7.1.3 Provider Network Enrollment, Retention and Referral Criteria

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References: CCR Title 9, Chapter 11, Article 4, §1810.405 and §1810.410; 42 CFR §438.12(a)(1) and §438.206(b)(1); 42 CFR §438.214; BHIN 24-020; BHIN 24-001; Sonoma County's Drug Medi-Cal Organized Delivery System Contract with Department of Health Care Services, Exhibit A, Attachment I; Sonoma County's Mental Health Plan Contract with Department of Health Care Services, Attachment 7 and 8.

Policy Owner: Behavioral Health Division, Behavioral Health Director

Director Signature: Signature on File

I. Policy Statement

It is the policy of the Sonoma County Department of Health Services (DHS), Behavioral Health Division (BHD) to add individual, group and/or organization network providers if they enhance the Division's capability to provide for the specialty mental health or substance use disorder (SUD) needs of Medi-Cal beneficiaries. DHS-BHD Provider Selection meets the requirements set out in the Intergovernmental Agreement between the Department of Health Care Services (DHCS) and DHS.

Providers being added to the network must meet all credentialing criteria, as set forth in BH Policy and Procedure 7.1.1 Provider Credentialing and Continuous Monitoring.

II. Scope

This policy applies to network providers, single case agreements and potential providers.

III. Definitions

A. Provider: Any organization, agency, or individual that provides mental health and/or substance use treatment services to Sonoma County Medi-Cal beneficiaries under contract with DHS-BHD, as part of the county's Mental Health Plan (MHP) or Drug Medi-Cal Organized Delivery System (DMC-ODS).

B. Individual Contract Provider: A single provider of behavioral health services rendering mental health or substance use treatment to beneficiaries through

the MHP or DMC-ODS, under direct contract with Sonoma County as a sole proprietor or as part of an employment agency. The most common individual contract providers include psychiatrists but may also include other service provider types (e.g., RN).

C. Network Provider: any provider, group of providers or entity that has a network provider agreement with BHD, or a subcontract, and receives funding directly or indirectly to order, refer or render covered services. Network providers include Single Case Agreements.

D. Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD): Sonoma County governmental agency functioning under contract with the state of California, as the Medi-Cal Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan.

E. Drug Medi-Cal Organized Delivery System (DMC-ODS): The State-County contract partnership between California Department of Health Care Services and Sonoma County that provides substance use treatment services to Medi-Cal beneficiaries through utilization of federal/state funds pursuant to Title XIX and Title XXI of the Social Security Act for covered services rendered by certified Drug Medi-Cal providers.

F. Mental Health Plan (MHP): The managed Mental Health Care plan for Medi-Cal eligible residents of Sonoma County, defined by a State-County contract partnership between California Department of Health Care Services and Sonoma County, authorized under Welfare & Inst Code §14680 – 1472.

IV. Policy

A. Credentialing and Recredentialing – DHS-BHD follows the DHCS established uniform credentialing and re-credentialing policy addressing behavioral and substance use disorders. DHS-BHD follows a documented process for credentialing and re-credentialing network providers and contracted out-of-network providers. See BH Policy and Procedure 7.1.1 Provider Credentialing and Continuous Monitoring for detailed procedures.

B. Nondiscrimination – The DHS-BHD provider selection policies and procedures, consistent with 42 CFR §438.12, do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

C. Excluded Provider – DHS-BHD does not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

D. Additional Requirements – DHS-BHD will comply with additional requirements established by DHCS.

E. Provider Selection and Certification – DHS-BHD:

1. Has written policies and procedures for selection and retention of providers that are in compliance with the terms and conditions of the intergovernmental agreement between the Department of Health Care Services (DHCS) and DHS-BHD and applicable federal laws and regulations.

2. Applies policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.

3. Does not discriminate against persons who require high-risk or specialized services.

4. Subcontracts with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.

5. Selects only providers that have a license and/or certification issued by the state that is in good standing.

6. Selects only providers that will enroll as Medi-Cal providers consistent with applicable State or Federal regulations for each provider type. Providers will not be allowed to render services prior to completing required enrollments (i.e., PAVE, Med-Cal Rx, etc.).

7. Selects only providers that have been screened in accordance with 42 CFR 455.450(c) as a “high” categorical risk prior to furnishing services under this Agreement, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104.

   DHCS shall deny enrollment and DMC-ODS certification to any provider (as defined in Welfare & Institutions Code section 14043.1), or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), that, at the time of application, is under investigation for fraud or abuse pursuant to Part 455 of Title 42 of the Code of Federal Regulations, unless DHCS determines that there is good cause not to deny enrollment upon the same basis enumerated in 42 CFR 455.23(e).

   If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to Welfare & Institutions Code section 14043.36. Upon receipt of a credible allegation of fraud, a provider shall be subject to a payment suspension pursuant to Welfare &

Institutions Code section 14107.11 and DHCS may thereafter collect any overpayment identified through an audit or examination.

During the time a provider is subject to a temporary suspension pursuant to Welfare & Institutions Code Section 14043.36, the provider, or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), may not receive reimbursement for services provided to a DMC-ODS beneficiary.

A provider shall be subject to suspension pursuant to Welfare and Institutions Code section 14043.61, if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal program.

A provider will be subject to termination of provisional provider status pursuant to Welfare and Institutions Code Section 14043.27, if the provider has a debt due and owing to any government entity that relates to any federal or state health care program and has not been excused by legal process from fulfilling the obligation.

Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015, would be required to undergo fingerprint- based background checks required under 42 CFR 455.434.

V. Procedures

A. Adding Network Providers

1. DHS-BHD will identify a need for new providers based on Medi-Cal client, clinical, or geographic needs. Upon identification of a need, DHS-BHD will identify and recruit providers who meet the necessary requirements.
2. Provider requests to be added to the network, the Quality Assessment and Performance Improvement (QAPI) Section staff will determine, in consultation with appropriate Section Managers and the BHD Director, if there is a need for that provider.
3. Need for additional providers will be based on the following:
    a. Anticipated Medi-Cal enrollment;
    b. Geographic access, considering distance and travel time (**30 miles** or **60 minutes** from client ’s residence), and the means of transportation ordinarily used by the client;
    c. The expected utilization of services;
    d. The characteristics and health care needs of the Medi-Cal population;

e. The numbers and types (in terms of training, experience and specialization) of network providers required to furnish contracted Medi-Cal services;

f. Availability of existing providers to take referrals based on utilization of services and/or availability to take referrals;

g. Physical access, reasonable accommodations, and accessible equipment for clients with physical or mental disabilities;

h. Capability to provide services to clients in their preferred language;

i. Clinical expertise in needed specialty areas:

(1) Children and families;

(2) Gender-specific issues;

(3) Developmental disabilities;

(4) Particular diagnoses or co-occurring disorders;

(5) Treatment specialty.

j. Cultural competence

k. The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

l. Other specific client requests

4. Appropriate requests for new providers are brought to QAPI for review and directed to the BH Division Director and DHS Department Head for approval to pursue contracting.

5. Once approved, DHS-BHD will collaborate with the Administrative Provider Services and Supports Unit (APSS) to develop and implement a Request for Proposal (RFP), Single Case Agreement, or other contracting mechanism process.

6. Prior to execution of the contract, providers must be credentialed and approved by the Credentialing Manager and/or the Credentialing Committee (consisting of administrative and licensed clinical staff). (See Policy 7.1.1 Provider Credentialing and Continuous Monitoring).

7. If DHS-BHD declines to add the provider to the network, QAPI will notify the applicant in writing, including information regarding reasons for the decision.

8. DHS-BHD can execute agreements with provider for up to **120 days**, pending the outcome of screening, enrollment, and revalidation. However, provider agreements will be terminated immediately upon determination of ineligibility for enrollment, or the provider cannot be enrolled during the allotted **120-day** period.

B. Referrals to Network Providers

1. Referrals to providers will be made according to the criteria set forth below, but not necessarily in this order:

   a. Geographic ease of access for the client to the provider's office location.

   b. Specialty needs of the client, for example:

      i. Language Capability, including sign language;

      ii. Ethnicity;

      iii. Cultural Competence;

      iv. Gender Issues;

      v. Co-occurring disorders;

      vi. Clinical specialty that matches the needs of the client;

      vii. Wheelchair accessibility.

   c. Client request

   d. Provider's responsiveness to BHD's needs, as demonstrated by their willingness to take referrals.

   e. The timeliness and quality of the provider's required documentation.

C. Retention of Network Providers

1. Provider satisfaction will be measured every two years and steps taken to improve provider satisfaction as part of the Division's Annual Quality Improvement Work Plan.

2. At the discretion of DHS-BHD, a provider will not be retained for the following reason (but not limited to):

   a. The provider has not treated any clients in the previous fiscal year and there is no anticipated need for the provider's services, or;

   b. Compliance or Quality of care issues have been identified and are not resolved to the satisfaction of the DHS-BHD, or;

c. The provider has lost their license, been convicted of a felony, or has been the subject of an unresolved licensing Board action that affects client care as determined by the DHS-BHD;

d. The provider has been identified as excluded/suspended from the eligible provider lists of federal and/or state agencies.

D. Network Provider Termination

1. At the discretion of the DHS-BHD Division Director, a provider may be given a written notice of termination.
2. If a provider is terminated, DHS-BHD will make a good faith effort to give written notice of termination of a contracted provider to each beneficiary who was seen on a regular basis by the terminated provider. The notice to the beneficiary shall be provided **30 calendar days** prior to the effective date of the termination or **15 calendar days** after receipt or issuance of the termination notice, whichever is later.
3. Written notice will be given to each client who received his or her primary care from, or was seen on a regular basis by, the terminated provider.
4. Follow-up care will be arranged, based on the client's need for continued services.
5. In instances where services are terminated or modified, reference the Notice of Adverse Benefit Determination (NOABD) Grid to identify the appropriate NOABD to issue to the affected client.
6. A copy of the written notice of provider termination shall be kept in the client record and a second copy will be given to QAPI.
7. Providers not accepted into the network or providers whose agreements are to be terminated will be notified in writing as to the reason(s) for the decision.

VI. Forms

None.

VII. Attachments

None.