



Orange County Final Rule Implementation

CalQIC 2019

March 14, 2019

Azahar V. López, PsyD, CHC
SUD Support Team Manager

Title 42 Code of Federal Regulations

- May 6, 2016 – Centers of Medicare and Medicaid published the Medicaid and Children’s Health Insurance Program Managed Care Final Rule.
- Aligns Medicaid managed care regulations with requirements of other major sources of health insurance coverage.
- County MHP and DMC-ODS pilot counties are considered Prepaid Inpatient Health Plans and must comply with managed care requirements.

Credentialing and Re-credentialing

42 CFR Part 438.214

- Managed care rules require the state to establish a uniform credentialing and re-credentialing policy that addresses mental health (MH) and substance use disorder (SUD) providers.
- Credentialing is one component of the comprehensive quality improvement system included in all plan contracts.
- Credentialing ensures that providers are licensed, registered, waived and/or certified as required by federal law.

MHSUDS Information Notice 18-019



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

DATE: April 24, 2018

MHSUDS INFORMATION NOTICE NO.: 18-019

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: PROVIDER CREDENTIALING AND RE-CREDENTIALING FOR MENTAL HEALTH PLANS (MHPs) AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) PILOT COUNTIES

PURPOSE

The purpose of this Mental Health and Substance Use Disorders Services Information Notice (IN) is to inform county Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) pilot counties, herein referred to as Plans unless otherwise specified, of the Department of Health Care Services' (DHCS) statewide uniform provider credentialing and re-credentialing requirements, established pursuant to Title 42 of the Code of Federal Regulations, Part 438.214.

BACKGROUND

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Final Rule), which aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. County MHPs and DMC-ODS pilot counties are considered Prepaid Inpatient Health Plans, and must therefore comply with federal managed care requirements (with some exceptions).

This IN also includes policy changes DHCS has made for compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule).

Mental Health & Substance Use Disorder Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
Phone: (916) 440-7800 Fax: (916) 319-8219
Internet Address: www.dhcs.ca.gov

MHSUDS INFORMATION NOTICE NO.: 18-019

Page 3

April 24, 2018

CREDENTIALING POLICY

For all licensed, waived, registered and/or certified providers⁴, the Plan must verify and document the following items through a primary source,⁵ as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the Plan unless the Plan can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

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.

In addition, Plans must verify and document the following information from each network 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 identification number;
5. National Provider Identifier 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/SandLanding.asp>; and
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

⁴ For SUD, providers delivering covered services are defined in Title 22 of the California Code of Regulations, Section 51051.

⁵ Primary source refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.

What is credentialing?

For all licensed, waived, registered and/or certified providers, the Plan must verify and document the following items through a primary source, as applicable.

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.

Secondary Source verification requirements

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 identification number;
5. National Provider Identifier 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.

Additional credentialing requirements

Attestation

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;
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.

Frequency

DHCS requires each Plan to verify and document at a minimum **every three years** that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed in the previous slides.

Re-credentialing requires

- New attestation
- Consideration of beneficiary grievances, quality improvement activities and medical records review.

What did Orange County do?

Assessed needs to ensure compliance

- Number of staff needing credentialing in the network
 - Includes County-operated and County-contracted
- Typical staff turn-over
- Current staffing in the division responsible for credentialing – Authority and Quality Improvement Services (AQIS)
- Expected credentialing volume
- Resources, expertise and tools needed for compliance
- Funding needs and sources

Approximately 2,000 staff for MHP and DMC-ODS would need to be credentialed in the first year

What did Orange County do?

Considered options

- Complete credentialing in-house
- Delegate credentialing process
 - Identified possible solutions for delegation
 - Contract with a credentials verification organization (CVO)
 - Identify existing partners that may be able to assist, such as the County's Medi-Cal health plan or the Administrative Services Organization

What did Orange County do?

Collaborated across divisions to identify and mitigate impact

- Human Resources
 - What would be the impact to existing staff?
- County Counsel
 - What are the legal implications for potentially changing the terms of employment?
- Office of Compliance
 - What processes are already in place through the compliance office requirements?

What did Orange County do?

Funding available through

- DMC-ODS QA/UR claiming
- MHP Final Rule

Additional staff would be needed regardless of solution

Decision -

Issue a Request for Proposal to identify CVOs that may be able to do the work as required.

Orange County credentialing solution

Currently in negotiations with a CVO to delegate the work

New managed care unit created in the AQIS division to perform credentialing and other Final Rule requirements

- Provider Directory
- Grievances and Appeals
- NOABD and other beneficiary protections
- Medi-Cal and DMC certifications
- Network Adequacy Certifications

Managed Care solution

Additional opportunities identified to create an internal database that will generate information on demand to comply with:

- NACT submissions
- Provider Directory
- Grievances and Appeals
- Credentialing

Health Care Agency Information Technology (IT) department currently engaged in developing a work plan.

Where do we go from here?

- Simultaneous implementation of CVO contract to comply with credentialing requirements and internal IT solution to fulfill the greater need.
- IT staff has been involved in evaluating CVO capabilities to ensure a smooth transition and the system's ability to transfer data routinely into the internal solution.
- New Managed Care unit in AQIS will manage the CVO contract and implementation process to maximize efficiencies and to reduce the demands for additional County staff.

Conversation

- What questions do you have?
- What are other counties doing?

THANK YOU!!!

Azahar López, PsyD, CHC

Orange County – Behavioral Health Services
Authority and Quality Improvement Services

AzLopez@ochca.com

(714) 796-0208

If you are a County DMC-ODS Q/I professional in the Southern California region, join us at the South Waiver Accountability Group (SWAG).



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