MCCMH MCO Policy 10-070

Chapter: **DIRECT OPERATED SERVICES**
Title: **CREDENTIALING AND RECREDENTIALING SERVICES**

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Proposed by: Traci Smith — 10/29/2026
Chief Executive Officer — Date

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I. ABSTRACT

This policy establishes the standards and procedures of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, on the credentialing and re-credentialing of individuals providing services. This policy ensures that only qualified practitioners are authorized to provide clinical treatment and related services to MCCMH persons served.

II. APPLICATION

This policy shall apply to all applicable MCCMH staff, contractual staff, volunteers, interns, independent contractors, and directly operated network providers).

III. POLICY

It is the policy of MCCMH that all individuals directly or contractually employed by MCCMH provide a level of care consistent with professionally recognized standards and in accordance with applicable credentialing and certification requirements of Michigan Department of Health and Human Services (MDHHS) and the Centers for Medicare and Medicaid Services (CMS). MCCMH is responsible for ensuring that providers meet all applicable licensing, scope of practice, contractual, and Medicaid Provider Manual (MPM) requirements.

IV. DEFINITIONS

A. Behavioral Health Customer Relationship Management (BH CRM)/ Michigan Crisis and Access Line (MiCAL)
The uniform Community Mental Health Services (CMHSP) credentialing program provided by MDHHS.

B. Clean File
A clean credentialing file is one with no outstanding concerns or issues identified

through the practitioner application and/or attestation, work history review, education verification, no findings/matches through primary source verifications, passing background check, all required supporting documents submitted, and no findings of misleading, false, or undisclosed information.

C. Credentialing
The process of determining the accuracy of a qualification reported by an individual includes licensing, relevant education, training or experience, current competence, and ability to perform requested privileges.

D. Credentialing Designee
The PIHP administrative team member responsible for the oversight and implementation of the organization's individual practitioner credentialing program.

E. Credentialing, Recredentialing and Privileging Committee
A peer-review body with members from the types of practitioners participating in the organization's network that reviews credentialing and privileging applications and makes determinations. MCCMH maintains a multidisciplinary committee, with representation from various specialties.

F. Credentialing Packet
Credentialing documents provided to the Credentialing, Recredentialing and Privileging Committee members may include, by way of example and without limitation: Credentialing Application, Privileging Application, Supervisor Review Form, attestation of training compliance, OIG exclusion search results, GSA/SAM search results, LARA search results, Michigan sanctioned provider list search results, official transcripts, verification of school's accreditation status, proof of liability insurance, criminal background check, current resume, results from a query of the National Practitioner Data Bank (NPDB), certification verification from Michigan Certification Board for Addiction Professionals, review listings in practitioner directories, and other documents as required by the Chief Quality Officer or Credentialing designee, Credentialing and Privileging Committee, Chief Executive Officer, and/or Chief Medical Officer.

G. National Practitioner Data Bank (NPDB)
A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers.

H. Peer Review
A process by which mental health professionals evaluate the clinical competence of staff and the quality and appropriateness of care. The records, data, and knowledge collected are confidential and not subject to public record or subpoena. Evaluations are based on criteria established by MCCMH, accepted standards of mental health professionals, and MDHHS.

I. Practitioner
A healthcare professional whose qualifications, licensure, and professional background are verified and monitored, while providing mental health or substance use services or treatment.

J. Privileging
The process of authorizing a healthcare professional to provide care within a defined scope. Privileging is performed in conjunction with the evaluation of an individual's clinical qualifications and/or performance and after a thorough review and validation of their credentials.

V. STANDARDS

A. All applicants seeking admission to MCCMH's provider network shall undergo a comprehensive review and verification of their education, experience, licensing, and other requirements consistent with criteria promulgated by pertinent regulatory and accrediting bodies.

B. It is the responsibility of MCCMH to:

1. Have a defined credentialing and recredentialing process that selects independent practitioners to provide the highest quality of care to persons served.

2. Ensure that information collected during the credentialing and recredentialing processes is confidential and the privacy of all applicants is respected and secured.

3. Establish credentialing and recredentialing processes that do not discriminate against applicants and continually monitor such processes.

    a. MCCMH's credentialing and recredentialing processes shall not discriminate against health care professionals:

        i. Who serve high risk populations or specialize in the treatment of conditions that require costly treatment;

        ii. To the extent the health care professional is acting within the scope of their license or certification under applicable state law; and

        iii. Based on race, ethnic/national identity, gender, age, patient type/insurance coverage, license, registration, certification, sexual orientation, disability, religion, or any other characteristic protected under applicable federal or state law.

    b. MCCMH ensures non-discriminatory practices by:

        i. Instilling preventative measures in MCCMH policies that mandate anti-discriminatory behaviors and practices for populations served and MCCMH staff;

        ii. Ensuring, the Credentialing Designee applies the same documented verification sources and criteria to all applicants within each practitioner category;

iii. At least annually the Quality Department, or designee, audits a sample of approved, denied and in-process files for inconsistent criteria, unexplained delays or decisions, that suggest discrimination;

iv. Findings, results, corrective actions and follow-up are documented and reported to the Credentialing, Recredentialing and Privileging Committee, and the Quality Committee

v. Requiring that each member of the Credentialing, Recredentialing and Privileging Committee sign an attestation upon appointment and annually thereafter stating that they will not discriminate or breach confidentiality of applications reviewed; and

vi. Practitioners may submit allegations of discrimination or confidentiality breaches to the Credentialing Team at credentialingteam@mccmh.net.

1. The Credentialing Designee records the allegation and refers it to the Chief Compliance Officer for investigation by a reviewer independent of the alleged conduct.

2. At least annually the Quality Department, or designee, reviews complaints for patterns of discrimination.

3. Findings and corrective actions are documented and reported to the Credentialing, Recredentialing and Privileging Committee

4. The Credentialing, Recredentialing and Privileging Committee reviews credentialing information and makes credentialing and recredentialing determinations in accordance with the Decision-Making and Notices section below.

5. Ensure that information provided in member materials and practitioner directory is representative of information gathered during the recredentialing process.

6. Ensure all credentialing and recredentialing information is securely maintained through information integrity practices. MCCMH confirms that processes are in place to secure, modify, and track modifications of credentialing files.

7. Comply with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid.

C. Credentialing Individual Practitioners

1. Initial credentialing shall occur prior to provision of billable services and prior to a practitioner being permitted access to the electronic medical record (EMR).

2. Recredentialing shall be conducted at least every three (3) years thereafter.

3. Credentialing and recredentialing shall be conducted and documented for at least the following health care professionals employed or individually contracted by MCCMH:

   a. Physicians (M.D.s or D.O.s)
   b. Physician Assistants
   c. Psychologists (Licensed, Limited License, Temporary License)
   d. Licensed Master's Social Workers, Licensed Bachelor's Social Workers, Limited License Social Workers (Masters and Bachelors), and Registered Social Service Technicians
   e. Licensed Professional Counselors, Limited License Professional Counselors
   f. Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses
   g. Occupational Therapists and Occupational Therapist Assistants
   h. Physical Therapists and Physical Therapist Assistants
   i. Speech and Language Pathologists
   j. Addiction Medicine Specialists
   k. Board Certified Behavior Analysts
   l. Behavioral Healthcare Specialists who are licensed, certified, registered by the state to practice independently
   m. Other persons referred to on the state's provider qualification document

4. Employment with MCCMH is contingent upon the practitioner receiving recognition of credentials and authorization of privileges as required by the position.

5. MCCMH shall ensure that individual practitioners meet all background checks, applicable licensing, scope of practice, contractual, and Medicaid Provider Manual requirements.

VI. PROCEDURES

In accordance with Public Act 282 of 2020, MCCMH utilizes the uniform Community Mental Health Services (CMHSP) credentialing program established by MDHHS for initial and recredentialing for licensed practitioners.

A. Initial Credentialing Process

1. Applicants requesting credentialed status must complete a signed and dated application package that attests to the following:

   a. Lack of present illegal drug use;

   b. History of adverse action, loss or limitation of license, registration, certification and/or felony convictions

   c. History of loss or limitation of privileges or disciplinary actions

   d. Current malpractice insurance coverage;

e. History of Medicare/Medicaid sanctions;

f. Summary of the applicant's work history for the previous five (5) years;

g. Attestation by the applicant that they can perform the essential functions of the position with or without accommodation; and

h. Attestation by the applicant confirming the correctness and completeness of the application.

2. If the application and attestation must be updated, only the practitioner may attest to the update, the Credentialing Designee or other designee may not update or alter the application.

3. MCCMH shall evaluate an applicant's work history for the prior five (5) years or since time of licensure if practitioner has less than five (5) years of experience.

a. Gaps in employment that exceed six (6) months but less than one (1) year in the prior five (5) years or since licensure may be addressed verbally or in writing during the application process.

b. Gaps in employment that exceed one (1) year in the prior five (5) years or since licensure must be addressed in writing during the application process.

4. When completing any type of credentialing process (initial credentialing, recredentialing, and/or provisional credentialing), MCCMH shall conduct a search that reveals information substantially similar to the information found on the Internet Criminal History Access Tool (ICHAT) check, as well as a National and State Sex Offender Registry Check for each direct-hire or contractually employed practitioner. Refer to MCCMH Policy 10-005, "Background Checks" for more information on MCCMH's background practices.

5. Information in the applicant's application shall be reviewed and verified. MCCMH uses primary sources (or its website); contracted agents of primary sources (or its website); and NCQA-accepted sources listed for credentials (or its website) to verify credentials.

6. MCCMH shall verify the applicant's primary sources of:

a. Licensure or certification, including restrictions or adverse actions. MCCMH reserves the right to deny any license or certification they are unable to verify through primary source verification.

i. Practitioners holding a compact license must have primary source verification completed in the State that holds their primary license.

b. Limitations on scope of practice.

c. Board Certification, or highest level of credentials attained or completion of any required internship/residency programs or other post graduate training.

d. Official transcripts of graduation from an accredited school with documentation supporting the accreditation status of the school attended.

e. Professional liability insurance, if applicable.

f. National Practitioner Data Bank (NPDB)/ Healthcare Integrity and Protection Databank (HIPDB) query.

g. Minimum five-year history of professional liability claims resulting in a judgment or settlement.

h. Disciplinary status with regulatory board or agency.

i. Complete history of Medicare/Medicaid sanctions.

j. MDHHS Medicaid Sanctioned Providers, Office of Inspector General (OIG)/LEIE, and the System of Award Management (SAM);

k. Medicare Opt Out;

l. DEA or CDS Certificate, if applicable;

m. If the individual undergoing credentialing is a physician, then physicians profile information obtained from the American Medical Association (AMA) or American Osteopathic Association (AOA) may be used to satisfy primary source requirements for:

   i. Board certification /highest level of credentials attained

   ii. Graduation from Medical School

   iii. Completion of required internships/residency programs/other postgraduate training

7. Primary source verification of written information shall bear the credentialing designee's signature/initials and date the information was verified. For oral/verbal verification, the credentialing designee shall note the information verified in the credentialing file, sign/initial, and date the note in the credentialing file.

8. The credentialing application includes a statement that informs the practitioner of his/her right to:

   a. Review information obtained from outside sources submitted to support their credentialing application;

b. Correct erroneous information that specifies:

i. The time frame for making corrections

ii. The format for submitting corrections

iii. Where to submit corrections

c. Receive the status of their credentialing or re-credentialing application, upon request and includes:

i. Guidance on how to submit an application status request and the organization's response process.

ii. Details of information that the organization is allowed to share with the practitioner.

9. MCCMH shall ensure that the initial credentialing of all individual practitioners applying for inclusion in MCCMH's network is completed within 90 calendar days of application submission. The start time begins when MCCMH has received a completed signed and dated credentialing application from the individual practitioner. Completion time is indicated when written communication is sent to the individual practitioner notifying them of MCCMH's decision.

B. Recredentialing Individuals

1. Recredentialing shall occur at least every three (3) years or when there is a change to any initial credentialing information.

2. Recredentialing may be extended beyond every three (3) years if practitioner is:

a. On active military assignment

b. On medical leave

c. On sabbatical

3. Practitioners granted an extension under section B.2. must complete recredentialing within thirty (30) days of returning to work.

4. Recredentialing shall include submission of the current credentialing application, an update of information obtained during the initial credentialing (if applicable), and primary source verification.

5. Individuals being recredentialed must be compliant with MCCMH & MDHHS training requirements and policies and Michigan Administrative Code R. 330.2125, Child Diagnostic Training Hour.

6. Recredentialing of physicians and other licensed, registered or certified individuals also includes verification of licensure and as applicable, DEA/CDS certificates, a review of any sanctions, complaints, and quality issues pertaining to the practitioner. This must include, at minimum, a review of Medicare/Medicaid sanctions. This must include, at minimum, a review of Medicare/Medicaid sanctions; monthly state sanctions checks; malpractice history; limitations on licensure, registration, or certification;); and concerns or issues pertaining to grievances (member complaints), adverse events, quality of care issues, and appeals.

7. MCCMH shall ensure findings from the Quality Assessment Performance Improvement Program (QAPIP) are submitted to the MCCMH Credentialing and Privileging Committee and considered in recredentialing decisions.

8. All documentation and information required may not be more than sixty (60) days old at the time of the Credentialing and Privileging Committee's review.

    a. If the signature attestation exceeds the sixty (60) days, prior to the credentialing decision being made, the practitioner must attest that the information within the application remains accurate and complete. The practitioner is not required to complete a new application but must re-attest to the required attestation questions.

C. Credentialing Review of Information

1. MCCMH shall notify the practitioner within ten (10) business days of obtaining credential information from other sources if the results vary substantially from what was provided by the practitioner.

    a. Upon notification of substantially varied information from other sources, the practitioner shall have the right to correct any erroneous information.

    b. The practitioner must complete a request in writing within seven (7) business days of receipt of notification that the information is incorrect.

    c. The practitioner shall have ten (10) business days to address the discrepancy.

    d. The Credentialing, Recredentialing and Privileging Committee may review submitted corrections.

2. The practitioner has the right to review information obtained by MCCMH to evaluate their credentialing application, attestation, or curriculum vitae (CV).

    a. The practitioner must send a written request to MCCMH.

    b. MCCMH may share information obtained from any outside source, apart from references, recommendations, or other peer-reviewed protected information.

    c. The practitioner must submit missing documentation within 14 calendar days of notification that the submission was incomplete.

3. The practitioner and their supervisor shall ensure the completeness of credentialing application prior to submission to the credentialing designee.

D. Practitioner Rights Process

1. Practitioners may request review of information obtained from outside sources or the status of an initial or recredentialing application by contacting the Credentialing Team at credentialingteam@mccmh.net.

   a. The Credentialing Team confirms identity, records the request, and provides a response through an approved secure channel within five (5) business days. Information shared may include receipt date, completion status, missing items, verification progress, anticipated next step and a finalized decision.

      i. References, recommendations and peer-review protected information are not disclosed.

   b. If verification information varies substantially from the practitioner's submission, MCCMH notifies the practitioner within ten (10) business days.

   c. Within seven (7) business days of receiving notice, the practitioner may submit to the Credentialing Team written correction that addresses the discrepancy, with supporting documentation.

   d. The Credentialing Team dates receipt, retains the correction in the file, re-verifies disputed information as appropriate, and refers the corrected file to Credentialing Committee for decision.

      i. MCCMH includes these rights and instructions in its application instructions and practitioner notices.

   e. In the event the correction and/or supporting documentation submitted is found insufficient by the Credentialing Committee:

      i. An initial credentialing applicant will be withdrawn from consideration.

      ii. A recredentialing applicant will be referred to HR, for guided next steps.

E. Participation of Chief Medical Officer

1. The Chief Medical Officer or their physician designee shall attend all Credentialing, Recredentialing and Privileging Committee meetings and provide directions during discussions to ensure the Committee complies with all applicable federal, state, and accreditation standards.

2. MCCMH's Chief Medical Officer (CMO) or physician designee, participates in the Credentialing, Recredentialing and Privileging Committee, provides clinical advice and expertise, and has overall responsibility for the credentialing program.

    a. The Committee reviews files that do not meet established criteria and document its discussion and determination. The CMO or physician designee does not independently deny a file in place of required Committee review.

3. Credentialing Designee presents clean files to the Credentialing, Recredentialing and Privileging Committee for review and approval as outlined under Decision Making and Notices section, below. The Chief Medical Officer or their physician designee participates in that review.

    a. Files with concern or unmet criteria are discussed in a real-time Committee meeting.

F. Temporary/Provisional Credentialing of Individuals

1. MCCMH shall maintain a temporary /provisional credentialing process to grant a one-time temporary or provisional credentialing status to practitioners applying to MCCMH, when it is in the best interest of persons served that those practitioners be available to provide care prior to formal completion of the entire credentialing process.

2. Temporary credentialing shall not be used in place of the initial credentialing process and shall not exceed sixty (60) days.

3. MCCMH shall have up to thirty-one (31) days from receipt of a complete application, accompanied by the minimum documents identified above, to render a decision regarding temporary credentialing.

4. For consideration of temporary or provisional credentialing, at minimum, an applicant shall complete a signed application that attests to the following items:

    a. Lack of present illegal drug use;

    b. History of adverse action, loss or limitation of license, registration, certification, and/or felony convictions;

    c. Any history of adverse action, loss or limitation of privileges or disciplinary action;

    d. Attestation by the applicant that they can perform the essential functions of the position with or without accommodation;

    e. Attestation by the applicant of the correctness and completeness of the application.

5. MCCMH shall evaluate an applicant's work history for the prior five (5) years or since time of licensure if it is less than five (5) years. Gaps in employment of six (6) months of more in the prior five (5) years or since licensure must be addressed in writing during the application process.

6. When completion any type of credentialing process (initial credentialing, recredentialing, and/or provisional credentialing), MCCMH shall conduct a search that reveals information substantially similar to the information found on the Internet Criminal History Access Tool (ICHAT) check, as well as a National and State Sex Offender Registry Check for each direct-hire or contractually employed practitioner. Refer to MCCMH Policy 10-005, "Background Checks" for more information on MCCMH's background practices.

7. MCCMH shall conduct primary source verification of the following:

    a. Licensure or certification, including restrictions or adverse actions. MCCMH reserves the right to deny any license or certification they are unable to verify through primary source verification.

        i. Practitioners holding a compact license must have primary source verification completed in the State that holds their primary license.

    b. Board certification, if applicable or the highest level of credential attained;

    c. Official transcript of graduation from accredited school and/or LARA license;

    d. NPDB query will be used to verify the following:

        i. Historical checks of criminal convictions related to the delivery of a health care item or service.

        ii. Historical checks of civil judgment related to the delivery of a health care item or service.

        iii. Disciplinary status with regulatory board or agency; and

        iv. Medicare/Medicaid sanctions and/or exclusions.

    e. History of Medicare/Medicaid sanctions; including the MDHHS Sanctioned Provider List, Office of Inspector General (OIG)/LEIE, System of Award Management (SAM).

    f. Medicare Opt Out, and

    g. Criminal Background check.

8. MCCMH's Credentialing, Recredentialing and Privileging Committee shall review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of full credentialing verification, as outlined, must be completed.

9. MCCMH does not perform provisional credentialing for practitioners who were credentialed by a delegate on behalf of the organization.

10. Provisionally credentialed practitioners may not deliver care prior to the completion of

provisional credentialing and shall not be listed in MCCMH's practitioner directory.

G. Credentialing File

1. MCCMH shall ensure that credentialing/re-credentialing documents are maintained for each credentialed practitioner for at least seven (7) years.

   a. Files from practitioners who do not onboard with MCCMH but complete the credentialing process are maintained for at least one (1) year following the date of the credentialing approval.

2. Each credentialing file must include:

   a. All initial credentialing and all subsequent recredentialing applications;

   b. Information gained through primary source verification;

   c. Actual copies of credentialing information;

   d. A detailed, signed/initialed, dated checklist which includes the name, source, and verification date;

   e. The signature/initial of the MCCMH staff person verifying the information, date, and notes, if applicable, for each source verified and specification of the source type;

   f. The status of the practitioner and other information found in practitioner directories;

   g. All written communications from MCCMH to the individual practitioner related to the credentialing process; and

   h. Any other pertinent information used to determine if the practitioner met MCCMH's credentialing and recredentialing standards.

3. Practitioners have the right to access certain information contained in the credentialing file to verify accuracy. This information includes:

   a. Documents authored by the practitioner;

   b. Documents addressed to the practitioner;

   c. Any sanction reports; and

   d. A summary of the remaining contents of the credentialing file.

4. A practitioner who is found to intentionally falsify or mislead in their submitted credentialing application or documents, may have their employment offer rescinded, and/or credentials immediately denied. The immediate denial is final and not subject to

the action appeal process.

H. Confidentiality Safeguards

1. MCCMH ensures the confidentiality of the credentialing program by:

   a. Maintaining all credentialing files and credentialing program documents within a Private Team with secure shared folders.

   b. Granting access to the secure Credentialing shared folder to members of the Credentialing Team.

      i. The Credentialing Designee authorizes role-based access and reviews current access permissions when roles change.

      ii. Access to the team is by invite-only and access approval is granted by the Credentialing Designee.

   c. Granting access to the MDHHS MiCAL Credentialing System to access required members of the Credentialing Team.

      i. The Credentialing Designee submits administrative account requests to the Chief Information Officer (CIO) for creation.

      ii. The Credentialing Designee will notify the CIO when access needs to be adjusted or terminated.

   d. Removing all access to members of the team who are no longer participating in the Credentialing program or employed by the organization.

   e. Transmitting electronic credentialing records through secure channels such as secure email, secure shared folders, Adobe Sign, and the MDHHS MiCAL system.

   f. Ensuring paper records are stored at our contracted offsite secure facility.

   g. Requiring a signed Workforce Confidentiality Agreement of all Credentialing Team members and the Credentialing, Recredentialing, and Privileging Committee.

   h. Disclosing documents and information when required and authorized to do so to maintain contract compliance and accreditations.

2. Suspected unauthorized access or disclosure related to credentialing files, practitioners, or privileged discussions, will be promptly reported to the Compliance Office for investigation and review.

3. Substantiated findings are reported to the Chief Executive Officer for disciplinary actions including but not limited to written discipline, suspension with or without pay, or termination.

I. Decision-Making and Notices

1. MCCMH shall provide written notification to practitioners of initial credentialing decisions and recredentialing decisions within thirty (30) calendar days from the Credentialing Committee's decision.

2. Credentialing Committee reviews:

   a. All initial and recredentialing files that meet the organization's, MDHHS, NCQA, and other federal and state defined criteria.

   b. Credentialing for practitioners who do not meet the defined criteria established by the organization, MDHHS, NCQA, and other federal and/or state policy or procedures.

   c. Information provided in the credentialing application with thoughtful consideration.

   d. Ongoing monitoring activities identified by the organization.

   e. Are documented in meeting minutes.

3. The Credentialing, Recredentialing and Privileging Committee may review and approve clean files by secure email. The Credentialing Designee retains the credentials reviewed, the practitioner's identifiers, the dated approval record and the identities of the approving reviewers.

   a. A file that does not meet established thresholds, or develops a concern during email review, is referred to the next real-time Committee meeting, in person or by audio-enabled video or web conference.

   b. Discussion and determinations for these files are documented in the minutes.

   c. The use of email to review and make a decision by the Committee will be reserved for use only on a case-by-case basis. MCCMH will not solely rely on the use of email review for its credentialing/recredentialing decisions.

4. If there are findings of a practitioner providing false or misleading credentialing information, the Credentialing Designee documents the discrepancy, requests clarification or correction as appropriate, and refers the file to the Credentialing, Recredentialing and Privileging Committee.

   a. The Credentialing, Recredentialing and Privileging Committee determines whether credentials are denied, suspended or terminated.

   b. MCCMH provides the applicable written notice and appeal instructions and the Formal Peer Review Process (Exhibit A).

   c. Immediate protective action is available when necessary to protect safety.

5. When credentialing or recredentialing is denied, suspended, or terminated for any reason other than lack of need, the practitioner shall be informed in writing of the reason(s) for MCCMH's adverse decision; their right to appeal the decision through the credentialing adverse action appeal process; and their right to review their file and present additional information for the Committee's review, if applicable.

    a. A practitioner's request to appeal the Committee's decision must be received by MCCMH within ten (10) business days from the date the notice was issued.

    b. An official hearing will be scheduled within thirty (30) calendar days of MCCMH's receipt of a practitioner's appeal request, consistent with the Formal Peer Review Process.

    c. At the hearing, both the practitioner and MCCMH may be represented by counsel, provide any relevant evidence, and/or submit a memorandum of law or medical points.

    d. Within fifteen (15) business days of the hearing, MCCMH shall issue an official decision letter to the practitioner.

6. The Chief Executive Officer shall reserve the right to approve, reasonably deny, suspend, or terminate authorization for recognition of credentials for any employee or contractor which requires their official approval with justification for such action.

    a. Justification may include, but is not limited to, the findings of the MCCMH QAPIP, Office of Recipient Rights, Corporate Compliance Office, Credentialing and Privileging Committee, the Talent Engagement personnel review, Bureau of Health Services (Licensure), or other monitoring and licensing bodies.

        i. Practitioners shall be given written notice of such an adverse action within five (5) working days.

        ii. Practitioners are given notice of their right to appeal the decision through the Adverse Action Appeal Process.

7. Summary suspension of a practitioner is appropriate when immediate action is necessary to protect the life or well-being of a person served or any person, or to reduce substantial imminent likelihood of significant impairment of the life, health, or safety of any person served.

    a. The MCCMH Chief Executive Officer, Chief Operations Officer, Chief Quality Officer, Chief Medical Officer, Chief Clinical Officer, Director of Managed Care Operations, or Program Supervisor may summarily suspend approval of any or all a practitioner's credentials and/or privileges on behalf of the Credentialing, Recredentialing, and Privileging Committee with immediate effect based on review of professional competence or conduct, or when a summary suspension has been imposed at another mental health entity, or by another peer review entity.

b. An investigation shall commence immediately, and the findings shall provide for either reinstatement or notice of adverse action.

8. Automatic suspension or limitation is the immediate termination or suspension of credentials and/or privileges based on the limitation of a practitioner's license, registration, certification or Medicare or Medicaid program exclusion/sanctions.

   a. A practitioner will be subject to discipline, which may include termination and will at least include a suspension without pay, in the event the practitioner fails to renew their license, registration, or privileges before they expire.

   b. MCCMH does not recognize any statutory allowances for the renewal of a license or registration after its expiration date.

   c. The practitioner's suspension will continue at least until they provide proof of a renewed license, registration, or privileges.

   d. Automatic suspension or limitation of credentialing and privileging takes effect immediately when the practitioner lacks required current licensure, certification or authorization to participate in billable services.

      i. The collaboration between Talent Engagement and the applicable Human Resources Department results in written notice of the basis and the process for disciplinary actions.

      ii. During a period of suspension, limitation, or while a required credential remains expired, the practitioner involved is not authorized to provide services.

9. As a requirement of the MDHHS PIHP, CMHSP, and CCBHC contracts, MCCMH may reciprocate and accept credentialing activities conducted by another PIHP of individual providers that deliver healthcare services to more than one PIHP in lieu of completing the credentialing process.

   a. The option for deemed status is considered on a case-by-case basis.

   b. In those instances where MCCMH chooses to accept the credentialing decision of another PIHP, it shall maintain copies of the credentialing PIHP's decisions in its administrative credentialing records, including applicable credentialing files.

   c. MCCMH may request a copy of the PIHP's Credentialing policy and a blank Credentialing application in addition to the PIHP's Credentialing Approval Letter.

   d. MCCMH will verify primary source verification information received from any PIHP that is not NCQA accredited.

   e. The Credentialing, Recredentialing and Privileging Committee shall review the documents and decide whether to grant deemed status.

f. If the Credentialing, Recredentialing and Privileging Committee approves reciprocity of another PIHP's credentialing decision, the Credentialing Designee records the basis, review date, decision and next credentialing due date.

10. If a practitioner terminates employment with MCCMH and later is reinstated, MCCMH will initially credential the practitioner if the period exceeds thirty (30) days or when there is a change in scope of practice.

    a. MCCMH will complete updated primary source verifications regardless of the last verification date prior to presenting the file to the Credentialing, Recredentialing and Privileging Committee for reinstatement of credentials and privileges.

J. Reporting Credentialing and Recredentialing Decisions

1. MCCMH, consistent with state and federal reporting requirements and in accordance with its corporate compliance program, shall report to the appropriate authorities (e.g., MDHHS, the provider's regulatory or licensure board or agency, the Office of the Inspector General, the Attorney General, the accrediting body, etc.) any known problems that result in an individual's suspension or termination from MCCMH's employment or network.

2. If MCCMH detects issues related to corporate compliance, MCCMH shall refer these issues to the MCCMH Compliance Officer.

3. MCCMH shall maintain documentation through its Corporate Compliance Program of all disciplinary measures and actions implemented.

4. The Credentialing Designee, or Talent Engagement as may be designated, evaluates whether an adverse credentialing action is reportable and identifies the appropriate authority and applicable deadlines.

    a. For an NPDB-reportable action, Credentialing Designee or Talent Engagement as may be designated, prepares and submits to NPDB a report of the action/event, in coordination with MCCMH Chief Executive Officer.

    b. Credentialing Designee, or Talent Engagement as may be designated, verifies timely submission and retains the reportability decision, submission confirmation and any subsequent correction or revision.

K. Staff Qualifications

1. MDHHS publishes qualifications and definitions for staff performing specialty services and supports in the Community Mental Health System in the Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services and HCPCS/CPT Codes. Additionally, the Office of Substance Use, Gambling and Epidemiology publishes staff qualifications and definitions for staff performing services in Substance Use Disorder programs.

2. All individuals seeking privileges in the MCCMH network shall be responsible to

review and comply with the credentialing requirements in the latest version of the Michigan Medicaid Provider Manual (Behavioral Health and Intellectual and Developmental Disability Supports and Services section) and any supplemental Medicaid bulletins.

3. All licensed or certified staff shall comply with the appropriate requirements regarding scope of service as promulgated in their respective licensure law.

L. Oversight and Ongoing Monitoring

1. The Credentialing Program is overseen and administered by the Credentialing Designee.

2. MCCMH provides continuous practitioner monitoring (and intervention as appropriate) through the collection and review of sanctions, complaints, and quality issues pertaining to the practitioner which include, at minimum, review of:

   a. Sources and documentation are specified in MCCMH's Credentialing Ongoing Monitoring Procedure (Exhibit B);

   b. Medicare and Medicaid sanctions and exclusions, and licensure sanctions, limitations and expiration, are collected and reviewed at least every 30 calendar days;

   c. License expiration dates are recorded and monitored to prevent practice with an expired license;

      i. Licensure limitations and current license status are reviewed at least every 30 calendar days from the applicable state licensing or certification agency or its website.

   d. Grievances and appeals information;

   e. Findings of the MCCMH Quality Assessment Performance Improvement Program (QAPIP);

   f. Training requirement for licensure/registration/certification; and

   g. Allegations of wrongdoing (e.g., recipient rights complaints, corporate compliance issues, etc.) or adverse events.

3. MCCMH reports findings of ongoing monitoring activities related to practitioner sanctions, exclusions, limitations, expirations, complaints, and/or adverse actions between recredentialing cycles to the Credentialing Committee.

   a. Credentialing Designee maintains a monitoring tracker that identifies review dates, sources, results and referrals.

   b. Monitoring findings are reported and acted upon as outlined in the corresponding On-going Monitoring procedure.

4. Improper conduct which results in adverse action by MCCMH will be reported, as required, to the appropriate authorities (i.e., MDHHS, the Attorney General, etc.) and the National Practitioner Data Bank, and in compliance with MCCMH MCO Policy 1-001, "Overview: Compliance Program/ Code of Ethics".

5. MCCMH shall identify instances of poor quality related to the areas of continuous monitoring and notify the appropriate division director. MCCMH shall determine applicable disciplinary action which may include by way of example, and without limitation: work improvement plans, written or verbal reprimands, suspension, and/or termination.

6. MCCMH monitors the Medicare Opt. Out database every 30 days. Individuals or providers that opt out of Medicare will not provide services to Medicare participants.

7. To comply with confidentiality regulations, when surveyors or auditors review MCCMH's credentialing files, confidential results of an NPDB query shall not be authorized for viewing purposes. The respective query history pages shall be supplied as formal evidence that a query was carried out.

M. Practitioner Directory

1. MCCMH maintains a practitioner directory available to its members.

2. The Credentialing Designee or other designee will verify information obtained during the initial or re-credentialing process matches the information published to its directory within thirty (30) days of the Committee's decision.

    a. Corrections to the practitioner directory will be made based off the information provided by the practitioner during the initial or recredentialing process.

3. MCCMH does not communicate the completion of a practitioner's fellowship to its members and is not published to the practitioner directory.

4. Practitioners who are provisionally credentialed will not be listed in the directory

N. Reporting Requirements

1. MCCMH shall complete a semi-annual report for MDHHS that outlines credentialing and recredentialing decisions made by the Credentialing and Privileging Committee outside of MDHHS's BH CRM system.

VII. REFERENCES / LEGAL AUTHORITY

A. Commission on Accreditation of Rehabilitation Facilities (CARF) Standards Manual, Section 1.I Workforce Development and Management
B. Health Insurance Portability and Accountability Act of 1996, P.L. 104-191

C. National Committee for Quality Assurance (NCQA), 2026 Behavioral Health Accreditation Standards and Guidelines

D. MCCMH Policy 10-005, "Background Checks of Employees/Independent Contractors/Interns/Volunteers"

E. MCCMH Policy 10-007, "Directly Operated Provider and MCCMH Administration Training and Development Program"

F. Medicaid Managed Specialty Supports and Services Program, Contract Attachment 7.1.1: MDHHS Behavioral & Physical Health and Aging Services Administration, "Credentialing and Re-credentialing Processes"

G. Medicaid Managed Specialty Supports and Services Program, Contract Attachment 7.9.1: Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans

H. MCL 333.20173 (a) and (b)

I. MDHHS Administrative Rule 330.2105 (b)

J. Michigan Department of Health and Human Services Medicaid Provider Manual

K. Michigan Public Act 282 of 2020 – Community Mental Health Services Credentialing

L. Protecting Access to Medicare Act of 2014, P.L. 113-93, April 1, 2014

M. Coronavirus Aid, Relief, and Economic Security Act, CARES Act, P.L. 113-136, March 27, 2020

N. Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics, 2016

VII. EXHIBITS

A. Formal Peer Review Process (procedure**)**

B. Credentialing Ongoing Monitoring Procedure

Annual Revision Attestation/Revision History

Revision #	Review Date	Revision Summary/Policy Update Notice Date	Reviewer/Department
1	11/20/2012	Began tracking revision history	Quality Department
2	05/29/2014	Policy Update/Review	Quality Department
3	09/21/2016	Policy Update/Review	Quality Department

4	04/30/2020	Policy Update/Review	Quality Department
5	12/28/2020	Policy Update/Review	Quality Department
6	12/21/2022	Policy Update/Review	Quality Department
7	09/12/2024	Policy Update/Review	Quality Department
8	07/15/2025	Refer to Policy Update Notice associated with policy signature date (07/30/2025)	Quality Department
9	08/19/2026	Refer to Policy Update Notice associated with policy signature date	Quality Department
10	10/29/2026	Refer to Policy Update Notice associated with policy signature date	Talent Engagement