Core Elements in Contracting and Credentialing with HealthChoice MCOs and BHOs

This document was developed by the Credentialing Subcommittee to help substance abuse treatment providers identify the core elements involved in the credentialing and contracting process with MCOs/BHOs in the HealthChoice Program, and thus facilitate contracting between providers and MCOs.

Core Elements of the Credentialing Process

The process in which the provider demonstrates that it has the qualifications to participate in the MCO/BHO network of providers. All MCOs/BHOs require the following:

1. Licensed or certified by the State.
2. Maintain $1million per incident or $3 million per aggregate in malpractice insurance, or have a waiver stating that the program falls under the state tort requirement (i.e., Local Health Departments).

Psychologists and Masters Level practitioners are only required to carry $1million/$1million.

3. Comply with the Americans with Disabilities Act.
4. If not accredited by CARP, JCAHO or AOA, the following is required:
    a. Sites visit every two years.

    ValueOptions conducts site visit every 3 years in conjunction with recredentialing.

    b. Proper format for medical record documentation
    c. Confidentiality of medical records
    d. Policy and procedures related to treatment options
    e. Quality improvement plan
    f. Health and safety procedures
5. Provider must have a Medicaid number, thought not necessarily be a Medicaid provider. Number can be obtained through the MCO.

- In addition, each MCO/BHO may have additional, specialized credentialing requirements.
- Proper credentialing of a provider by the MCO/BHO to participate in the HealthChoice Program does not automatically imply that a provider is credentialed for commercial business.
-

Contracting

The contract describes the financial, procedural requirements agreed to by the provider and the MCO/BHO, and is contingent upon the provider meeting the credentialing requirements. A contract does not necessarily obligate the MCO/BHO to refer enrollees to the provider.

The provider must be credentialed by ValueOptions. Once the credentialing is complete ValueOptions works with the provider to establish a contract which includes establishing set rates. ValueOptions' reimbursement methodology is fee for service.

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FACILITY/PROGRAM INITIAL CREDENTIALING APPLICATION

To ensure timely processing of your application, please return the following:

- ☐ Completed Facility/Program Application (Attached)
- ☐ Completed Service Location Addendum(s) - One Per Service Location (Attached)
- ☐ Completed Facility Program Addendum(s) - One Per Program Type (Attached)
- ☐ Copies of all applicable state licenses
- ☐ Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identifies the limits of liability of $1mil/$3mil and the policy period (documents must show "Professional Liability")
- ☐ Copy of a completed W-9 form or IRS letter
- ☐ NPI Enumerator Documentation
- ☐ Accreditation Certificate(s)
  - ☐ JCAHO – Joint Commission on Accreditation of Healthcare Organizations]
  - ☐ NCQA – National Committee for Quality Assurance
  - ☐ CARF – Council on Accreditation of Rehabilitation Facilities
  - ☐ AOA – American Osteopathic Association
  - ☐ COA – Council On Accreditation
  - ☐ CHAP – Community Health Accreditation Program
  - ☐ AAAHC – Accreditation Association for Ambulatory Health Care
- ☐ Certification(s):
  - ☐ Other State licensure reports (i.e., Dept. of Human Services, Dept. of Mental Health and Mental Retardation)
  - ☐ Medicaid
  - ☐ Medicare

RETURN COMPLETED APPLICATION TO:

ValueOptions® - Facility Credentialing Department
P. O. Box 4080
Virginia Beach, Virginia 23454

FAX: (757) 893-8658

NON ACCREDITED ORGANIZATIONS:
If your organization is not accredited by JCAHO, NCQA, CARF, COA, AOA, CHAP or AAAHC , then a site review of your Facility/Program will need to be conducted based upon the need for providers in your area. A site survey preparation document will be sent to you in advance of the site survey which will be scheduled at a mutually agreed upon date. A copy of a CMS Certification letter or on site survey results performed by the State may be accepted in lieu of an on site review by ValueOptions®. Please provide this information with your application if applicable.

INDIVIDUAL TAX IDENTIFICATION NUMBERS AND NPI NUMBERS:
ValueOptions® Credentials and Contracts facilities based on single Tax Identification Numbers (TIN's/EIN's). If your organization bills under multiple Tax Identification Numbers, you will need to complete multiple application packets. However, if your organization has multiple NPI (National Provider Identification) numbers, please include that information in this application with an explanation to which programs and/or locations to which the multiple NPI numbers apply.

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I. GENERAL INFORMATION (Please print/type) **NPI** #: _____

A. TIN Owner Name/Legal Name: _____

DBA/Trade Name: _____

Primary Mailing Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone #: (___)_____ TAX ID#:_____

B. Facility/Program points of contact

Chief Executive Officer: _____ Phone: _____

Managed Care Director: _____ Phone: _____

Person completing this application / Title: _____

Phone: _____ Fax: _____ Email: _____

Billing/Claims Contact Person:_____ Phone: _____

Contracting Contact Person / Title:_____

Phone: _____ Fax: _____ Email: _____

Website Address of Facility: www._____

C. Please complete if facility/program is part of a corporate health system:

Corporate Name: _____

Contact Name: _____ Title: _____

Primary Mailing Address: _____

City: _____ State: _____ Zip Code: _____-_____ County: _____

Phone #: _(____)_____ Fax #: (_____)_____

D. Select <u>one</u> description from the following list that best describes the facility:

- ☐ General Hospital
- ☐ Free standing Acute Psychiatric Facility
- ☐ Residential Treatment Center
- ☐ Community Mental Health Center
- ☐ Free standing Partial/Day Treatment Facility
- ☐ Free standing Intensive Outpatient Program
- ☐ Home Health Agency
- ☐ Free standing Substance Abuse Rehabilitation Facility
- ☐ Other: _____

E. Business Classification (Please Check only one box for Ownership and only one box for Status)

1. Ownership: ☐ Private ☐ Public ☐ Government Program
2. Status: ☐ For-Profit ☐ Not-for-Profit
3. Pennsylvania Medicaid Providers <u>only</u>: ☐ Single County Authority ☐ Base Service Unit ☐ Not Applicable

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F. This organization is accredited or certified by one or more of the following:

☐ JCAHO ☐ CARF ☐ AOA ☐ COA ☐ CHAP ☐ AAAHC ☐ NCQA

☐ OTHER:_____ ☐ None

☐ MEDICARE # _____ (Please provide supporting documentation)

☐ MEDICAID # _____ (Please provide supporting documentation)

II. PROVIDER PROFILE / MALPRACTICE CLAIM HISTORY

A. Please answer the following questions regarding your organization's **behavioral health program(s):**

1. Has the facility/program had professional liability insurance refused, revoked, declined or accepted on special terms in the past five years? ☐ Yes ☐ No

2. Has any government agency suspended, revoked, or taken other action against the facility/ program's license to conduct business in the past five years? (To include Medicaid /Medicare) ☐ Yes ☐ No

3. Have any memberships in professional organizations and/or accreditations been revoked, reduced, denied, or suspended by others or voluntarily given up by the facility/program in the last five years, or are any actions now under way which may lead to such sanctions? ☐ Yes ☐ No

4. Have any owners, officers, or shareholders of the facility/program **ever** been convicted of a crime, excluding misdemeanors? ☐ Yes ☐ No

5. Has the facility/program **ever** been previously denied acceptance into the ValueOptions Network, disenrolled from the ValueOptions Network, or withdrawn from ValueOptions Network participation? ☐ Yes ☐ No

   PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTIONS ABOVE (1-5) THAT WERE ANSWERED "YES"

6. Has the facility/program had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If Yes, enter the total number:_____ ☐ Yes ☐ No

7. If the facility/program is **not** JCAHO, AOA, CARF, COA, CHAP or AAAHC accredited, please answer the following question: Has the facility/program been a defendant in five (5) or more lawsuits within the **past five (5) years** in regard to the practice of **behavioral health treatment** or any lawsuits in the **past five (5) years** where there has been awards or payments of $250,000.00 (two hundred and fifty thousand dollars) or more? If Yes, enter the total number:_____ ☐ Yes ☐ No ☐ N/A-Accredited

   PLEASE COMPLETE THE MALPRACTICE CLAIM INFORMATION WORKSHEET ON THE FOLLOWING PAGE FOR ANY QUESTIONS ABOVE (6-7) THAT WERE ANSWERED "YES"

8. Does the facility/program comply with §1128 of the Social Security Act by not hiring, continuing to employ, or contracting with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)? ☐ Yes ☐ No

   PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTION 8 IF ANSWERED "NO"

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MALPRACTICE CLAIM INFORMATION WORKSHEET

B. Please attach information on what the organization's response was to the allegations and what steps were taken to prevent any future incidents for each claim listed below. This page can be copied to accommodate additional claim information.

1. Date of Occurrence: _____ Date Claim Filed: _____ Date of Settlement: _____
Allegations and Action Taken: _____
_____
_____

Case Settled: ☐ In Court ☐ Out-of-Court Total Amount Paid to Claimant
☐ With Prejudice ☐ Without Prejudice on Behalf of Facility/Program: $_____

2. Date of Occurrence: _____ Date Claim Filed: _____ Date of Settlement: _____
Allegations and Action Taken: _____
_____
_____

Case Settled: ☐ In Court ☐ Out-of-Court Total Amount Paid to Claimant
☐ With Prejudice ☐ Without Prejudice on Behalf of Facility/Program: $_____

3. Date of Occurrence: _____ Date Claim Filed: _____ Date of Settlement: _____
Allegations and Action Taken: _____
_____
_____

Case Settled: ☐ In Court ☐ Out-of-Court Total Amount Paid to Claimant
☐ With Prejudice ☐ Without Prejudice on Behalf of Facility/Program: $_____

4. Date of Occurrence: _____ Date Claim Filed: _____ Date of Settlement: _____
Allegations and Action Taken: _____
_____
_____

Case Settled: ☐ In Court ☐ Out-of-Court Total Amount Paid to Claimant
☐ With Prejudice ☐ Without Prejudice on Behalf of Facility/Program: $_____

5. Date of Occurrence: _____ Date Claim Filed: _____ Date of Settlement: _____
Allegations and Action Taken: _____
_____
_____

Case Settled: ☐ In Court ☐ Out-of-Court Total Amount Paid to Claimant
☐ With Prejudice ☐ Without Prejudice on Behalf of Facility/Program: $_____

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III. DEMOGRAPHIC DATA

This information is for demographic purposes only, and will **not** be used for credentialing. This information will be used in the aggregate, to supply data to state and federal government agencies, as part of the state and federal contracting process.

Please be advised that the following information will be disclosed only to the state and federal government for the purposes outlined above.

1. Could your business be classified as a small business, as defined by the Small Business Administration?

   *Small Business Enterprise is defined as a corporation, partnership, sole proprietorship, or other legal entity formed for the purpose of making a profit, which is independently-owned and operated, has **either** fewer than 100 employees **or** less than $1,000,000 (one million dollars) in annual gross receipts.*

   ☐ Yes ☐ No

2. Could your business be classified as a women-owned business, as defined by the Department of Minority Enterprises?

   Women-Owned Business is defined as a business enterprise at least 50 percent of which is owned by women or (in the case of a publicly-owned business) where at least 51 percent of the stock is owned by women.

   ☐ Yes ☐ No

3. Could your business be classified as a minority-owned business, as defined by the Department of Minority Enterprises?

   Minority-Owned Business is defined as a business enterprise that is owned and controlled by one or more socially and / or economically disadvantaged persons. Such disadvantages may arise from cultural, racial, chronic economic circumstances or background or other similar cause. Such persons include but are not limited to African Americans, Hispanic Americans, Asian Americans, American Indians, Eskimos and Aleuts.

   ☐ Yes ☐ No

4. This question is optional.
   If your business could be classified as a minority-owned business, which of the following categories would it fall under may check more than one?

   ☐ African American ☐ Hispanic American ☐ Asian American

   ☐ American Indian ☐ Eskimo ☐ Aleuts

   Other, please specify: _____

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IV. PARTICIPATION STATEMENT

For purposes of making this application for participation in the ValueOptions, Inc. provider network, the Facility/Program certifies that all information provided to ValueOptions is true and correct to the best of the Facility/Program's knowledge. The Facility/Program agrees to notify ValueOptions promptly if there are any material changes in the information provided, whether prior to or after the Facility/Program's acceptance as a ValueOptions participating provider. The Facility/Program understands and agrees that if ValueOptions discovers that this application contains any significant misstatement, misrepresentations or omissions, ValueOptions may void, in its sole discretion, its application and any related participating provider agreements.

The Facility/Program authorizes ValueOptions and its Credentialing Verification Organization (CVO) to consult with State licensing agencies, accreditation bodies, malpractice insurance carriers, and, upon notification to Facility/Program of additional specific entities or organizations, any other entity from which information may be needed to complete the credentialing process, and the Facility/Program authorizes the release of such information to ValueOptions and its CVO. The Facility/Program releases ValueOptions and its CVO and its employees and agents and all those whom ValueOptions contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating the Facility/Program's application.

The Facility/Program further understands and agrees that; (a) the Facility/Program is responsible for producing all information required or requested by ValueOptions and its CVO in connection with this application; (b) ValueOptions is under no obligation to complete the processing of this application until such information is provided by the Facility/Program; (c) in the event that ValueOptions decides not to accept the Facility/Program as a participating provider and the Facility/Program desires to have this decision reviewed, the Facility/Program will appeal such determination to the ValueOptions Provider Appeals Committee ("PAC").

_____
Facility Name

_____ Dated (mm/dd/yy): _____/_____/_____
Authorized Signature

_____
Name (Please Print)

_____
Title

VALUEOPTIONS®
Improving Behavior to Improve Health

FACILITY CREDENTIALING - SERVICE LOCATION ADDENDUM
INSTRUCTIONS: COMPLETE ONE PAGE PER SERVICE LOCATION
(PHOTOCOPY AS NEEDED)

SERVICE LOCATION:

Address Line 1: _____

Address Line 2: _____

City, State, ZIP: _____

Phone Number: _____

BILLING ADDRESS: (Please confer with your Billing Dept)

Address Line 1: _____

Address Line 2: _____

City, State, ZIP: _____

Phone Number: _____

This location is: ☐ Yes ☐ No - *Americans with Disabilities Act* Compliant ☐ Yes ☐ No - Accessible by Public Transportation

VALUE OPTIONS, INC. **PROGRAMS OFFERED AT THIS SERVICE LOCATION**	**# OF UNITS**	**CHILD (5-12)**	**ADOL (13-17)**	**ADULT (18-64)**	**GERI (65+)**	**PROGRAM DIRECTOR NAME & LICENSURE** *REQUIRES MD OR DO	**FACILITY/ PROGRAM LICENSE NUMBER**
INPATIENT PSYCHIATRIC						*	
INPATIENT (ACUTE) DETOXIFICATION						*	
INPATIENT SUBSTANCE ABUSE REHAB						*	
INPATIENT DUAL DIAGNOSIS						*	
INPATIENT EATING DISORDER						*	
RESIDENTIAL TREATMENT (PSYCH)						*	
RESIDENTIAL TREATMENT (SUB ABUSE)						*	
RESIDENTIAL TREATMENT DUAL DIAG						*	
RESIDENTIAL TREATMENT EATING DIS						*	
PARTIAL HOSPITALIZATION (PSYCH)						*	
PARTIAL HOSPITALIZATION (SUB ABUSE)						*	
PARTIAL HOSPITAL DUAL DIAGNOSIS						*	
PARTIAL HOSPITAL EATING DISORDER						*	
23 HOUR OBSERVATION	N/A					*	
AMBULATORY DETOXIFICATION	N/A					*	
INTENSIVE OUTPATIENT (PSYCH)	N/A						
INTENSIVE OUTPATIENT (SUB ABUSE)	N/A						
INTENSIVE OUTPATIENT DUAL DIAG	N/A						
INTENSIVE OUTPATIENT EATING DIS	N/A						
DAY TREATMENT (PSYCH)	N/A						
DAY TREATMENT (SUB ABUSE)	N/A						
DAY TREATMENT DUAL DIAGNOSIS	N/A						
DAY TREATMENT EATING DISORDER	N/A						
HALFWAY HOUSE	N/A						
METHADONE MAINTENANCE THERAPY ***Indicate # of days per week in # of Units Column**							
TREATMENT GROUP HOME	N/A					*	
HOME HEALTH	N/A					*	
OUTPATIENT CLINIC (PSYCH)	N/A						
OUTPATIENT CLINIC (SUB ABUSE)	N/A						
OUTPATIENT CLINIC DUAL DIAGNOSIS	N/A						
EAP	N/A						

SPECIALTY SERVICES: ☐ ECT ☐ Crisis/Evaluation in ER

Attestation Statement:
My signature below indicates that all of the information provided above, and in any attachments to this application document, is true and correct to the best of my knowledge.

Name:_____ Title:_____ Signature:_____ Date:_____