CLIA certificate or hospital-based CLIA exemption;
- Hospices;
- Providers of End-Stage Renal Disease (ESRD) services;
- Providers of outpatient diabetes self-management training services;
- Portable X-ray suppliers; and
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

These organizations are assessed for compliance with applicable regulatory, accreditation, and Medicare participation requirements but are not credentialed through the Plan's facility credentialing process**.**

Health Delivery Organizations Subject to Credentialing

Licensed and regulated facilities requesting participation in the Plan's network that are designated by the Plan as credentialed provider types shall undergo credentialing prior to participation and recredentialing at least every thirty-six (36) months thereafter.

Credentialed organizations must satisfy all credentialing criteria established for their specific provider type. The Plan will not contract with organizations that fail to meet applicable credentialing requirements.

The Plan credentials only licensed and regulated facilities as defined below.

Definitions:

Acute General Hospitals - must provide inpatient, outpatient and emergency services. At a minimum, the hospital must have been reviewed and approved by a recognized accrediting body (i.e. The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP), DNV Healthcare Inc. (DNVHC) or Centers for Medicare & Medicaid Services (CMS) Accreditation.), be certified/ licensed by and in good standing with state and federal regulatory bodies (i.e. NYS Department of Health, Medicare and Medicaid), and maintain general and malpractice insurance limits of $1/$3 million. Contracted hospitals with greater than 50 beds, if not working with a Patient Safety Organization (PSO), must implement an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events, that reduces all cause preventable harm, prevents hospital readmission or improves care coordination.

Freestanding Dialysis Centers - at a minimum, must be accredited by Centers for Medicare & Medicaid Services (CMS), be certified/licensed by and in good standing with state and federal regulatory bodies (i.e. NYS Department of Health, Medicare and Medicaid), and maintain general and malpractice insurance limits of $1/$3 million.

Freestanding Sleep Study Center - at a minimum, the facility must have been reviewed and approved by the American Academy of Sleep Medicine (AASM), be certified/licensed by and in good standing with state and federal regulatory bodies (i.e. NYS Department of Health, Medicare and Medicaid), and maintain general and malpractice insurance limits of $1/$3 million.

Freestanding Surgical Centers - at a minimum, must have been reviewed and approved by a recognized accrediting body (i.e. The Joint Commission (TJC), Accreditation Association for Ambulatory Health Care (AAAHC), be certified/licensed by and in good standing with state and federal regulatory bodies (i.e. NYS Department of Health, Medicare and Medicaid), and maintain general and malpractice insurance limits of $1/$3 million.

Freestanding Urgent Care Centers - at a minimum, the center must be licensed by the NYS Department of Health as an Article 28 Diagnostic and Treatment Center and have been reviewed and approved by the Joint Commission (TJC) or other recognized accrediting body (e.g., National Urgent Care Center Accreditation (NUCCA), Accreditation Association for Ambulatory Health Care (AAAHC), or Urgent Care Association (UCA). If the center is **not** accredited by TJC, all physicians and other licensed independent practitioners practicing at the center must be credentialed by the Plan. All independently practicing Nurse Practitioners must be credentialed by the Plan, and all supervised Nurse Practitioners must register with the Plan, as applicable. If the center provides office-based surgical or invasive procedures, the center must maintain accreditation by one of the New York State Department of Health–approved accrediting agencies for office-based surgery, in accordance with NYS requirements. The center and all practitioners must be in good standing with all applicable state and federal regulatory bodies, including but not limited to the Office of Professional Medical Conduct (OPMC) and Medicare and Medicaid programs. All providers must maintain current, unrestricted professional licensure, be in good standing, and carry general and professional liability (malpractice) insurance with minimum coverage limits of $1 million per occurrence / $3 million aggregate, or as otherwise required by the Plan.

Home Health Agencies - must make available the services of registered and licensed practical nurses, certified home health aides, as well as occupational/physical/speech therapists. At a minimum, the agency must be certified/licensed by and in good standing with state and federal regulatory bodies (i.e., NYS Department of

Health, Medicare and Medicaid), and maintain general and malpractice insurance limits of $1/$3 million (exceptions to limits may be approved by the Corporate Risk Manager on a case by case basis.)

Skilled Nursing Facilities - must provide discharge planning services, nursing supervision and services by registered or licensed practical nurses, nurses aids, occupational/physical/speech therapists, routine medical supplies and semi-private room and board. At a minimum, the facility must be certified/licensed by a recognized entity (i.e. The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Continuing Care Accreditation Commission (CCAC) and in good standing with state and federal regulatory bodies (i.e. NYS Department of Health, Medicare and Medicaid), and maintain general and malpractice insurance limits of $1/$3 million (exceptions to limits may be approved by the Corporate Risk Manager on a case by case basis.)

Outpatient Mental Health Treatment Facilities (Community Mental Health Centers) – for New York facilities, the facility must have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or operated by the Office of Mental Health (OMH) and, in other states, similarly licensed or certified. The facility must maintain general and malpractice insurance with limits of $1/$3 million (exceptions to limits may be approved by the Corporate Risk Manager on a case-by-case basis).

Outpatient Substance Use Disorder Treatment Facilities - for New York facilities, the facility must be certified by Office of Alcoholism and Substance Abuse Services (OASAS); or licensed by OASAS as an outpatient clinic or medically supervised ambulatory substance abuse program, and, in other states, licensed or certified by a similar state agency or accredited by The Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. The facility must maintain general and malpractice insurance with limits of $1/$3 million (exceptions to limits may be approved by the Corporate Risk Manager on a case-by-case basis).

Inpatient Mental Health Facilities - for New York facilities, the facility must be either (a) a "hospital" as defined in Mental Hygiene Law 1.03(10) (such as, a psychiatric center or inpatient facility under the jurisdiction of the New York State Office of Mental Health; a state or local government run psychiatric inpatient facility; a part of a hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health; or a comprehensive psychiatric emergency program or other facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health); or if out of state, similarly licensed or certified in that state to provide the same level of treatment. The facility must maintain general and malpractice insurance limits of $1/$3 million.

Inpatient Substance Use Disorder Facilities – for New York facilities, the facility must be certified by the Office of Alcoholism and Substance Abuse Services (OASAS); and, for out of state facilities, the facility must be licensed or certified by a similar state agency or The Joint Commission accredited as an alcoholism, substance abuse or chemical dependence treatment program to provide the same level of treatment. The facility must maintain general and malpractice insurance limits of $1/$3 million.

Mental Health Residential Treatment Facility: for New York facilities, the facility must be either (a) a "residential treatment facility for children and youth" as defined in Mental Hygiene Law 1.03(33), or (b) a facility that is part of a comprehensive care center for eating disorders identified in accordance with Public Health Law Article 27-J; and for out-of-state facilities, the facility must be licensed or certified in that state to provide the same level of treatment. The facility must maintain general and malpractice insurance limits of $1/$3 million.

Substance Use Disorder Residential Treatment Facility: for New York facilities, the facility must be Office of Alcoholism and Substance Abuse Services (OASAS) certified to provide services defined in 14 NYCRR 819.2(a)(1), ***820.3(a)(1) and (2),*** and Part 817; and for out-of-state facilities, the facility must be licensed by a similar state agency or The Joint Commission accredited as an alcohol, substance use, or chemical dependency treatment program to provide the same level of treatment.

New York State Operated Psychiatric Outpatient Centers ("NYS Operated Center"): These are facilities providing behavioral health services for "government-sponsored programs" defined as managed care products offered to eligible individuals under New York State's managed care programs. The NYS Operated Center must be certified by the New York State Office of Mental Health (OMH) Bureau of Inspection and Certification (BIC). BIC conducts onsite inspections and periodic re-inspections of all mental health outpatient treatment programs that are subject to licensing under the requirements of New York State Mental Hygiene Law.

Process:

1. Upon receipt of a request from a provider to become participating, the Contract Manager will forward a letter verifying the credentialing requirements. The same process shall also be applied should the request for contract be initiated internally.

a) As information is received, the Contract Manager will initiate a Provider Checklist. The checklist will be completed as various certificates, licenses and other documentation is received.
b) Copies of program summaries, statistics, and staffing information will be collected and forwarded to the appropriate clinical manager or staff to evaluate and determine appropriateness for coverage.
c) A Health Delivery Organization Credentialing Worksheet will be initiated or updated relative to provider specialty.

2. Once the provider file is complete, a determination will be made to (re) credential/not (re) credential the provider based on the following:

a) The provider meets/does not meet (re)credentialing criteria.
b) The services meet/do not meet our program requirements.
c) The services are/are not considered covered benefits.
d) There is/is not a need for additional access to care/providers.

3. A decision is made to credential the provider.

A. If a decision is made to credential the provider, the Contract Manager will determine whether an appropriate contract exists:

1) If yes, a package will be forwarded to the provider containing two (2) sets of contracts for consideration and signature.
2) If no, the Contract Manager will draft the contract, circulate it to appropriate clinical staff for review and input. Upon completion of clinical review, the Contract Manager will submit the contract through the Corporate Contract Approval process for final review and endorsement. The contract package will then be sent to the provider for review and signature.
3) Credentialing will assist the applicant in accessing a Plan accepted application.
4) Notify the applicant of missing or incomplete elements of the application.

5) Notify the applicant, within 60 days of receipt of a completed application, whether he/she is credentialed or whether additional time is needed to make a determination because a third party has failed to provide necessary documentation.
6) Where additional time is needed to make a determination due to the failure of a third party to provide necessary documentation, ensure that every effort is made to obtain such information as soon as possible, and shall make a final determination within 21 days of receiving the necessary information from a third party.

The Plan's processes, strategies and methodologies for determining and applying credentialing requirements is comparable and no more stringently applied to mental health/substance use disorder providers as applied to medical/surgical providers.

B. If a decision is made not to credential the provider, the Contract Manager will send a letter notifying the provider of the decision to deny participation status at that time.

4. There are established (re) credentialing criteria for each health delivery organization provider type. If a health delivery organization does not meet the criteria listed below, they may be considered for participation following an on-site review. Refer to item 5 below.

A. Hospitals:
   a. Operating License and Certificate;
   b. Accreditation from a recognized accrediting body (e.g. TJC, HFAP, DNVHC or CMS)
   c. Medicare and Medicaid Certification;
   d. Certification from the OMH for Acute Care General Hospitals with Mental Health Services.
   e. Certificate of Insurance.

B. Freestanding Dialysis Centers:
   a. Operating License and Certificate;
   b. Accreditation by Centers for Medicare & Medicaid Services (CMS)
   c. Medicare and Medicaid Certification;
   d. Certificate of Insurance.

C. Freestanding Sleep Study Centers:
   a. Operating License and Certificate:
   b. Medicare and Medicaid Certification:
   c. AASM Accreditation.
   d. Certificate of Insurance.

D. Freestanding Surgicenters/Ambulatory Care Organizations:
   a. Operating License and Certificate;
   b. Medicare and Medicaid Certification;
   c. Accreditation from a recognized accrediting body (e.g. TJC, AAAHC);
   d. Certificate of Insurance.

E. Freestanding Urgent Care Centers:
1. Operating License Certificate;
2. TJC Accreditation. An on-site review may be required as stipulated in item number 5; **OR**
3. Accreditation by a recognized accrediting body (i.e. Urgent Care Center Accreditation (UCCA), American Academy of Urgent Care Medicine (AAUCM) **AND**
4. Independently practicing Nurse Practitioners must be credentialed, **AND**
5. All employed providers must be credentialed, and all Nurse Practitioners supervised by an on-site credentialed physician must be registered with the Health Plan.
6. Current unrestricted licensure of providers and nurse practitioners;
7. Medicare and Medicaid Certification.
8. Certificate of Insurance.

F. Home Health Agencies: (including Certified Home Health Agencies and Licensed Home Health Agencies)
1. Operating License and Certificate.
2. Medicare and/or Medicaid Certification.
3. Accreditation from a recognized accrediting body (e.g. TJC or ACHC)-Organizations not accredited are requested to submit their most recent Department of Health Survey.
4. Certificate of Insurance.

G. Skilled Nursing Facilities:
1. Operating License and Certificate;
2. Medicare and Medicaid Certification;
3. Accreditation from a recognized accrediting body (e.g. TJC, CARF or CCAC) – Organizations not accredited are requested to submit their most recent NYSDOH Survey;
4. Certificate of Insurance.

H. Outpatient Mental Health Treatment Facilities (Community Mental Health Centers):
1. Operating License and Certificate and/or;
2. Operated by the OMH;
3. Medicare and Medicaid Certification;
4. List of qualified individuals providing services and stated credentials;
5. Certificate of Insurance.

I. Outpatient Substance Use Disorder Treatment Facilities (Chemical Dependency Treatment Centers):
1. Operating License and Certificate.
2. Medicare and Medicaid Certification;
3. Certification from OASAS.
4. List of qualified individuals providing services and stated credentials;
5. Certificate of Insurance.

J. Inpatient Mental Health Facilities:
1. Operating License and Certificate;

2. Medicare and Medicaid Certification;
3. Certification from OMH.
4. (i)for New York facilities, the facility must be either (a) a "hospital" as defined in Mental Hygiene Law 1.03(10);
   (ii) For out of state facilities, licensed or certified in that state to provide the same level of treatment
5. Certificate of Insurance.

K. Inpatient Substance Use Disorder Facilities:
1. Operating License and Certificate;
2. Medicare and Medicaid Certification;
3. (i) For New York facilities, certification from OASAS;
   (ii) For out of state facilities, licensure or certification from a similar state agency, or accreditation from TJC as an alcohol, substance use, or chemical dependency treatment program, providing the same level of care;
4. Certificate of Insurance.

L. Mental Health Residential Treatment Facility
1. Operating License and Certificate.
2. Medicare and Medicaid Certification.
3. (i) For NY facilities, the facility must be either (a) a "residential treatment facility for children and youth" as defined in Mental Hygiene Law 1.03(33), or (b) a facility that is part of a comprehensive care center for eating disorders identified in accordance with Public Health Law Article 27-J
   (ii) For out-of-state facilities, licensure or certification in that state to provide the same level of treatment.
4. Certificate of Insurance

M. Substance Use Disorder Residential Treatment Facility
1. Operating License and Certificate.
2. Medicare and Medicaid Certification.
   (i) For NY facilities, certification from OASAS to provide services defined in 14 NYCRR 819.2(a)(1) and Part 817
   (ii) For out-of-state facilities, licensure from a similar state agency or accreditation from The Joint Commission (TJC) as an alcohol, substance use, or chemical dependency treatment program to provide the same level of treatment
3. List of qualified individuals providing stated services.
4. Certificate of Insurance

N. NYS Operated Centers
a. OMH self-certifies its State-operated programs. OMH will provide NYS Operated Center with a letter with a corresponding list of such certified programs to obviate the need for proof of licensure or certificate of need information or certification appears on the approved OMH BIC listing.
b. New York State provides malpractice coverage: NYS Operated Center is operated by State of New York and therefore the State of New York is liable for claims arising out of NYS Operated Center's, and/or its employee's' performance pursuant to Section 8 of the New York State Court of Claims Act.

5. An on-site review will be conducted if the above criteria are not met. The guidelines used for the on-site review includes verification of:

A. A current, active Quality Management Program.
B. Current, active Policy and Procedure Manual.
C. Quality Management meetings are held and appropriate to the organization.
D. Indicators are in place to address the measurement, action and frequency of reports/monitoring.
E. Monitoring/reporting of member complaints are being identified and appropriate action taken.
F. Outcome studies are being performed.
G. Individual member's plan of care corresponds to that prescribed by the member's physician.
H. An interview with the organizations Director of Quality Program is also conducted at the time of the on-site visit.

Cross Reference:
Adopted from BlueCross BlueShield of the Rochester Area MCO Policy and Procedure #CR-7 Dated 1/98, BlueCross BlueShield of Utica-Watertown HMOBlue Policy and Procedure #CR-VI Dated 4/99, BlueCross BlueShield of Central New York HMO-CNY Corporate Policy, Standard and Procedure # Assessment of Health Delivery Organizations Dated 1/24/99.

Committee Approvals:
Corporate Credentialing Committee: 1/6/06, 4/19/06, 3/21/07, 9/17/08, 8/18/10, 8/15/12, 11/14/2012, 5/15/13, 7/15/15, 10/21/15rev, 10/19/16 rev; 10/17/18 renewal; 12/19/2019 rev; 4/21/2021 rev; 11/16/2022 rev; 10/16/2024 renewed; 5/21/2025 rev; 5/20/2026 revised

Excellus Credentialing Committee: 12/16/02, 6/20/05
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MCOCC 11/13/00
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