Health Care Agency Mental Health and Recovery Services Policies and Procedures	Section Name: Sub Section: Section Number: Policy Status:	Compliance Credentialing 07.04.04 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Chief of Operations Mental Health and Recovery Services	_Signature on File_____	_6/13/2022_____

SUBJECT:	Credentialing and Re-credentialing of Individual Providers

PURPOSE:

To detail the credentialing and re-credentialing requirements for staff providing services under the County of Orange Medi-Cal Mental Health Plan (hereby referred to Orange MHP) and the Drug-Medi-Cal Organized Delivery System (DMC-ODS).

POLICY:

It is the policy of Mental Health and Recovery Services (MHRS) that credentialing and re-credentialing of providers to participate in the provision of Orange MHP and DMC-ODS services are as follows:

- Providers providing services under the Orange County MHP and DMC-ODS shall be credentialed in accordance with the requirements set out by the Department of Health Care Services (DHCS) and 42 Code of Federal Regulations (CFR), Part 438.

- Credentialing/re-credentialing policies and procedures shall be reviewed and approved by the Mental Health and Recovery Services (MHRS) credentialing governing body or designee, upon recommendation from the MHRS credentialing committee, which consists of MHRS Authority and Quality Improvement Services (AQIS) and MHRS service area managers.

- Responsibility for recommendations regarding credentialing decisions rest with MHRS as described below.

- Credentialing approval of individual providers shall be completed and approved prior to providing eligible Medi-Cal services.

- Shall comply with additional requirements established by DHCS.

SCOPE:

Staff at County-operated and County-contracted programs providing services to Medi-Cal beneficiaries under the Orange MHP and DMC-ODS. Network providers in the County's

Administrative Services Organization (ASO) are credentialed by the ASO per contractual obligations.

REFERENCES:

DHCS MHSUD Information Notice 18-019 (IN-18-019) - Provider Credentialing and Re-Credentialing for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties

MHRS P&P 07.04.05 Individual Provider Credentialing Committee

MHRS P&P 07.04.01 Verification of Individual NPI Numbers and Professional Licenses at Initial Medi-Cal Certification and Medi-Cal Re-Certification

Social Security Act, Section 1128 [42 U.S.C. §1320a-7] Exclusion of certain individuals and entities from participation in Medicare and State health care programs

Executive Order 12549 –Debarment and Suspension [51 FR 6370, 3 CFR, 1986 Comp, p. 189]

HCA P&P VIII-16.09 Screening for an Ineligible Person/Entity

DEFINITIONS:

Credentialing – Credentialing is a uniform process for verifying, through primary source, the education, training, experience, licensure and overall qualifications of behavioral health and substance use disorder services providers.

Re-credentialing - the process of verification every three years that a provider continues to meet Orange MHP and DMC-ODS credentialing requirements.

Credentialing Committee – a multi-disciplinary body approved by the Deputy Agency Director of Mental Health and Recovery Services (MHRS), or designee to ensure that providers providing services to Medi-Cal beneficiaries meet or continue to meet credentialing/re-credentialing requirements.

Credentialing Verification Organization (CVO) – an agency delegated to gather, verify and process all information necessary to complete the credentialing and re-credentialing process.

PROCEDURE:

I. Selection of Individual Providers

   A. Shall include implementation of provider credentialing and re-credentialing requirements set out by DHCS. The process for implementing these requirements is set out in MHRS Policy and Procedure 07.04.01 Verification of Individual NPI Numbers and Professional Licenses at Initial Medi-Cal Certification and Medi-Cal Re-Certification.

B. Shall include processes to ensure that County employed or County contracted provider are not excluded from participation in Federal health care programs. The process for implementing this is set out in MHRS Policy and Procedure 07.04.01 Verification of Individual NPI Numbers and Professional Licenses at Initial Medi-Cal Certification and Medi-Cal Re-Certification.

C. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

D. Shall not allow employment or subcontracting with providers excluded from participation in Federal health care programs; under either section 1128 or section 1128A of the act.

E. Shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

II. Credentialing and Re-Credentialing of Individual Providers

A. MHRS shall delegate the gathering and processing of credentialing information to a professional Credentialing Verification Organization (CVO), which shall be contracted with a formal and detailed agreement regarding the credentialing activities. The contracting process shall include an initial review to assure that the credentialing entity has the administrative capacity, task experience and budgetary resources to fulfill its responsibilities. MHRS monitoring of the contracted CVO shall be performed by the Authority and Quality Improvement Services (AQIS) Managed Care Support Team (MCST) and shall include continuous monitoring, evaluation and approval of the delegated functions.

B. Identifying information shall be captured by MHRS for all licensed, waivered, registered and/or certified individual providers providing services claimable to Medi-Cal for either the Orange MHP and/or the DMC-ODS.

C. The credentialing process shall occur electronically through the CVO's online system. The CVO shall generate a link to the credentialing application, which shall be completed by the individual provider within seven (7) calendar days.

D. If the individual provider fails to complete the credentialing application submission within seven (7) days, the application shall be denied.

E. For all network providers who deliver covered services, each individual provider's credentialing application shall include a signed and dated statement attesting to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;

2. A history of loss of license or felony conviction related to exclusions by the Office of the Inspector General (OIG);

3. A history of loss or limitation of privileges or disciplinary activity;

4. A lack of present illegal drug use; and

5. The application's accuracy and completeness.

F. The credentialing process shall include all documents required in DHCS IN 18-019, as applicable to the provider type and as listed below. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information shall be verified by the CVO unless there is documentation that the applicable licensing, certification and/or registration board have previously verified the required information.

G. The CVO shall perform primary source verification of the following items:

1. The appropriate license and/or board certification or registration, as required for the particular provider type;

2. Evidence of graduation or completion of any required education, as required for the particular provider type;

3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and

4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

H. In addition, the CVO shall verify and document the following information from each individual provider, as applicable, but need not verify this information through a primary source:

1. Work history;

2. Hospital and clinic privileges in good standing;

3. History of any suspension or curtailment of hospital and clinic privileges;

4. Current Drug Enforcement Administration (DEA) identification number (if applicable);

5. National Provider Identifier (NPI) number;

6. Current malpractice insurance in an adequate amount, as required for the particular provider type;

7. History of liability claims against the provider;

8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;

9. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp and

10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

I. The CVO shall complete all credentialing checks and return the completed credentialing packet to AQIS MCST within 30 days of receiving a complete application from each individual provider. Providers shall not be eligible to provide Medi-Cal covered services until their credentialing application has been approved.

J. Upon receipt of the completed credentialing packet from the CVO, MHRS shall apply the following review process:

   1. The AQIS MCST shall evaluate each packet returned from the CVO. This evaluation shall consist of a review of all materials contained in the credentialing packet submitted by the CVO and a review of any past grievances or quality of care deficiencies demonstrated by the provider, as applicable. If there are no irregular items found on the credentialing application, the packet shall be moved for approval by the AQIS MCST Manager. These evaluations shall be known as first level reviews

K. If upon initial evaluation of the credentialing or re-credentialing packet any of the following, or other irregular items are noted, the packet will be forwarded to the credentialing committee for review and to solicit quality assurance/quality improvement recommendations from the committee. However, this action shall not result in automatic denial of an application. These evaluations shall be known as second level reviews.

   1. A history of grievances against the provider for quality of care reasons.

   2. A history of inappropriate clinical practices based on records reviews.

   3. Issues identified through the plan's quality improvement activities.

   4. A history of past or present adverse entries into the provider's profile found in any of the databases reviewed by the CVO during the credentialing process.

L. Credentialing applications that demonstrate a history of the following items shall result in credentialing denials and exclusion from participation in the Orange MHP or DMC-ODS.

1. Individuals excluded from participation by the secretary of the Office of the Inspector General (OIG) as stated on sections 1128 and 1128A of the Social Security Act.

2. An individual that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

M. In the event that an individual provider loses or allows to expire his or her license, certification, waiver or registration at any time, the provider shall cease providing services to Medi-Cal beneficiaries and shall be referred to his or her organization's Human Resource or other applicable department for further action, if needed.

N. AQIS MCST shall report serious quality deficiencies that result in suspension or termination of an individual provider to the Department of Health Care Services (DHCS) and other authorities as appropriate.

O. The CVO shall be responsible for maintaining a provider file for each credentialed provider, which shall include the following:

1. Routine sanction screenings as required,

2. Maintenance of each provider's credentials expiration dates,

3. Licensing or certification body renewals,

4. Required continued education,

5. Any special designations or certifications,

6. Any changes in provider NPI or certifying/licensing body registration numbers or status.

P. Re-credentialing shall occur at a minimum every three (3) years to ensure that each individual provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. Providers shall be required to submit to the CVO any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition to the initial credentialing requirements, re-credentialing shall include documentation that MHRS has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

Q. Individual providers whose credentialing applications are denied or whose privileges are suspended or terminated may file an appeal with Orange County MHRS. Such appeal shall be decided by a committee that does not include any individuals who were involved in the original denial decision. The appeals sub-committee shall be composed of at least three of the following credentialing committee representatives, as appropriate for the situation. Decisions by the appeals committee shall be considered final.

1. Authority and Quality Improvement Services (AQIS), Division Manager or designee

2. Adult and Older Adult (AOA), Division Manager or designee

3. Children, Youth and Prevention (CYP), Division Manager or designee

4. MHRS Medical Director or Associate Medical Director designee

R. Serious quality deficiencies that result in suspension or termination of an individual provider's eligibility to provide services to Medi-Cal beneficiaries shall be reported by the AQIS MCST to DHCS and other authorities as appropriate.

S. Any possible disciplinary actions that may be required as a result of the credentialing process shall be deferred to the authority of the individual provider's organization's Human Resources and/or other appropriate bodies, and such entity shall apply its policies and procedures as deemed appropriate by the entity.