



JENNIFER KENT
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

DATE: September 27, 2016

ALL PLAN LETTER 16-012
SUPERSEDES POLICY LETTER 02-003

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING AND RECREDENTIALING

PURPOSE:

The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of updated provider credentialing/recredentialing requirements and to reinforce existing provider enrollment screening requirements that each MCP must follow for contracted providers who deliver Medi-Cal covered services. This APL incorporates and supersedes Policy Letter (PL) 02-03¹ and incorporates the provider enrollment screening requirements issued by the federal Centers for Medicare & Medicaid Services (CMS) in rulemaking CMS-6028-FC², dated February 2, 2011, and the provider credentialing and recredentialing requirements in rulemaking CMS-2390-F³, dated May 6, 2016.

BACKGROUND:

The credentialing process is one component of the comprehensive quality improvement system included in all MCP contracts. The contract defines credentialing as the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, and/or professional association membership. Credentialing ensures that providers are licensed and certified as required by state and federal law.

On February 2, 2011, CMS issued rulemaking CMS-6028-FC to enhance provider enrollment screening requirements pursuant to the Affordable Care Act. These regulations (see Title 42, Code of Federal Regulations (CFR), Part 455, Subpart E) are meant to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification. Specifically, these regulations categorize medical service provider types into three risk levels for committing fraud or abuse (limited, moderate, and high) and provide the screening

¹ PL 02-03 is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf>.

² CMS-6028-FC is available at: <https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf>.

³ CMS-2390-F is available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.

steps each MCP must take for the appropriate risk level.⁴ Attachment 1 at the end of this APL lists provider types by their risk categories.

CMS' most recent rulemaking, CMS-2390-F, further enhances provider credentialing and licensure by requiring the Department of Health Care Services (DHCS) to establish uniform provider credentialing and recredentialing policies that each contracting MCP must follow.

POLICY:

The uniform credentialing and recredentialing requirements in this APL apply to all medical providers contracting with MCPs to deliver Medi-Cal covered services, including but not limited to acute, primary and specialist physicians, non-physician medical practitioners (NMPs),⁵ behavioral health,⁶ Substance Use Disorder (SUD),⁷ and Long-Term Services and Supports (LTSS)⁸ providers.

MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their medical service providers. Each MCP must ensure that its governing body or the designee of its governing body reviews and approves these policies and procedures. Each MCP must ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

Each MCP must ensure that all of its contracted medical providers are qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified, or registered. These providers must have good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in any MCP's provider network.

⁴ 42 CFR Part 455.450.

⁵ NMPs include but are not limited to, advanced practice registered nurses (nurse practitioners, certified nurse midwives and certified nurse specialists) and physician assistants.

⁶ Behavioral health providers include, but may not be limited to, the following provider types: physicians, NMPs, licensed psychologists, licensed clinical social workers, marriage and family therapists, professional clinical counselors and qualified autism service providers. Qualified autism service paraprofessionals are providers who provide treatment and services, meets criteria in the California Welfare and Institution Code Section 4686.3, are supervised by a qualified autism service professional, have adequate training, education, and experience.

⁷ SUDs providers must be appropriately licensed, certified, or registered as one of the following:

- (a) A physician licensed by the Medical Board of California;
- (b) A psychologist licensed by the Board of Psychology;
- (c) A clinical social worker or marriage and family therapist licensed by the California Board of Behavioral Sciences ; or
- (d) An intern registered with the California Board of Psychology or the California Board of Behavioral Sciences.

⁸ LTSS providers include, but may not be limited to, physicians, NMPs, social workers, and nurse managers.

Provider Credentialing

Each MCP is required to verify the credentials of its contracted medical providers. Such providers include, but are not limited to, acute, primary and specialist physicians, NMPs, and behavioral health, SUD, and LTSS providers.

The MCP must verify the following items through a primary source,⁹ as applicable.¹⁰

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.

For all provider types, MCPs must also receive the following information from each 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.ncsbn.org/418.htm>;
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 MCP'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.

Attestation:

For all medical service provider types who deliver covered medical services, each provider's application to contract with an MCP must include a signed and dated

⁹“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.

¹⁰ The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.

statement attesting to:

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.¹¹

Provider Recredentialing

DHCS requires each MCP to verify every three years that each contracted provider that delivers medical services continues to possess valid credentials. Each MCP must review a new application from these providers and verify the items listed above under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing should include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation provided in the provider's initial application.

Each MCP must maintain a system for reporting serious quality deficiencies that result in suspension or termination of a provider to the appropriate authorities. Each MCP must maintain policies and procedures for disciplinary actions, including reducing, suspending, or terminating a provider's privileges. MCPs must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their primary care provider sites. For detailed guidance see PL 14-004 : Site Reviews, Facility Site Review and Medical Record Review¹² and any subsequent revisions. MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

An MCP may delegate its authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually

¹¹ These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The Americans with Disability Act Attachment is available at (pg. 7): <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf>.

¹² Policy Letter 14-004 is available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf>.

responsible for the completeness and accuracy of these activities. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform these activities and includes an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;
- Ensures that the subcontractor meets the MCP's and DHCS's standards; and
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations, may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their own discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to meet DHCS's requirements for credentialing. Such MCPs will be exempt from DHCS's medical review audit of credentialing practices. MCPs; however, retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations and other contract requirements as well as DHCS guidance, including applicable APLs and Dual Plan Letters. If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality & Monitoring Division
Department of Health Care Services

Attachment

Attachment 1: Provider Types and Categories of Risk

(1) Limited Risk Provider Types Physician or non-physician practitioners and medical groups or clinics;

- Providers or suppliers that are publicly traded on the NYSE or NASDAQ;
- Ambulatory Surgical Centers (ASCs);
- End-Stage Renal Disease (ESRD) facilities;
- Federally Qualified Health Centers (FQHCs);
- Histocompatibility laboratories;
- Hospitals, including Critical Access Hospitals (CAHs);
- Indian Health Service (IHS) facilities;
- Mammography screening centers;
- Organ Procurement Organizations (OPOs);
- Mass immunization roster billers,
- Portable x-ray suppliers;
- Religious Nonmedical Health Care Institutions (RNHCIs);
- Rural Health Clinics (RHCs);
- Radiation therapy centers;
- Skilled nursing facilities (SNFs), and
- Public or Government-Owned Ambulance Services Suppliers.

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers;
- Comprehensive outpatient rehabilitation facilities;
- Hospice organizations;
- Independent diagnostic testing facilities;
- Independent clinical laboratories; and
- Non-public, non-government owned or affiliated ambulance services suppliers. (Except that any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered “limited” risk.)
- Currently enrolled (re-validating) home health agencies. (Except that any such provider that is publicly traded on the NYSE or NASDAQ is considered “limited” risk.)
- Currently enrolled (re-validating) suppliers of DMEPOS. (Except that any such supplier that is publicly traded on the NYSE or NASDAQ is considered “limited” risk.)

(3) High Risk Provider Types. Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

Provider Credentialing Activities Required by 42 CFR Part 455

| | Requirement | Risk Level | New Rqmt | Citation |
|---|---|-----------------------------|-----------------|---|
| 1 | Verify that providers and suppliers meet applicable state and federal regulations | Limited, Moderate, and High | No | Exhibit A, Attachment 4, Credentialing and Recredentialing |
| 2 | Verify that providers and suppliers meet applicable licensure requirements | Limited, Moderate, and High | No | Exhibit A, Attachment 4, Credentialing and Recredentialing |
| 3 | Check databases during the enrollment process to verify that providers meet enrollment criteria | Limited, Moderate, and High | No | Exhibit A, Attachment 4, Credentialing and Recredentialing |
| 4 | Check databases following the enrollment process to verify that providers meet enrollment criteria | Limited, Moderate, and High | No | Exhibit A, Attachment 4, Credentialing and Recredentialing |
| 5 | Conduct unannounced pre-enrollment site visits (may be announced). | Moderate and High | No (announced) | Exhibit A, Attachment 4, Delegation of Quality Improvement Activities and Site Review |
| 6 | Conduct unannounced post-enrollment site visits (may be announced). | Moderate and High | No (announced) | Exhibit A, Attachment 4, Delegation of Quality Improvement Activities and Site Review |
| 7 | May revoke Medi-Cal billing privileges for providers and suppliers that are no longer operational | Limited, Moderate, and High | No | Exhibit A, Attachments 7 and 8 |
| 8 | May revoke Medi-Cal billing privileges for providers and suppliers that fail to maintain the established provider or supplier performance standards | Limited, Moderate, and High | No | Exhibit A, Attachments 7 and 8 |

| | Requirement | Risk Level | New Rqmt | Citation |
|----|--|-----------------------------|-----------------|-----------------|
| 9 | Conduct criminal background checks for all providers and anyone with a 5-percent-or-greater ownership | High | Yes | Pending |
| 10 | Require fingerprinting of all providers and anyone with a 5-percent-or-greater ownership | High | Yes | Pending |
| 11 | Revalidate the enrollment of all providers at least every 5 years. | Limited, Moderate, and High | Yes | Pending |
| 12 | Revalidate the enrollment of high-risk providers at least every 3 years. | High | Yes | Pending |
| 13 | CMS may conduct off-cycle revalidation, particularly of Home Health Aid (HHA) and Durable Medical Equipment (DME) providers. | High | Yes | Pending |