MCCMH MCO Policy 10-070

(Combined MCCMH MCO Policies 10-070 and 10-075)

Chapter: **DIRECTLY OPERATED PROGRAM MANAGEMENT**
Title: **CREDENTIALING AND RE-CREDENTIALING**

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Chief Executive Officer Date

I. ABSTRACT

This policy establishes the credentialing and re-credentialing policy of the Macomb County Community Mental Health Board of Directors (MCCMH Board) to ensure that only qualified health practitioners are authorized to provide clinical treatment and related services.

II. APPLICATION

This policy shall apply to all applicable administrative and directly operated network provider employees, volunteers, interns and independent contractors of the MCCMH Board.

III. POLICY

It is the policy of the MCCMH Board that all health practitioners must be both qualified and competent. Credentialing and re-credentialing are the processes by which qualifications and competencies are formally recognized.

A. Credentialing and re-credentialing shall occur for all MCCMH Directly Operated Network Providers, volunteers, clinical interns, administrative employees holding a credential and/or certification, administrative employees, interns, and volunteers needing access to the electronic medical record, and independent contractors to ensure that practitioners provide a level of care consistent with professionally recognized standards in accordance with MCCMH policy, and applicable credentialing and certification requirements of state and federal law, the Michigan Department of Health and Human Services, and the Centers for Medicare and Medicaid Services.

B. Credentialing and Re-Credentialing, as described in this policy, shall occur for directly-operated network provider employees, volunteers, interns, and independent contractors: At the time of hire and at least every two (2) years thereafter.

IV. DEFINITIONS

A. QUALITY DIVISION
The Quality Division is the MCCMH administrative division responsible for the credentialing and re-credentialing process.

B. CREDENTIALING PACKET
Credentialing documents provided to the Professional Standards Committee members which may include, by way of example and without limitation: Credentialing Application, Privileging Application, Supervisor Review form, Training Records, OIG exclusion search results, GSA/SAM search results, Medicare Preclusion List search results, LARA search results, Michigan sanctioned provider list search results, 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 Designee, Professional Standards Committee, Chief Executive Officer, and/or Chief Medical Officer.

C. CHIEF OF STAFF OR DESIGNEE
MCCMH administrative employee who communicates with the Macomb County Human Resource and Labor Relations Department.

D. INDIVIDUAL CREDENTIALING FILE
A file located within the employee's MCCMH personnel file that includes:
1. Criminal background check;
2. All Credentialing and Re-Credentialing applications;
3. Information gained through primary source verification; and
4. Any other pertinent information used in determining whether or not the practitioner met the credentialing and/or re-credentialing standards.

E. INDIVIDUAL CREDENTIALING AND RE-CREDENTIALING
A process which requires reviewing, evaluating, and verifying a practitioner's qualifications and background (e.g. education, training, clinical experience, licensure, board and/or other certification, other relevant credentials, malpractice history and/or disciplinary actions, Medicaid/Medicare status, and a review of practitioner directory information) to ensure the practitioner possesses the education, training and skill to fulfill the requirements of the position. Re-credentialing shall occur every two (2) years.

F. MCCMH DIRECTLY OPERATED NETWORK PROVIDER:
MCCMH mental and physical health practitioner employees; and independent contractor mental and physical health practitioner employees.

G. NPDB (National Practitioner Data Bank) A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers [more information at https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp]

H. PEER REVIEW
A process by which mental health professionals of a PIHP or community mental health services program 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. The evaluations are based on criteria established by MCCMH, accepted standards of mental health professionals, and the Michigan Department of Health and Human Services.

I. PRACTITIONER PEER REVIEW COMMITTEE
The Peer Review Committee will render a final decision following a request for an appeal of an adverse action and report to the National Practitioner Data Base (NPDB). The committee shall include MCCMH Chief Executive Officer, Chief of Staff, Chief Quality Officer, and Chief Compliance Officer or designees.

J. PIHP
Pre-Paid Inpatient Health Plan is an entity under contract with the Michigan Department of Health and Human Services (MDHHS) to provide managed behavioral health services to Medicaid eligible individuals.

K. PRACTITIONER
A person authorized to provide mental health or substance abuse services or treatment.

L. PRIVILEGING
A part of the Credentialing process which determines the scope of an individual's competencies to perform specific services or procedures within the MCCMH Provider Network as determined by peer review, training, licensure, and registration.

M. PROFESSIONAL STANDARDS COMMITTEE
The Professional Standards Committee reviews credentialing and clinical privileging applications and appeals, providing recommendations for action to the MCCMH Chief Executive Officer and Chief Medical Officer.

N. PROVIDER
Any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the state in which he or she delivers the services.

V. STANDARDS

A. CREDENTIALING INDIVIDUAL PRACTITIONERS
MCCMH DIRECTLY-OPERATED PROVIDER NETWORK

1. Practitioners
Credentialing shall be conducted at time of employment for all MCCMH Directly Operated Network Providers, clinical interns, volunteers, and administrative employees with a credential and/or certification.. Re-credentialing shall be conducted a minimum of every two (2) years thereafter. Administrative employees, interns, or volunteers without a credential and/or certification may be credentialed at any point in their employment or internship if access to the electronic medical record is needed. Credentialing and re-credentialing shall be conducted and documented by the Quality Division for at least the following health care professionals employed or individually contracted or employed by MCCMH:
   a. Individuals that require a Bachelor Degree or higher for the position;
   b. Independent licensed practitioners serving MCCMH persons served;
   c. Non-physician practitioners who have an independent relationship with MCCMH, and who are authorized to provide care under MCCMH's benefit plan;
   d. Telemedicine practitioners who have an independent relationship with MCCMH, and who are authorized to provide care under the MCCMH benefit plan;
   e. These include practitioners identified at https://www.michigan.gov/documents/mdhhs/PIHP-MHSP_Provider_Qualifications_530980_7.pdf
   f. Bachelor and Master level clinical student interns

2. Non Discrimination
   a. MCCMH shall ensure:
      (1) The credentialing and re-credentialing processes do not discriminate against:
         (i) A qualified health care professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment; or
         (ii) A qualified health care professional based on race, ethnic/national identity, gender, age, or sexual

orientation, disability, religion, or any other characteristic protected under applicable federal or state law.

(2) Each member of the Professional Standards Committee shall sign a non-discrimination statement.

b. Compliance is ensured by:

(1) Preventative Measures which include MCCMH anti-discriminatory policies that include both population served and staff; and

(2) Monitoring non-discrimination compliance by annually auditing credentialing files and complaints of discrimination.

3. Federal Requirements

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

4. Credentialing File

The Quality Division shall ensure that credentialing/re-credentialing documents are maintained in each credentialed employee's MCCMH personnel file. Re-credentialing will occur a minimum of every two (2) years.

a. Each credentialing file must include:

(1) All initial credentialing and all subsequent re-credentialing applications;

(2) Information gained through primary source verification;

(3) Actual copies of credentialing information;

(4) A detailed, signed/initialed, dated checklist which includes the name, source and verification date;

(5) 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;

(6) The status of the practitioner and other information found in practitioner directories; and

(7) Any other pertinent information used to determine if the practitioner met MCCMH's credentialing and re-credentialing standards.

5. Authentication

Primary source verification of written information shall bear the signature/ initials and date of the Quality Division designee who verifies the information. For oral/verbal verification, the Quality Division designee shall sign/initial, date, and note the information verified in the credentialing file. All queries shall be dated and noted in the credentialing file.

6. Confidentiality

The Quality Division is responsible for maintaining the confidentiality of all practitioner information. Practitioner information, for verification or storage in a confidential electronic database, is accessed only by authorized personnel. The credentialing documents, and all relevant credentialing and re-credentialing information, are maintained in a personnel file which is securely stored in a locked file cabinet and is accessed only simultaneously by both the Human Resources Liaison and the Quality Division Designee.

7. Active and Unencumbered Status

It is the responsibility of MCCMH to verify the active and unencumbered license, registration, certification, and status of all practitioners who provide treatment or related services to persons served. Verification shall occur upon initial credentialing, re-credentialing, and at regular intervals throughout the year. It is the responsibility of the practitioner to renew their license or registration before its expiration and to notify their supervisor and the MCCMH Quality Director or Designee immediately in the event that any required qualification, licensure, certification or other credential is expired, revoked or suspended. MCCMH does not recognize any statutory allowances for the renewal of a license or registration after its expiration date. A practitioner's failure to maintain required licensure, registration or other credential, or to immediately notify his/her supervisor of any lapse in any such licensure, etc., may result in disciplinary action, up to and including possible termination of employment.

8. Initial Credentialing

At a minimum, the following are required:

a. A written application that is completed, signed, and dated by the practitioner that attests to the following elements:
   (1) Lack of present illegal drug use;
   (2) Able to perform the essential functions of the position
   (3) Any history of adverse action, loss or limitation of license and/or felony convictions;
   (4) Any history of adverse action, loss or limitation of privileges or disciplinary action; and
   (5) Attestation by the applicant of the correctness and completeness of the application.

b. Verification of the practitioner's prior work history (from the application, resume, or curriculum vitae) including contact information or all work history if the person has less than five years of experience.

c. All information obtained by the Macomb County Human Resources Department during the hiring process and any supplemental information.

d. Verification from primary sources of:
   (1) Licensure or certification, including restrictions or adverse actions;
      (a) MCCMH reserves the right to deny any license or certification they are unable to verify through primary source verification.
   (2) Limitations on scope of practice;
   (3) Board Certification, or highest level of credentials attained if applicable, or completion of any required internship/ residency programs, or other post graduate training.
   (4) Documentation of graduation from an accredited school with documentation supporting the accreditation status of the school attended;
   (5) Relevant Work History from past 5 years with a clarification of all gaps in employment that exceed 6 months;
   (6) Professional Liability Insurance if applicable
   (7) National Practitioner Data Bank (NPDB)/ Healthcare Integrity and Protection Databank (HIPDB) query or all of the following must be verified:
      a) Minimum five-year history of professional liability claims resulting in a judgment or settlement;
      b) Disciplinary status with regulatory board or agency;
      c) Complete history of Medicare/Medicaid sanctions;
   (8) MDHHS Medicaid Sanctioned Providers, OIG/LEIE, System of Award Management (SAM), and the Medicare Preclusion List
   (9) Review of other applicable practitioner directories to ensure consistency with credentialing data, including education, training, board certification, and specialty;
   (10) DEA or CDS Certificate, if applicable; and
   (11) If the individual undergoing credentialing is a physician, then physician profile information obtained from the American Medical Association or American Osteopathic Association may be used to satisfy the primary source requirements of (1), (2), and (3) above.

9. Temporary Credentialing of Individuals

Temporary credentialing of individuals is intended to be used in a situation that requires an increase in the available network of providers in underserved areas, whether rural or urban. Temporary credentialing shall not be used in place of the Initial Credentialing process. MCCMH shall allow temporary credentialing of individuals only when it is the best interest of persons served that providers be available prior to formal completion of the entire credentialing process.

a. Temporary credentialing status shall be allowed not more than once and shall not exceed 90 calendar days during which time the initial credentialing process must be completed.

b. MCCMH shall render a decision regarding temporary credentialing within thirty-one (31) calendar days from receipt of a completed application, accompanied by the minimum documents identified below.

c. The temporary credentialing packet must be provided to the employee at the time of hire and completed within twenty-four (24) hours.

d. For consideration of temporary credentialing, at minimum, an applicant shall complete a signed application that attests to the following items:
   (1) Lack of present illegal drug use;
   (2) Able to perform the essential functions of the position
   (3) Lack of a history of adverse action, loss or limitation of license, registration, or certification, and/or felony convictions;
   (4) Lack of a history of adverse action, loss or limitation of privileges or disciplinary action;
   (5) A summary of their work history for the prior years (i.e., a resume or curriculum vitae including contact information) or all work history if the person has less than five years of experience;
   (6) DEA or CDS Certificate, if applicable; and
   (7) Attestation by the applicant of the correctness and completeness of the application.

e. Primary Source Verification
   MCCMH shall conduct primary source verification of the following:
   (1) Licensure or certification;
   (2) Board certification, if applicable or the highest level of credential attained;
   (3) History of Medicare/Medicaid sanctions, including the MDHHS Sanctioned Provider List, OIG/ LELE, System of Award Management (SAM), and Medicare Preclusion List; and
   (4) Criminal background check.

f. Following approval of temporary/provisional privileges, the formal process of initial credentialing shall be completed by the expiration of their temporary privileges and shall not exceed the 90 days' time frame for temporary/provisional privileges.

10. Initial Credentialing Packet

The Initial Credentialing packet will be provided to the employee at or before the time of hire and completed within twenty-four (24) hours.

a. Initial credentialing shall occur before the employee is permitted to enter into the electronic medical record or provide any billable services. Employment is contingent upon the individual receiving recognition of credentials and authorization of privileges as required by the position.

11. Practitioner Rights

MCCMH shall notify practitioners about their rights to:

a. Review information submitted to support their credentialing application;
b. Correct erroneous information (See Standard 13);
c. Receive the status of their credentialing or re-credentialing application, upon request.

12. Credentialing Information Discrepancies

Notification of the practitioner shall occur by a Quality Division staff member within ten (10) business days when the credentialing information obtained by MCCMH from other sources varies substantially from that provided by the practitioner. The practitioner shall have ten (10) business days to address the discrepancy.

a. The Quality Division staff shall resolve all credentialing information discrepancies or concerns regarding credentialing information with as much primary source documentation as possible including, but not limited to, FOIA information regarding the applicant's license, certifications, legal actions, disciplinary actions, and all pertinent information. Any discrepancies which are the result of an applicant's untruthfulness may result in the immediate denial of credentials.

13. Authorization to Modify Information

a. In the event modifications need to be made to the information provided within the application, the following staff is authorized to access, modify, and delete information:
   (1) Applicant
   (2) Applicant's supervisor
   (3) Quality Division Designee
   (4) Credentialing Facilitator
   (5) Chief of Staff
b. Circumstances when modification or deletion is appropriate:
   (1) Erroneous information is provided within the application
   (2) Inappropriate privileges are selected
   (3) Missing information within the application

(4) Inappropriate information has been added into the NPDB
(5) Old and duplicate applications within the MCCMH Web Application
(6) Any other circumstance(s) that are deemed appropriate by the Quality Division Designee and/or Credentialing Facilitator

14. File Review
    a. Practitioners have the right to access certain information contained in the credentialing file in order to verify accuracy. This information includes:
        (1) Documents authored by the practitioner;
        (2) Documents addressed to the practitioner;
        (3) Any sanctions reports; and
        (4) A summary, prepared by MCCMH, of the remaining contents of the credentialing file.
    b. Practitioners are notified on the Credentialing Application of their right to review information submitted to support their credentialing or re-credentialing application and be informed of their credentialing or re-credentialing status, upon request.

15. False/Misleading Information
    A practitioner who provides any false and/or misleading information regarding credentialing and re-credentialing information or documents may have their credentials immediately denied. The immediate denial is final and not subject to the adverse action appeal process.

16. Initial Sanction Information
    Complete practitioner sanction information shall be received before a credentialing decision is made. Sanction information shall include, but is not limited to, state sanctions, restrictions on licensure and/or limitations on scope of practice, and Medicaid and Medicare sanctions.

17. Documentation Expiration
    All documentation and information required may not be more than sixty (60) days old at the time of the Professional Standards Committee review.

18. Missing Documentation
    All required and necessary documentation must be present at the time of the Professional Standards Committee review. Any missing documentation will prevent the practitioner file to be reviewed.

If documentation is missing at the initial credential, the practitioner's start date may be altered.

If the documentation is missing at re-credentialing and the practitioner expires, the practitioner may be suspended without pay in the event the practitioner fails to renew their credentials and privileges before they expire. The practitioner's suspension will continue until he/she provides proof of renewed credentials and privileges.

19. Privileging
Privileges to provide certain services or procedures are granted based on the scope of practice of an individual's recognized credentials and competency. A practitioner's competency is determined by skills verification that is based on credentials, experience, resume, professional competence, demonstrated ability, and job performance.

20. Review Standard
Each practitioner's credentialing documents are reviewed by the Quality Division for accuracy based on the credentialing criteria prior to presentation to the Professional Standards Committee. Any practitioner whose credentials might not be approved shall be reviewed by the Chief Quality Officer for a determination as to whether the application should proceed.

21. Credentialed for Current Position
All practitioners must be credentialed in accordance with their current position description, and may apply to be credentialed in accordance with other position descriptions if they meet those position requirements.

B. CREDENTIALING INDIVIDUAL PRACTITIONERS
CREDENTIALING COMMITTEE

1. Professional Standards Committee
There shall be a Professional Standards Committee ("Committee") established for the purposes of reviewing credentialing and clinical privileging applications and providing recommendations for action to the MCCMH Chief Executive Officer and Chief Medical Officer.

2. Committee Composition
There shall be a maximum of five (5) Committee members. The Committee shall be composed of MCCMH staff representing the scope of practice of the individuals being credentialed and include following professional classifications: social work, nursing, psychology/psychiatry, and professional counseling. Upon request, the Director or Designee of the Division in which

the applicant will be employed shall be allowed as a Guest Member. The Chair of the Committee shall compile and forward a list of eligible candidates to the applicable MCCMH Division Director. The MCCMH Division Director shall recommend Committee membership from the eligible candidates and forward the recommendation to the Chief Quality Officer or Designee. Committee members shall be appointed by the Chief Quality Officer or Designee with approval of the Chief Executive Officer. Terms shall be for two (2) years with the possibility for re-appointment.

3. Committee Meetings
The Committee shall be chaired by the MCCMH Chief Quality Officer Designee. Meetings shall take place on a monthly basis, or at the discretion of the Chief Quality Officer or Designee. Dismissal of a Committee member by the Chief Quality Officer may occur when three (3) consecutive meetings are missed due to unexcused absences or for other reasons as determined by the Chief Quality Officer.

4. Committee Member Replacement Process
In the event that a Committee member is removed, resigns, or MCCMH employment is terminated, the process to replace that member shall follow the process used in V.B.2. above.

5. Application Action
There shall be at least three (3) Committee members in attendance for action to occur on an application. The Committee shall forward, to the Chief Executive Officer and Chief Medical Officer, as appropriate, as well as the applicable Division Director, its written recommendation to approve, defer, or deny credentialing or re-credentialing within ten (10) business days of meeting.

6. Committee Responsibility
The Professional Standards Committee is responsible for reviewing the credentialing activities of new practitioners, the re-credentialing activities of existing practitioners and reviewing all practitioners with an identified or potential deficiency in their credentials.

7. Documentation of Proceedings
The proceedings of the Professional Standards Committee meetings shall be documented in minutes and summary reports which shall be reported to the MCCMH Chief Executive Officer or Chief Medical Officer. Minutes are maintained by the Quality Division.

8. Committee Determination
The Professional Standards Committee approves, defers, or denies status based on its review of credentialing information and all relevant

documentation. It makes a determination only when all information required to make a credentialing decision is present. It acts as a peer review committee to review the credentials of practitioners and to make recommendations to the MCCMH Chief Executive Officer or Chief Medical Officer.

9. Basis of Recommendation

The basis of Committee recommendations includes, but are not limited to:

a. Provision of services which the practitioner is privileged to perform;
b. Incident report findings;
c. Compliance investigation findings;
d. Recipient rights complaint findings;
e. Physical, mental, or emotional conditions, including substance abuse, affecting performance;
f. Criminal conviction;
g. License, Registration, Certification;
h. Michigan PIHP/CMHSP Provider Qualifications Per Medicaid Services and HCPCS/CPT Codes;
i. Michigan Medicaid Provider Manual;
j. Other significant performance related factors.

10. Form of Recommendation

Favorable recommendations regarding credentials and privileges are reflected in the minutes. All recommendations, favorable and unfavorable, are communicated to the practitioners in writing and reflected in the minutes. The Chief Quality Officer or Designee shall give practitioners written notice, documented in the credentialing file, of adverse recommendations within five (5) working days. Practitioners are given notice of their right to appeal the Professional Standards Review Committee decision through the Adverse Action Appeal process.

11. Practitioner Privacy

The Committee shall respect individual privacy in its work. The credentialing applications and substantiating documentation acquired by the Committee contain, and are considered to be, personal and private information. Committee members must use reasonable efforts to maintain privacy of the information and submitted documents. Committee documents shall be distributed for internal use only within MCCMH.

12. Official Written Approval for Physicians

Official written approval, documented in the credentialing file, of credentialing and re-credentialing for physicians shall be made within five (5) working days by the MCCMH Chief Medical Officer, with consideration given to the recommendations of the Professional Standards Committee.

13. Official Written Approval for Credentialed Staff, Other Than Physicians
Official written approval, documented in the credentialing file, of credentialing and re-credentialing for all credentialed staff, other than physicians, shall be made within five (5) working days by the MCCMH Chief Executive Officer, with consideration given to the recommendations of the Professional Standards Committee.

14. Re-credentialing Individuals
Re-credentialing of physicians and other licensed, registered, or certified individuals shall occur:
a. At least every two years; or
b. When there is a change to any initial credentialing information.

15. Change of Credentialing Authorization
The Chief Executive Officer and Chief Medical 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. Justification may include, but is not limited to, the findings of the MCCMH QAPIP, MCCMH Office of Recipient Rights, MCCMH Corporate Compliance Office, MCCMH Professional Standards Committee, the MCCMH Chief Operations Officer personnel review, Bureau of Health Services (Licensure), or other monitoring and licensing body. Practitioners shall be given written notice of adverse actions within five (5) working days. Practitioners are given notice of their right to appeal the decision through the Adverse Action Appeal process.

16. Summary Suspension
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. The MCCMH Chief Executive Officer, Chief Operating Officer, Chief Quality Officer, Chief Medical Officer, Chief Clinical Officer, Director of Community and Behavioral Health Services, or Program Supervisor may summarily suspend approval of any or all of a practitioner's credentials and/or privileges 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. An investigation shall commence immediately and the finding shall provide for either reinstatement or notice of adverse action.

17. Automatic Suspension or Limitation
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 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. MCCMH does not recognize any statutory allowances for the renewal of a license or registration after its expiration date. The practitioner's suspension will continue at least until he/she provides proof of a renewed license, registration, or privileges. Automatic suspension or limitation is immediate, final, and not subject to the adverse action appeal process.

18. Completed Application
It is the responsibility of each employee and independent contractor, including MCCMH contract psychiatrists, to submit the completed application to the MCCMH Chief Quality Officer or Designee.

19. Notification of Status
Employees and independent contractors shall provide immediate notification to the MCCMH Chief Quality Officer or Designee regarding any changes in status of license, certification, registration and any information or documentation obtained in the credentialing process. An employee's failure to immediately notify their supervisor and the MCCMH Chief Quality Officer or Designee in the event that any required qualification, licensure, certification, registration or other credential is expired, revoked or suspended, may result in disciplinary action, up to and including possible termination of employment.

C. DEEMED STATUS

1. Recognition
MCCMH may recognize and accept credentialing activities conducted by another PIHP of individual or organizational providers that deliver healthcare services to more than one PIHP in lieu of completing the credentialing process. This option is considered on a case-by-case basis.

2. Documentation
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 individual or provider credentialing files.

D. NOTIFICATION

Practitioners shall be notified in writing within twenty-one (21) days regarding all determinations made by the Professional Standards Committee, including adverse credentialing decisions. Written notification shall include the reason for the adverse determination.

E. APPEAL OF ADVERSE ACTIONS

Only adverse actions which constitute grounds for appeal are afforded the right to appeal. The Professional Standards Committee or the Chief Quality Officer designee notifies the practitioner in writing, in the form of a "Proposed Adverse Action," of its proposed action within five (5) working days of its decision. Notification includes the proposed action, reason for the decision, the right of the practitioner to review the file, attend an informal meeting with the Professional Standards Committee, and/or petition MCCMH to correct erroneous information submitted by the practitioner or a third party. The practitioner's request to review the file or for an informal meeting to appeal the action must be received within ten (10) days of the notification. The same appeal process is afforded to a practitioner if they believe that adverse actions were submitted in error by MCCMH to the NPDB.

1. Adverse Actions
   Adverse actions include, by way of example and without limitation, the following:
   a. Denial, suspension, restriction, limitation or termination of credentials or privileges recognition based upon professional competence or conduct;
   b. Failure to obtain necessary clinical training;
   c. Significant consultation or monitoring requirements.

2. Informal Meeting
   A meeting may be conducted by the Professional Standards Committee in the form of an informal discussion among colleagues. The meeting is not conducted according to any formal rules or procedures. Neither party is represented by counsel at the informal meeting. The meeting shall be documented in minutes.

3. Formal Meeting
   Professional Standards Committee recommendations for adverse action are forwarded to the Chief Executive Officer, Chief of Staff, and Chief Quality Officer designee for a final decision. The practitioner has thirty (30) days from the date of the Notice of Proposed Adverse Action to request a formal meeting. The Request is in written form to the Chief Quality Officer.

a. The Formal Meeting will be scheduled and commence within thirty (30) days of receipt of the Formal Meeting Request.
b. At the Formal Meeting, both the provider and MCCMH may be represented by counsel, provide any relevant evidence, submit a memorandum of law and/or medical points and authorities, and question witnesses.

4. Notice of Formal Meeting
The date, time, and place of the meeting, , the reasons for the adverse action including acts or omissions of the practitioner, relevant documents including records of patient care, and a list of persons expected to speak at the Formal Meeting.

5. List of Evidence
Before the Formal Meeting, the parties may exchange lists of documents to be provided at the meeting and of all persons expected to speak at the meeting.

6. Decision
After conclusion of the Formal Meeting, Chief Executive Officer, Chief of Staff and Chief Quality Officer Designee shall issue, within fifteen (15) days, a written decision.

F. TERMINATION

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

G. REPORTING CREDENTIALING AND RE-CREDENTIALING 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, National Practitioner Databank (NPDB), the accrediting body, etc.) any known problems that result in an individual's or organizational provider's suspension or termination from the MCCMH's employment or network.

2. In the event that MCCMH detects issues related to corporate compliance, MCCMH will refer these issues to the MCCMH Chief Compliance Officer.

3. MCCMH shall maintain documentation through its corporate compliance program of all disciplinary measures and actions implemented regarding a practitioner.

H. STAFF QUALIFICATIONS

1. The Michigan Department of Health and Human Services (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 MDCH Bureau of Community Based Services, Office of Recovery Oriented Systems of Care publishes staff qualifications and definitions for staff performing services in Substance Use Disorder programs.

2. These qualifications are modified from time to time. Therefore, **all individuals seeking privileges anywhere 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 supplement 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.**

I. MONITORING

1. Continuous Practitioner Monitoring

   The Quality Division or designee provides continuous practitioner monitoring (and intervention if appropriate) through the collection and review of sanctions, complaints, and quality issues pertaining to the practitioner which include, at minimum, review of:

   a. Medicare/Medicaid exclusions and State sanctions on a monthly basis;
   b. State limitations on licensure, registration, or certification on a yearly basis;
   c. Grievances (complaints) and appeals information;
   d. Findings of the MCCMH Quality Assessment Performance Improvement Program (QAPIP);
   e. Training requirements for licensure/registration/certification; and
   f. Allegations of wrongdoing (e.g., recipient rights complaints, corporate compliance issues, etc.) or adverse events

2. Improper Conduct
Improper conduct which results in an 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."

3. Corrective Action Plan
The Quality Division shall identify instances of poor quality related to the areas of continuous monitoring and notify the appropriate Division Director. The Division Director shall determine applicable disciplinary action which includes by way of example, and without limitation, Work Improvement Plan, written or verbal reprimand, suspension, and/or termination.

J. PRACTITIONER OFFICE SITE QUALITY

1. Audit Criteria
MCCMH shall audit the quality of each practitioner's office site for the following criteria: physical accessibility, physical appearance, adequacy of waiting and examination room space, and adequacy of the persons served administrative and clinical record keeping process.

2. Site Visit
A site visit shall be conducted within sixty (60) days of determining that the complaint threshold has been met. MCCMH considers a reasonable complaint threshold to be three per six month period.

3. Corrective Action Plan
A quality improvement corrective plan of action shall be implemented for instances of poor quality related to the practitioner office site.

4. Corrective Action Plan Evaluation and Documentation
The effectiveness of corrective action plans shall be evaluated at least every six (6) months, until the deficit is remedied and follow up visits to offices with deficiencies shall be documented.

K. TIMELINESS OF CREDENTIALING PROCESS

MCCMH completes the credentialing and re-credentialing process within 90 days of receipt of the initial or renewal application for credentials and privileges. If the 90 day timeliness standard is not met, the Credentialing Facilitator, Quality Designee, and Chief Quality Officer will meet to assess what can be done to improve the timeliness of the organization's credentialing and re-credentialing processes. The Quality Designee tracks and monitors the organization for achievement of timeliness.

VI. PROCEDURES

A. INITIAL CREDENTIALING PROCESS

1. General
   a. Upon notification of hire, a practitioner shall obtain and complete Applications for the recognition of Credentials and Privileges within twenty-four (24) hours of notification. Reassigned practitioners shall apply for additional privileges required by the job description within twenty-four (24) hours of reassignment notification.
   b. The practitioner shall complete all sections of the Applications for Recognition of Credentials and Clinical Privileges and forward the form with any substantiating documentation to his/her supervisor for signature within twenty-four (24) hours of notifications of hire. Psychiatrists and other medical professionals shall submit their applications to the Medical Director.
   c. Following appropriate supervisory signature, the completed credentialing/ re-credentialing application shall be forwarded by the Supervisor to the Chief Quality Officer or Designee for review.
   d. The individual shall provide evidence to support each requested privilege. Recommendations by the appropriate Supervisor shall be made regarding full or provisional status for each privilege requested on the practitioner's application. The appropriate Supervisor shall complete the Supervisory Review form. The Supervisory Review Form shall be forwarded to the Chief Quality Officer or Designee with a copy to the practitioner.
   e. Prior to referring an application to the Professional Standards Committee, the Quality Division Designee shall conduct a professional status review consisting of primary source verification of license, credentials, registration, certification, and practitioner exclusion/sanction information, as applicable, according to the Standards provisions of this policy.

2. Application and Documentation Review
   a. The Quality Division Designee performs a professional status review then places the credentialing packet on the agenda for review by the Professional Standards Committee. The Professional Standards Committee meeting schedules are public record and a schedule of these meetings can be obtained from the Chief Quality Officer or designee.
   b. The Committee will review and evaluate the applications and any accompanying documents to determine whether to recommend

approval or denial of credentials and privileges recognition and provide the rationale for its recommendations.

c. The Committee will complete the recommendations section of the application forms with accompanying rationale and submit it to the Chief Executive Officer for approval or denial of official authorization of credentials and privileges.

d. The completed applications will be returned to the Chief Quality Officer or Designee for forwarding to the practitioner following action of the Chief Executive Officer. The Human Resources Liaison shall file a copy in the practitioner's MCCMH personnel file and forward a copy to the appropriate supervisory personnel and to the county for inclusion in their county personnel file.

3. Application Recommendations

a. The bases for Committee and Chief Executive Officer's review and recommendation for approval or denial of credentialing recognition is contained in the provisions of this policy.

b. The basis of credentialing recommendations of the Committee, Supervisors, Chief Medical Officer, Chief Executive Officer, include, but are not limited to:

(1) Provision of services is within the practitioner's scope of practice;
(2) Incident report findings;
(3) Compliance investigation findings;
(4) Recipient rights complaint findings;
(5) Grievances and appeals findings;
(6) PIHP quality concerns and issues;
(7) Compliance with PIHP and MDHHS training requirements
(8) Physical, mental, or emotional conditions, including substance abuse affecting performance;
(9) Criminal conviction;
(10) License, Registration, Certification;
(11) Other significant performance related factors.

4. Application Approval

a. Favorable recommendations are reflected in the Committee minutes.

b. Official written credentialing approval shall be made within ten (10) days by the applicable MCCMH Chief Executive Officer.

5. Application Denial

a. Unfavorable Committee recommendations are communicated to the practitioner in writing and reflected in the minutes.

b. The Chief Quality Officer or Designee shall give practitioners written notice of adverse recommendations within five (5) working days.

c. Practitioners are given notice of their right to appeal the Committee decision through the Adverse Action Appeal process.

6. Adverse Action Appeal Process
   a. Only adverse actions which constitute grounds for appeal are afforded the right to appeal. See Section V.F.
   b. Actions which are not appealable include:
      (1) The provision of false and/or misleading credentialing information or documents; or
      (2) Automatic suspension or limitation.
   c. Informal Meeting. See section V.F.
   d. Formal Meeting. See section V.F.
   e. Decision. See Section V.F.

B. RENEWAL CREDENTIALING PROCESS
   1. General
      a. Practitioners who hold full privileges shall complete an application for renewal of credentials and privileges thirty (30) days prior to the expiration date contained on the Authorization Report. Practitioners must renew their credentials and privileges **before** the expiration date. A practitioner may be suspended without pay in the event the practitioner fails to renew their credentials and privileges before they expire. The practitioner's suspension will continue until he/she provides proof of renewed credentials and privileges.
   2. Considerations
      a. Practitioners who complete an application for renewal of credentials and privileges must complete the attestation document associated with grievances and appeals, rights complaints, and compliance investigations. Furthermore, practitioners must complete the MCCMH Office of Recipient Rights Release of Information form. The Quality Designee will verify with the corresponding departments the completeness and accuracy of the form through internal primary source verification. Any findings will be reviewed and considered by the Credentialing Committee.
      b. The Quality Designee will confer with the Quality Administrator and/or Quality Coordinator who oversees submitted Quality Concern Referrals. Practitioners who apply for renewal of credentials and privileges will be checked against the Quality Department concern database. Practitioners with quality concerns will have the concerns considered during the review of their renewal of credentials and privileges.

C. CHIEF OF STAFF OR DESIGNEE

1. Obtain current background check and credentialing information before offer of employment.
2. Maintain custody of personnel files.

D. QUALITY DIVISION DESIGNEE

1. Perform preliminary status check to ensure practitioner or organizational provider meets credentialing requirement.
2. Notify appropriate staff of licensure and credentialing concerns.
3. Submit credentialing documents to Professional Standards Committee.
4. Notify appropriate staff of credentialing status after Committee review. Document relevant credentialing information.
5. Perform monthly practitioner exclusion/sanction search and quarterly licensure updates.
6. Report adverse credentialing and re-credentialing decision information to appropriate authorities.

E. PRACTITIONER PEER REVIEW PROCESS FOR ADVERSE ACTIONS

The peer review process will be utilized when there is a decision by the PIHP to sanction a practitioner for fraud, waste, abuse, neglect or other adverse action (Ex: malpractice). This decision may affect the practitioner's ability to obtain/renew a professional license, obtain liability insurance, and/or bill Medicaid in the State of Michigan. The practitioner will be notified of this adverse decision and rationale within 5 working days of the PIHP's decision via e-mail and written correspondence. The practitioner will be given 30 days to request an appeal via email or in writing to the committee following notification.

If the Peer Review Committee receives a request for an appeal, they will notify the Chief of Staff to schedule an appeal hearing. The practitioner will be given a date within 30 days of the receipt of the request to participate in a hearing conducted by the MCCMH Peer Review Committee. This committee will include representatives from the Compliance Office, Office of Recipient Rights, Medical Office, MCCMH Human Relations, Quality and Clinical Departments. The hearing may be conducted in person or via confidential tele-communications (Ex: Zoom, Skype, etc.).

If the practitioner prefers, they may request that the Peer Review Committee conduct the hearing without their presence. The practitioner may provide additional information to the committee, if warranted. The Peer Review Committee will render the final decision regarding sanctions following the appeal process within 15 days. The practitioner will be notified within 7 days. Chief of Compliance or designee will report the findings to all licensing bodies. NPDB will be notified of any and all sanctions within 7 days by the Chief of Staff or designee.

VII. CREDENTIALING SYSTEM CONTROLS

A. TRACKING CREDENTIALING MODIFICATIONS

Once the online application is completed within the MCCMH Credentialing Web Application and generated by the applicant; all modifications to the application have to be completed on the original paper copy of the application that contains the applicant's signatures and their supervisor's signatures. Modifications made by an authorized modifier must cross out the information needing modification, write their initials, and the date the modification was made.

Modifications to correct erroneous information outside of simple expiration dates or typos will require modification note from the authorized modifier explaining why the modification has been made.

B. SECURING CREDENTIALING INFORMATION

The MCCMH Credentialing Web Application grants accounts to applicable program, clinical, and administrative supervisors. The Credentialing Facilitator or Quality Designee grants identified supervisors' access to the credentialing application. Supervisors are provided with a unique username and password, which they are prompted to change upon receipt. The Credentialing Facilitator or Quality Designee reserves the right to deny account creation for requesting staff. They will verify prior to account creation that inquiring supervisor needs access to the system in order to do their job.

All users of the MCCMH Credentialing Web Application must adhere to MCO Policy 10-460: Password Management, which states:

> "The MCCMH password management system shall include the following emphases: (1) Rules to be followed in creating and changing passwords, including password adequacy (e.g. length, complexity) and frequency considerations, including:
>
> a. For MCCMH Systems other than FOCUS:
>
> a. Password shall be at least ten (10) characters long
> b. Passwords must contain a minimum of three (3) of the following four (4) options: (i) upper case letter, (ii) lower case letter, (iii) number, and/or (iv) symbol.
> c. Users are required to change their password every ninety (90) days. The MCCMH Information Technology (IT) staff shall periodically send reminders to do so.
>
> (2) the importance of keeping passwords confidential and include storage considerations to ensure protection, and (3) authorization and/or supervision of the MCCMH workforce who work with EPHI or in locations where it might be accessed. "

They Quality Designee will ensure user accounts for the MCCMH Credentialing Web Application are deactivated immediately upon the termination of a user's last day of employment with MCCMH.

During the credentialing process, the Quality Designee locks up all pending initial and renewal application in their office file cabinet. The Quality Designee is the only person who has access to this file cabinet. Applications are only removed from the lock cabinet when processing is needed, or the application is being presented to the committee. Files remained locked up until they are submitted to the MCCMH Personnel Senior Office Assistant for filing.

Once the credentialing process has finished, the Quality Designee sends the original initial and renewal applications to the main administration building. Applicant personnel files are housed and maintained at the main administration building. Personnel files are accessible to a limited number of administrative team members. Administrative team members ensure file cabinets stay locked at all times and unauthorized personnel do not have access to the files. MCCMH team members who wish to view their personnel file will have an MCCMH administrative team member oversee the review of their personnel file to ensure unauthorized modifications to recent and past credentialing applications.

C. CREDENTIALING PROCESS AUDIT

The MCCMH Quality Department will conduct an annual internal credentialing process audit to ensure the system controls are being adhered to and credentialing applications are of the highest quality. The Chief Quality Officer will designate a Quality Auditor(s), excluding the Quality Designee, to complete the annual review. The MCCMH Quality Department will audit 5% or 20 clinician files that were initially credentialed and re-credentialed during the previous 12 months.

The auditors will assess that primary source verification is being conducted in a timely manner, within the personnel file, and ensure the data is being properly stored and tracked. Auditors will ensure that any modifications made to the application meets the modification requirements and that an authorized modifier completed the modification. Auditors will assess the security of the applications by retrieving them from their locked file at the administration building. Lastly, auditors will ensure there are no terminated users within the MCCMH Credentialing Web Application.

VIII. DEVELOPMENT AND EVALUATION

The Chief Clinical Officer/Designee is responsible for the annual review and evaluation of this policy.

IX. REFERENCES / LEGAL AUTHORITY

A. Commission on Accreditation of Rehabilitation Facilities (CARF) Standards Manual, Section 1.I Workforce Development and Management

B. National Committee for Quality Assurance (NCQA), 2020 MBHO Standards and Guidelines

C Medicaid Managed Specialty Supports and Services Program FY 2020, Contract Attachment 7.1.1: MDHHS Behavioral Health and Developmental Disabilities Administration, "Credentialing and Re-credentialing Processes"

D. Medicaid Managed Specialty Supports and Services Program FY2020, Contract Attachment 7.9.1: Quality Assessment and Performance Improvement Programs for Specialty Pre-Paid Inpatient Health Plans

E. Michigan Mental Health Code

F. Michigan Public Health Code

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

H. MCCMH MCO Policy 3-001, "Audit Content and Timetable."

I. MCCMH MCO Policy 10-800, "Quality Concerns Referral"

J. MCCMH MCO Policy 10-460 "Password Management"

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

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

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

N. Department of Health and Human Services Substance Abuse and Mental Health Services Administration FY2020 Certified Community Behavioral Health Clinic Expansion Grants

X. EXHIBITS

A. MCCMH Application for Temporary Credentialing, Initial Credentialing/Re-Credentialing; MCCMH Application for Privileges

B. MCCMH Supervisor Review Form

C. MCCMH Criminal Background Check form