

**SANTA CRUZ COUNTY
Behavioral Health Services**

POLICY AND PROCEDURE MANUAL

Subject: Panel Providers for Managed Care Services Policy Number: 2332


Date Effective: 3/27/2018

Pages: 5

Replaces: 1/17/2018

**Responsible for Updating:
Director of Managed Care Services**

Approval: 
Behavioral Health Director


Date

POLICY:

Santa Cruz County Medi-Cal beneficiaries who meet medical necessity criteria (and do not have Medicare) are entitled to outpatient services through the Mental Health Plan (MHP). The Managed Care Panel is a pool of licensed therapists and clinics in the community that contract with the County to provide mental health services for Medi-Cal beneficiaries.

PURPOSE:

To provide procedures to establish and maintain the Managed Care Panel according to all federal and state regulations.

DEFINITIONS:

1. Managed Care Services:

Mental Health Services provided by credentialed Panel Providers to Medi-Cal beneficiaries that meet criteria for Specialty Mental Health Services. These include services that are authorized by the Managed Care Manager and are for specialized services not available within the system of care.

2. Point of Authorization:

The Managed Care Manager is the point of authorization for Managed Care Specialty Mental Health Services for Santa Cruz Medi-Cal beneficiaries.

PROCEDURES:

1. Provider Selection Process

a. Application

- i. Licensed mental health professional can apply to MHP to become a member of the Managed Care Panel of Providers by completing the Provider Application.
- ii. MHP reviews the applications and then forwards them to a credentialing verification organization. (See policy **3413: Credential Verification Process** for more information.)

b. Number of Panel Members

- i. The MHP enrolls the number of providers necessary to meet the service needs of its beneficiaries.
- ii. The MHP will determine the number of providers needed for the network based on the following principles. The panel will provide:
 - Sufficient numbers of providers to meet or exceed the current demand for service;
 - Sufficient types of providers to meet the range of services required in all necessary languages and to all special populations.
 - Geographic accessibility throughout Santa Cruz County so that beneficiaries will not have to travel more than 30 minutes to obtain services.

2. Provider Selection Criteria:

- a. Individual and Group Providers: In order for an individual or group provider to contract with the MHP, the following conditions must be met:

- i. Independent licensure: Providers must be licensed to practice psychotherapy independently.
 - Board-eligible psychiatrists (MD)
 - Psychologists (Ph.D. or Psy.D)
 - Licensed Clinical Social workers (LCSW)
 - Marriage and Family Therapists (MFT).
 - Licensed Professional Clinical Counselor (LPCC)
- ii. Physical facility:
 - Providers must maintain a safe facility
 - ADA access is preferred for all providers
 - Providers must permit physical review of the office by a representative of the MHP.
- iii. Medications: Providers must store and dispense medications in a manner that meets state and federal standards.

- iv. **Quality Management:**
 - 1) Providers must maintain client records in a manner that meets state and federal standards.
 - 2) Providers must meet the quality standards, including cultural and linguistic standards, of the MHP.
 - 3) Providers must be willing to participate in the County Quality Improvement Program.
 - 4) Providers must be willing to provide access to client records for clinical and financial audits within the guidelines of state and federal standards for confidentiality.

- v. **MHP Credentialing Standards: Providers must meet the Mental Health Plan's Credentialing standards:**
 - 1) Providers must be in good standing with the appropriate licensing board;
 - License must be current and valid;
 - No license suspensions, revocations, or limitations on practice.
 - No board disciplinary actions.
 - 2) Physicians must have a valid DEA or CDS certificate.
 - 3) Providers must provide a history of professional liability claims which resulted as: convictions of a felony, termination of hospital privileges, dismissal from hospital employment for conduct, and in other areas as deemed necessary.
 - 4) Providers must be physically, mentally, and emotionally able to conduct business in a reasonable manner.
 - 5) Providers must not be on any state or federal sanction list.

- vi. **Insurance Requirements: Providers must meet the MHP's insurance requirements:**
 - 1) Psychiatrist must have minimum liability insurance of: \$1,000,000 individual occurrence, \$3,000,000 aggregate coverage; and
 - 2) All other allied mental health professionals: \$1,000,000 / \$1,000,000; and
 - 3) Providers must not have outstanding malpractice claims; and
 - 4) Providers must provide a history of professional liability claims which resulted in settlements or judgments paid by or on behalf of the provider.

- vii. **Background: Providers must submit:**
 - 1) A work history
 - 2) Verification of their highest academic degree
 - 3) Information supporting any specialties that they practice

- viii. **MHP Re-credentialing: Providers must submit an application to be re-credentialed by MHP every two years.**
(See policy **3413: Credential Verification Process** for additional information.)

3. **Provider Selection Appeals**

- a. The Mental Health Plan will provide written notice to providers when the MHP declines to contract with them.
- b. Providers may request a review of a denied application.
- c. The written appeal should be submitted to the Managed Care Program Manager.
- d. The Managed Care Program Manager will convene a review panel consisting of the Quality Improvement Manager, Access Manager, and at least one additional Manager.
- e. The provider may submit written material, appear for an in-person appeal, and/or may request witnesses to provide additional information to the panel.
- f. The panel will return a decision within 30 days of receiving the request.

4. **Contract Provisions:** The contract between the Mental Health Plan and each provider must meet federal contracting requirements (per Title 42, Code of Federal Regulations, Section 434.6 and 438.214) and include the following stipulations that the provider will:

- a. Ensure that beneficiaries receive the same level of services provided to all other clients served.
- b. Not discriminate against beneficiaries in any manner.
- b. Describe how the provider will make records available for authorized review for fiscal audits, program compliance, and beneficiary complaints.
- c. Specify that the rate included in the contract is considered to be payment in full, subject to third party liability and beneficiary share of cost.
- d. Adhere to Title XIX of the Social Security Act and conform to all other applicable Federal and State statutes and regulations.
- e. MHP will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

5. **Processing New Individual Panel Providers:** Once an individual panel provider has been approved for inclusion in the Panel Provider list, the following actions take place to add that provider to all applicable data systems:

- a. **Business/Data Systems**
 - i. The Managed Care Manager will give a copy of the application to the QI Administrative Aide for credentialing who will then forward to the Business Office Supervisor.
 - ii. The Business Office Supervisor will then inform the Business Office staff that a new Panel Provider has been approved.
 - iii. Business Office Staff will then:
 - IT will enter the provider information into the electronic medical record.
 - Add the provider agreement information, services and rates.
 - Make sure that each new panel provider will have the complete set of possible codes and rates according to their specialty listed

in the Santa Cruz County Mental Health Plan Reimbursement
Codes Rates.

b. Administrative Systems

- i. The Managed Care Manager submits Panel Provider application to Administration for execution of the Master Agreement for Panel Providers following approval of credentialing.
- ii. Master Agreement is executed.

6. Organizational Providers: Organizational providers will follow procedures for Short-Doyle/Medi-Cal Provider Certification as described in policy number 3417. In addition, they will follow all current county contract boilerplate language.

7. Termination of Providers: MHP will provide beneficiaries with written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

PRIOR VERSIONS: 1/17/2018, 4/20/2006

REFERENCES: 42 CFR, Sections 438.10; 438.206 & 438.68; CCR Title 9, section 1810.310;
MHP Contract

FORMS/ATTACHMENTS:

- MHE44 provider application for credentialing
- Behavioral Health Documentation Manual
- Reauthorization request form
- MHE 30-1 1st reauthorization
- MHE 29 provider initial authorization
- MHE 30-2 provider 2nd re-authorization