MCCMH MCO Policy 3-004

Chapter: **PROVIDER NETWORK MANAGEMENT**
Title: **NETWORK APPLICATION / PROFILING PROCESS**

Prior Approval Date: 10/14/10
Current Approval Date: 9/20/12

Approved by: _____ 09/20/12
Executive Director Date

I. ABSTRACT

This policy establishes the standards and procedures of the Macomb County Community Mental Health (MCCMH) Board for the application process for interested providers to apply for participation in the MCCMH provider network.

II. APPLICATION

This policy shall apply to all contract network providers and applicant providers of the MCCMH Board.

III. POLICY

It is the policy of the MCCMH Board that organizations seeking MCCMH network participation must submit a completed Provider Profile Application to the MCCMH Business Management Division.

IV. DEFINITIONS

A. None.

V. STANDARDS

A. Prospective network providers shall meet minimum competency requirements, and demonstrate the capacity to deliver high quality and best value clinical and support service programs in compliance with all applicable standards for its programs.

B. Prospective network providers shall submit a completed Provider Profile Application (Exhibit A) pursuant to the MCCMH request for proposals (RFP). These will be submitted to the Chair of the Provider Procurement Committee.

C. All other prospective network providers shall submit a completed Provider Profile Application (Exhibit A) to the MCCMH Business Management Division.

D. Approval for MCCMH network participation must be re-secured at least every two years. The Provider Management unit will notify the provider of the need for renewal. The re-application process will follow the same format as the initial application/profile process and require updated information in all areas. MCCMH reserves the right to deny contract renewal based on significant unsatisfactory performance related factors, including but not limited to financial compliance, contract compliance investigation findings, corporate compliance investigation findings, incident report findings, recipient rights complaint findings, internal quality review findings, external Medicaid verification review findings, consumer satisfaction results, and outcome performance measures.

E. MCCMH is prohibited from contracting with providers excluded from participation under either Medicare or Medicaid.

VI. PROCEDURES

A. Provider Profile Application Process

A completed application submitted by the applicant organization shall contain the following supporting documentation:

1. A copy of any license or certification required for the type of program for which the provider organization is seeking approval.

2. A copy of a certificate of insurance demonstrating the existence of professional liability insurance protection with coverage and limits appropriate to the type of program for which the provider organization is seeking approval.

3. A signed application containing, at a minimum:

   a. Philosophy and goals of the organization.

   b. Code of Ethics of the organization.

   c. Specific services which the organization wishes to provide for the Board.

   d. Organizational history which contains a statement by the Provider Organization's representative who is knowledgeable about its professional liability claims history which includes:

      (1) Any prior incidents of loss or suspensions of licensure, certification, or accreditation or disciplinary actions against the organization in its current or

former name, or against its service providers by the State of Michigan or other regulatory body,

(2) Any Medicare/Medicaid sanctions and/or legal actions resulting in liability or disciplinary procedures against the organization, its owners, or its Board of Directors.

e. Documentation of the organization's plan for, and completion of, its credentialing and privileging process for direct services staff.

f. Documentation of the organization's process for and completion of criminal conviction background checks for all employees and contractual staff, especially those who provide services to consumers.

g. Copy of JCAHO, CARF, or COA accreditation or evidence that accreditation is in process (to be followed by accreditation award letter).

h. Copy of the overall Quality Improvement Plan for the organization.

i. Documentation of process for and results of consumer satisfaction surveys formerly conducted by the organization and plan for continuation.

j. Copy of the organization's corporate compliance plan.

k. Documentation of the organization's capacity to meet HIPAA, EDI, privacy and security requirements.

l. Outcome and performance data (for contract renewals).

m. Disclosure of ownership and control information.

B. MCCMH, through its Business Management Division, reserves the right to review the applicant organization's policies and procedures, its financial records and audits, and its personnel records.

C. The provider organization's site(s), where services are to be delivered or consumers seen, is (are) required to be barrier-free, clean, safe, and accessible.

D. MCCMH may initiate an on-site review of the provider organization's site(s) as well as relevant clinical, administrative or compliance records and audits.

E. Provider Profile Application Review

1. Upon receipt of the organization's application it will be reviewed for completeness. If the application is incomplete it will be returned to the applicant.

2. If the application is complete, the Provider Network unit of the Business Management Division will search the Office of Inspector General's exclusions database

(http://exclusions.oig.hhs.gov) to ensure that the provider entity and any individuals with five percent or more ownership or control interests in the provider entity have not been excluded from participating in federal health care programs. If finding no exclusions for participation, the Provider Network unit shall contact references, review all materials, and interview the applicant (as indicated).

3. The Provider Network unit will submit the completed application with any findings and comments to the MCCMH Provider Procurement Committee (if related to a Request for Proposals). If not related to a Request for Proposals, it will be sent to the Director of Business Management.

4. The Provider Procurement Committee will review the application, the findings and comments of the Provider Network Unit, and submit their recommendations for approval or non-approval and any conditions thereof to the MCCMH Director of Business Management. The recommendation will then be forwarded to the Executive Director and/or Deputy Director and taken to the MCCMH Community Mental Health Board for action.

5. The Business Management Division will notify the applicant organization of the MCCMH Board's decision as to approval or non-approval of the application and conditions to be met, if any.

6. Following issuance of contract, if any, the Provider Network unit will notify the Access Center and other appropriate providers of the new Provider and pertinent information as to its approved services.

7. For Provider Profile Applications that are not related to a Request for Proposals, the application shall be filed and entered into a data base. Individual agencies whose applications have been entered as described will be notified when a Request for Proposals is offered. In situations where an urgent or emergent situation exists, the Director of Business Management may make a recommendation to the Executive Director and/or Deputy Director to issue a contract for the service. Final approval shall be made by the Board of Directors.

F. Renewal of MCCMH Network Participation

1. The Director of Business Management shall provide the members of the MCCMH Executive Staff with a listing of contracts that are up for renewal (i.e., that are nearing the end of the two-year contract period), and shall request each Executive Staff member to detail issues/concerns, if any, which may prevent continuing a contract with each listed provider.

2. The Director of Business Management shall review the information provided by members of Executive Staff, and where there are no concerns raised, notify the MCCMH network provider of the need for renewal. Procedures for contract renewal shall proceed according to the provider profile application renewal process outlined in VI.E., above.

3. Concerns raised by Executive Staff members regarding renewal of contracts with any provider shall be addressed at the next MCCMH Executive Staff meeting. Executive Staff shall do one of the following:

   a. Determine contract renewal shall proceed; provider concerns shall be addressed directly with the provider, and when appropriate, through contract provisions.

   b. Determine that the contract shall not be renewed; a recommendation not to renew the contract shall be made to the MCCMH Board.

VII. References / Legal Authority

A. MDCH / MCCMH Medicaid Specialty Supports and Services Contract, FY 13; MDCH / MCCMH Managed Mental Health Supports and Services Contract, FY 13

VIII. Exhibit

A. Provider Profile Application

Macomb County Community Mental Health
Provider Profile Application

ALL INFORMATION SUBJECT TO VERIFICATION

CORPORATE INFORMATION	Corporate/Legal Name:		
	Organization/DBA Name:		
	Organization Mailing Address:		
	City:	State:	Zip code:
	Billing Address (if different than mailing)		
	Tel.:( )	Fax:( )	E-Mail:

ADMINISTRATIVE INFORMATION	Chief Administrative Officer:	
	Chief Financial Officer:	
	Chief Medical Officer:	
	Chief Clinical Manager:	
	Recipient Rights Contact:	
	Business Manager:	
	Primary Contact Person:	E-mail:
	Secondary Contact Person:	E-Mail:
PLEASE ATTACH A LISTING OF THE PROGRAM'S CURRENT BOARD OF DIRECTORS (specifying number of primary and secondary consumers on Board)		

TYPE OF PROGRAM ***(Please check ALL that apply)***	___ Assertive Community Treatment ___ Assistance w/Challenging Behavior ___ Children's Model Waiver ___ Children's Residential ___ Case Management Services ___ Community Living Supports (___ MI or ___ DD) ___ Crisis Residential (Adult or Child) ___ Day Programs ___ Emergency/Crisis Unit – hospital based ___ Family Support Services (___ MI or ___ DD) ___ General Hospital ___ Hab Waiver Services ___ Home Based Services ___ Intensive Crisis Stabilization Services	___ O.T. ___ P.T. ___ SP & L ___ Out of County Case Management Services ___ Out of County Outpatient Services ___ Out of County Residential Services ___ Outpatient Clinic Mental Health Services ___ Peer Delivered or Operated Services ___ Psychiatric Hospital (Adult or Child) ___ Psycho-Social Rehabilitation Programs ___ Residential Group Home ___ Respite Care ___ Skill Building Services (___ MI or ___ DD) ___ Supported Indep. Program (SIP) ___ Wrap Around Services ___ Other (specify):

TYPE OF ORGANIZATION *(Please check one)*

___ Federal ___ State ___ County	___ City ___ Private Non-profit ___ Privately Owned	___ Corporation ___ Partnership ___ LLC/LLP
Parent Corporation or Owner of Organization:		
Street Address:		
City:	State:	Zipcode:
Telephone: ( )	Fax: ( )	
Name and Title of Corporate Executive Officer:		

Important Note: *All programs listed in this application must correspond to the Tax Identification Number (TIN) and Payee listed below. If there is more than one TIN, an additional application must be completed.*

TAX ID	TIN:	Payee:
	Medicaid # (if applicable):	Agency NPI # (if applicable):
	Medicare # (if applicable):	

LICENSOR/CERTIFICATION AND/OR ACCREDITATION

Is the organization state licensed/certified: _____ Yes *(If yes, complete the following license information*
_____ No *and attach a copy*.)

Type:	License #:	Exp. Date:
Type:	License #:	Exp. Date:
Type:	License #:	Exp. Date:
Type:	License #:	Exp. Date:

		Yes	No	N/A	Exp. Date
ACCREDITATION/CERTIFICATION	Has the organization been reviewed and accredited by JCAHO?				
	Has the organization been reviewed and accredited by CARF?				
	Has the organization been certified by COA?				
	Has the organization been reviewed and accredited by DCH?				
	Has the organization been approved or certified by Medicaid?				
	Has the organization been approved or certified by Medicare?				
	Please indicate any other accreditation/certifications:				

(Please attach a current copy of all Accreditation Award Letters or Certificates)

LIABILITY/INSURANCE INFORMATION	Company Name of Liability Carrier:		
	Policy Number:		
	LIMITS:	Per Occurrence:	Aggregate:
	DATES:	Effective Date:	Expiration Date:
	Company Name of Liability Carrier:		
	Policy Number:		
	LIMITS:	Per Occurrence:	Aggregate:
	DATES:	Effective Date:	Expiration Date:

(Please attach a current copy of the policy face sheet with limits and expiration dates listing coverage for organization sites. ***ALL ADDRESSES*** *must be listed.)*

ORGANIZATION PROFILE

(Please complete this section in its entirety. Your responses need to cover the past five (5) calendar years plus current year to the present. If a question does not apply to your organization, you may check "N/A" (Not Applicable.)

	Yes	No	N/A
Has the organization's state license/certification ever been revoked, suspended, or limited?			
Is there action pending to suspend, revoke, or limit the organization's license/certification?			
Has the organization ever had its JCAHO accreditation revoked, suspended, or limited?			
Is there action pending to revoke, suspend, or limit the organization's JCAHO accreditation?			
Has the organization ever had its CARF accreditation revoked, suspended, or limited?			
Is there action pending to revoke, suspend, or limit the organization's CARF accreditation?			
Has the organization ever had its COA certification revoked, suspended, or limited?			
Is there action pending to revoke, suspend, or limit the organization's COA certification?			
Has the organization ever had any other certification/accreditation revoked, suspended, or limited?			
Is there action pending to revoke, suspend, or limit the organization's other certification/accreditation?			
Has the organization ever had sanctions imposed by Medicare and/or Medicaid?			
Has the organization ever been denied professional liability insurance or has its insurance ever been canceled or denied renewal?			
Has the organization ever been a defendant in any lawsuit in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?			
Has the organization had any malpractice claims in regard to the practice of mental health or substance abuse treatment?			
* Note: If you have answered "yes" to any of the above questions, please provide the current status and details on a separate sheet of paper. Please include the following: description of incident, correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events; however, your application cannot be processed without the necessary official documentation.			

ADMITTING PRIVILEGES FOR PSYCHIATRIC HOSPITALIZATION (if applicable)

Please list all psychiatric providers who have admitting privileges at your organization. _____N/A

Provider Last Name	Provider First Name	Licensor

PROGRAM PROFILE

Your organization may provide more than one of the identified program types on page one of this application. If so, please photocopy this page (page THREE), plus pages FOUR and FIVE, and complete for <u>each</u> program service.

HOURS OF OPERATION (e.g., 8:30 am - 8:00 pm)	Mon.	Tue.	Wed.	Thur.	Fri.	Sat.	Sun.

TREATMENT STAFF ROSTER – CREDENTIALS
Please complete the attached Credential Verification Form (Attachment A-1).

Please identify the person in your organization responsible for ensuring staff have and maintain appropriate credentials:

Staff Responsible for Credentialing	Phone Number

AGE GROUP AND GENDER
Please check (✓) the groups for which this program provides services.

Child/Adolescent (0 -17)	Adult (18 - 59)	Senior (60 and up)
___ Female ___ Male	___ Female ___ Male	___ Female ___ Male

Please respond to the following questions regarding the service address(es):	Yes	No
Does this service address comply with ADA (Americans w/Disabilities Act) regulations?		
Is this service address accessible by public transportation (within 0.5 mile)?		
Do you accept Medicaid?		
Do you accept Medicare?		
Do you have a provider agreement with BC/BS for this address?		
List all HMOs and other organizations with which you have a provider agreement:		

PROGRAM AND SERVICE INFORMATION
Please provide a list of all services unique to the service site.

Component	Capacity

OUTCOME STUDIES	Does the program conduct Outcome Studies? ___ Yes ___ No *(If yes, briefly describe and include examples.)*

LANGUAGE COMPETENCE

In addition to English, please identify the languages in which the program offers service (including American Sign Language):

PROBLEM FOCUS OR SUPPORT SERVICES

(The following information is for internal Macomb CMH use only. Each consumer's benefit plan will determine if a problem area or service is reimbursable.) Check all that apply.

	Adjustment Disorders		Elimination Disorders		Mood Disorders		Somatoform Disorders
	Anxiety Disorders		Factitious Disorders		Motor Skill Disorders		Substance Related Disorders
	Attention Deficit & Disruptive Behavioral Disorders		Forensic Evaluation		Personality Disorders		Tic Disorders
	Communication Disorders		Impulse-Control Disorders NOS		Schizophrenia & Other Psychotic Disorders		Others (specify):
	Delirium, Dementia, and other Cognitive Disorders		Learning Disorders		Sexual & Gender Identity Disorders		
	Dissociative Disorders		Mental Disorders due to a General Medical Condition		Physical/Sexual Abuse		
	Eating Disorders		Developmental Disabilities		Sleep Disorders		

SPECIAL POPULATIONS

Please indicate if you have any resource/expertise to service the following populations. Check all that apply.

___ Hearing impaired ___ Visually impaired ___ Speech impaired ___ Other (specify below):

AFTERCARE

Does the program offer aftercare? ___ Yes ___ No If yes, please complete this section.

Type of Program	Duration in Weeks	# Sessions per Week	Duration of Session

QUALITY IMPROVEMENT

Please attach a copy of the Organization's current Quality Improvement Plan and most recent report of Quality Improvement activities.

Identify the person responsible for Quality Improvement activities:

Responsible Quality Improvement Staff	Phone Number

CORPORATE COMPLIANCE
Please attach a copy of the organization's current Corporate Compliance Plan and most recent report of Compliance activity.

Identify the following staff as related to Compliance requirements:

Staff Person	Compliance Officer	HIPAA Privacy Officer	HIPAA Security Officer
Name			
Phone			

STAFF TRAINING
On the attached Provider Training Transcript (Attachment A-2), please complete the information on required staff training.

Please identify the person in your organization responsible for staff training.

Staff Responsible for Staff Training	Phone Number

CRIMINAL BACKGROUND CHECKS
On the attached Criminal Background Check Verification Form (Attachment A-3), please list the date, source and outcome for each staff person.

Please identify the person in your organization responsible for criminal background checks.

Staff Responsible for Criminal Background Checks	Phone Number

DELEGATED FUNCTIONS
Certain functions, as identified in the provider contract, have been delegated to the agency.

Please describe below how the organization ensures that functions that have been delegated are being completed and monitored. Please identify the person(s) responsible for monitoring the completion of delegated functions.

Delegated Function(s)	*Staff Responsible*

CERTIFICATION, RELEASE, AND SIGNATURE

I hereby certify that all information contained in this application, and all its attachments is accurate, complete, and true.

I understand that in making this application to Macomb County Community Mental Health (CMH), the organization agrees to the following:

1. Any information contained in this application which subsequently is found to be false could result in denial of my application or termination of participation in the CMH Provider Network;
2. It is the organization's responsibility to promptly advise CMH of any changes or additions to the information contained in this application;
3. All the information contained in this application or its attachments is subject to CMH investigation and review;
4. This is an application only and that submission of this application does not automatically result in participation in the CMH Provider Network; and
5. The information contained in this document provides a basis for monitoring of the contractual requirements between this agency and MCCMH. Information provided could result in adverse contract action including sanction, suspension or termination.

We hereby authorize the Macomb CMH to consult with administrators and members of the organization and/or institutions which the agency has been or is currently associated with, and others, including past and present malpractice carriers, who may have information bearing on professional competence, character, and ethical qualifications. We further consent to the inspection by representatives of Macomb CMH of all documents that may be material to an evaluation of the organization's professional competence, character, and ethical qualifications.

WE HEREBY RELEASE FROM LIABILITY ALL REPRESENTATIVES OF MACOMB CMH FOR THEIR ACTS PERFORMED IN GOOD FAITH AND WITHOUT MALICE IN CONNECTION WITH EVALUATING THIS APPLICATION, CREDENTIALS, AND QUALIFICATIONS, AND WE RELEASE FROM ANY LIABILITY ANY AND ALL INDIVIDUALS AND ORGANIZATIONS WHO PROVIDE INFORMATION TO MACOMB CMH IN GOOD FAITH AND WITHOUT MALICE CONCERNING PROFESSIONAL COMPETENCE, CHARACTER, AND ETHICS. WE HEREBY CONSENT TO THE RELEASE AND EXCHANGE OF INFORMATION RELATING TO ANY DISCIPLINARY ACTION, SUSPENSION, OR CURTAILMENT OF PROFESSIONAL PRIVILEGES AND/OR CLINICAL SERVICES TO THE MACOMB CMH PROVIDER NETWORK.

A. All applications for participation in the CMH Provider Network shall be reviewed by the CMH Business Management Division. Recommendations for CMH Provider Network participation will be forwarded to the CMH Board, or designee for approval.

   By signing this, the organization gives consent for verification of the information provided in this application.

B. In the event that the agency, organization, or institution is accepted for participation in the CMH Provider Network, we consent to CMH inspection of our patient records relating to consumers as necessary for its peer and utilization review process.

   We understand that if this application is rejected for reasons relating to professional conduct or competence, CMH may report the rejection to the appropriate State licensing board and/or the National Practitioner Data Bank.

   1. To abide by applicable bylaws, rules and regulations, policies and procedures of the CMH Provider Network as in force at the time of this application, and agree to be bound by the terms thereof in all matters related to the consideration of this application.

   2. Acknowledge the organization's obligation to provide continuous care and supervision to all for whom we have responsibility, and that the organization will seek clinical consultation as necessary to insure the highest quality of consumer care.

   3. That the organization, or designee will be willing to appear before any appropriate committee of CMH with regard to this application.

It is understood that failure to comply with the agreements specified above or providing inaccurate, incorrect, or withholding information on this application will automatically terminate appointment as a provider of behavioral health service in the CMH Provider Network.

_____ _____

Signature of Organization CEO or Designated Representative Date

A PHOTOCOPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL (Rev. 2/10)

MACOMB COUNTY COMMUNITY MENTAL HEALTH - Primary Verification of Credentials

Provider Organization: _____ Contract Provider ID #: _____ Date: _____

Staff Name (Last, First)	Degree / Date of Graduation	License, Registration, Certificate				Verification Source(s)			NPI #
		Type(s)	Number(s)	Current Status	Expiration Date	State of MI	AMA	NPDB	
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									
16.									
17.									
18.									
19.									
20.									

Authorized By (Title) : _____ Phone: _____

Macomb County Community Mental Health - Provider Training Transcript

Provider Organization: _____ Contract Provider ID#: _____ Date: _____

Staff Information			Required Training															
Staff Name (Last, First)	**Position**	**Credential**	Rights of Person Served	Person/ Family-Centered Services	Cultural Competency	Language Proficiency	Grievances and Appeals	Crisis Management / Health and Safety	HIPAA	Corporate Compliance	Infection Control	Co-Occurring Disorders	Behavior Management	Children's Services (24 hrs.)	Direct Care Staff Training	Nonviolent Crisis Intervention	Assertive Community Treatment
1.																	
2.																	
3.																	
4.																	
5.																	
6.																	
7.																	
8.																	
9.																	
10.																	
11.																	
12.																	
13.																	
14.																	
15.																	
16.																	
17.																	
18.																	
19.																	
20.																	

Completed By: _____ Phone: _____

ENTER TRAINING DATES FOR EACH STAFF PERSON. In order to meet contractual requirements all provider staff must complete the training described above, with the exception of Residential Group Home Training which applies only to residential providers. Provider agencies must use this form to document, at least annually, training received by all staff members. Add additional pages, as necessary. Information provided on this form will be verified via an on-site review process. Questions regarding required training may be directed to the MCCMH Network Training Office @ 586.465.8326

Training described on this transcript DOES NOT constitue all training that may be required by law, license, accreditation, certification, credential or service setting.

MACOMB COUNTY COMMUNITY MENTAL HEALTH - BACKGROUND CHECK VERIFICATION

Provider Organization: _____ Contract Provider ID#: _____ Date: _____

STAFF INFORMATION		BACKGROUND CHECK INFORMATION				
		Criminal Background Check				
Staff Name (Last, First)	Position	Date	Data Source	Outcome	Motor Vehicle Record	E-Verify Outcome
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						

Completed By: _____ Phone: _____