

VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY POLICIES & PROCEDURES

Title: Credentialing & Recredentialing
Network Providers

Number: I.08.01

Approved By: Executive Team

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DIRECTIVE: This procedure shall serve as a guideline to ensure that all customers served receive care from Network Providers that are properly credentialed, licensed and/or qualified. The Contract, Provider Network, and Compliance Office shall be responsible for the oversight and implementation of the credentialing and privileging of Independent Contractors and Organizational Providers.

DEFINITIONS:

Civil Judgment: 45 CFR 60.3 defines civil judgment as a court-ordered action rendered in a federal or state court proceeding, other than a criminal proceeding. This does not include consent judgments that have been agreed upon and entered to provide security for civil settlement in which there was no finding or admission of liability.

Criminal Conviction: The Social Security Act 1128(i) states that an individual or entity is considered to have been convicted of a criminal offense related to the delivery of a health care item or service when:

1. A judgment of conviction has been entered against an individual or entity by a federal, state, tribal, or local court regardless of whether there is an appeal pending or the conviction or other record relating to criminal conduct has been expunged. There has been a finding of guilt against an individual or entity by a federal, state, tribal, or local court; or
2. A plea of guilty or nolo contendere (no contest) by the individual or entity has been accepted by a federal, state, tribal, or local court; or
3. When an individual or entity has entered participation in a first offender, deferred adjudication, or other arrangement where conviction has been withheld.

National Practitioner Databank (NPDB) and the Healthcare Integrity and Protection Databank (HIPDB): The U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance, Practitioner Data Banks Branch is responsible for the management of the NPDB and the HIPDB. They can be located on the Internet at <https://www.npdb.hrsa.gov/>.

Network Provider: A Network Provider is both an Organizational Provider and/or a Solo Practitioner/Independent Contractor and is not a VBCMh employee.

Organizational Provider: An entity that directly employs and/or contracts with individuals to provide health care services. Examples of Organizational Providers include, but are not limited to, community mental health services programs (CMHSPs); hospitals, nursing homes; homes for the aged; psychiatric hospitals, psychiatric units, and partial hospitalization programs; substance use disorder programs; and home health agencies.

Solo Practitioner/Independent Contractor: An individual who is self-employed and holds a fully executed agreement with VBCMh to provide health care services.

STANDARDS AND GUIDELINES:

A. MDHHS Community Mental Health Services (CMHSP) Credentialing Program (Universal Credentialing)

Van Buren and network providers shall cooperate in the implementation and use of the MDHHS CMHSP Credentialing Program (commonly referred to as “Universal Credentialing”).

B. Timeframes for Credentialing and Re-Credentialing Organizational Providers

1. Initial credentialing of all organizational providers applying for inclusion in the Van Buren network must be completed within 90 calendar days.
 - a. The 90-day time frame starts when Van Buren has received a completed, signed and dated credentialing application from the organizational provider.
 - b. The completion time is the date when written communication is sent to the organizational provider notifying them of Van Buren’s decision.
 - c. Primary source verification must be completed within the 180 days preceding the credentialing decision date.
2. Re-credentialing shall occur at least every three (3) years.
3. During initial credentialing and at re-credentialing, Van Buren will ensure that organizational providers are notified of the credentialing decision in writing within 10 business days following a decision. In the event of an adverse credentialing decision, the organizational provider will be notified of the reason(s) in writing and of their right to and process for appealing/disputing the decision in accordance with SWMBH Policy 2.14.

PROCEDURES:

A. Network Provider Assignments

1. SWMBH is responsible for credentialing/re-credentialing the following organizational provider types, on behalf of the Region:
 - a. Substance Use Disorder
 - b. Psychiatric Inpatient
 - c. Crisis Residential
 - d. Autism Services
 - e. Financial Management Services
 - f. Specific Specialized Residential service providers as determined by the Regional Provider Network Management Committee
2. Participant CMHSPs are responsible for credentialing/re-credentialing all other organizational provider types for inclusion in each participant CMHSP subcontracted network of providers.
3. SWMBH retains the right to approve, suspend, or revoke/terminate from participation in the provision of Medicaid funded services, any provider (organizational or practitioner) in the Region 4 network (including participant CMHSP network providers), regardless of whether SWMBH or a participant CMHSP performed the credentialing activities.

B. Requirements for Credentialing and Re-Credentialing Network Providers

1. Before executing an initial contract and at least every three (3) years thereafter, Van

Buren will validate the standards contained in the table below, for network providers wishing to provide contracted services in the Van Buren network.

2. During initial credentialing and at re-credentialing, Van Buren will submit credentialing packets along with primary source verifications and other supporting documentation to its Credentialing Committee for a decision regarding inclusion in the Van Buren Provider Network. Packets will be reviewed for completeness prior to any Committee meeting. If files meet clean file criteria in every category listed, the Medical Director (or designee) of the agency completing the credentialing may sign off to approve the provider, in lieu of review and decision by the Credentialing Committee. See Van Buren Policy 2.04 Clean Credentialing and Re-credentialing Files for additional information.
 - a. Credentialing and recredentialing files and supporting documentation shall be maintained in accordance with SWMBH Policy 2.05.

Credentialing Standard	Verification Method	Clean File Criteria	Required for Initial Credentialing?	Required for Re-credentialing?
Fully completed current SWMBH Organizational Credentialing Application, signed and dated by an authorized representative of the organizational provider.	Review of completed Organizational Credentialing Application.	Complete, signed application with no positively answered attestation questions.	Yes	Yes
The organizational provider is licensed or certified and in good standing as necessary to operate in the state.	State License verification (LARA) Certification verification (certifying entity) Record of any violations or special investigations	Current valid license/certification; No license/certification violations and no special state investigations within the most recent five (5) years for initial or three (3) years for re-credentialing.	Yes	Yes
Accreditation by a national accrediting body, if obtained. Accreditation is required for Substance Use Disorder (SUD) treatment providers	Proof of accreditation by any of the following: CARF Joint Commission DNV Healthcare NCQA CHAPS COA AOA	Full accreditation status during the last accreditation review.	Yes	Yes

and Inpatient providers.				
<p>If the organizational provider is not accredited (and is not required to be), an on-site or alternative quality assessment is conducted by SWMBH or CMHSP prior to contracting.</p> <p>An on-site quality assessment is for Specialized Residential sites (homes). The parent organization's accreditation does not eliminate this requirement.</p>	<p>On-site quality assessment (can be from another Region as part of Credentialing Reciprocity) OR Alternative quality assessment for solely community-based providers (i.e. no "site" to perform an on-site review)</p>	<p>No plan of correction resulting from the on-site/alternative quality assessment.</p>	Yes	No
<p>Primary source verification of the past five (5) years of civil judgments or malpractice claims.</p>	<p>National Practitioner Data Bank (NPDB) Query Verification from provider's malpractice insurance carrier</p>	<p>No malpractice lawsuits and/or civil judgments related to the delivery of a health care item or service within the last five (5) years.</p>	Yes	Yes
<p>The organizational provider, and any individuals listed as a "Screened Person" under SWMBH Policy 10.13, are not excluded from participation in Medicare, Medicaid, other federal contracts, and are not excluded from participation through the MDHHS</p>	<p>CMS Sanctioned Provider List: https://exclusions.oig.hhs.gov</p> <p>MI Sanctioned Provider List: www.michigan.gov/MDHHS (Providers > Information for Medicaid Providers > List of Sanctioned Providers) System for Award Management (SAM): https://sam.gov</p>	<p>Initial Credentialing: Organizational provider and any "Screened Persons" are not listed as excluded or sanctioned.</p> <p>Recredentialing: Monthly sanctioned provider monitoring results from initial credentialing through recredentialing show the organizational</p>	Yes	Yes – monthly sanctioned provider screening results

Sanctioned Provider list.	**Checked during initial credentialing and monthly thereafter via monthly sanctioned provider screenings**	provider and any "Screened Persons" are not listed as excluded or sanctioned.		
Organizational provider's current insurance coverage meets contractual expectations.	Copy of the organizational provider's liability insurance policy declaration sheet.	Current insurance coverage meets contractual requirements.	Yes	Yes
A quality review is completed at recredentialing.	<p>Documented review of the following:</p> <ul style="list-style-type: none"> • Grievances & appeals • Recipient Rights complaints/investigations • Customer services complaints • Program Integrity & Compliance Investigations • MMBPIS or other applicable performance indicators • The most recent annual site review/monitoring report. 	Grievances & appeals, recipient rights, and customer services complaints are within the expected threshold given the provider's size; there has been no substantiations of credible allegations of fraud; MMBPIS and other performance indicators substantially meet set standards (if applicable).	No	Yes
The organizational provider is enrolled in the MDHHS CHAMPS System.	Verification of CHAMPS enrollment.	Organization is enrolled in CHAMPS.	Yes	Yes
If the organizational provider seeks to contract to provide services/programs that require MDHHS certification, the organizational provider has already obtained MDHHS certification. (Crisis Residential, SUD	Verification of program/service certification by MDHHS.	Applicable programs/services have MDHHS certification	Yes	Yes

ASAM Level of Care, etc.)				
Any other standards applicable to the organizational provider type of services.	As needed depending on the applicable standard(s).	As needed depending on the applicable standard(s).	Yes	As needed depending on the applicable standards.

- b. Information discovered through the credentialing process that may impact the quality of care of service provided to customers will prompt an additional review of the applicant. Such circumstances are likely to be, but not limited to, information about malpractice litigation, missing information or inconsistent information. In such instances, the Committee will review the information and request the credentialing designee to further research the issue with the provider. The provider file will be pended until the investigation can be completed. The investigation will include review of the information submitted, interview with the provider and obtaining of any further information as requested by the Credentialing Committee. The investigation will be documented by the designated staff. The designated staff will review the investigation findings with the Credentialing Committee and/or the Medical Director and develop a summary of the issues. This summary will be presented at the next scheduled Credentialing Committee meeting once the investigation and summarization is complete. The committee will make a credentialing determination at that time.

Applicants have the right to review the information submitted in support of their credentialing application and will be permitted to do so upon request in writing to the Credentialing Committee and/or the Credentialing Committee.

C. Temporary/Provisional Credentialing Process

1. Temporary or provisional status can be granted one time to organizations until formal credentialing is completed. Temporary or provisional credentialing should be used when it is in the best interest of Medicaid members to have providers available to provide care prior to formal completion of the entire credentialing process.
2. **Timeframes**
 - a. A decision regarding temporary/provisional credentialing shall be made within 31 days of receipt of a complete application and the minimum documents listed below:
 - b. Temporary/provisional credentialing status shall not exceed 150 days, after which time the credentialing process shall move forward according to this credentialing policy.
 - c. Primary source verification must be completed within the 180 days preceding the provisional credentialing decision date.
3. **Requirements**
 - a. **Standard Requirements**
 1. Provider's seeking temporary or provisional status must complete the current approved SWMBH Organizational Credentialing Application, signed and dated by an authorized representative.
 2. Van Buren shall perform verification from primary sources of:
 - a. Current valid license or certification and in good standing as necessary to operate in the State of Michigan.

- b. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following:
 - Minimum five (5) year history of professional liability claims resulting in a judgment or settlement; and
 - Disciplinary status with regulatory board or agency
 - c. Medicare/Medicaid sanctions (OIG, SAM, and Michigan Sanctioned provider lists)
 - d. CHAMPS Enrollment
 - 3. Van Buren shall evaluate the network provider's continuing operation as a provider for the prior five (5) years. Gaps in operation of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.
- b. **Requirements Specific to Accreditation and CHAMPS enrollment.**
 - 1. Temporary or provisional status may be considered for organizational providers that are required to be accredited while their accreditation is pending, only with written permission from MDHHS and SWMBH.
 - a. Accreditation is a precursor requirement for some provider types to securing a Medicare Number, which is a precursor requirement to CHAMPS enrollment. This means that some providers who are awaiting accreditation will not yet be enrolled in CHAMPS.
 - 2. Temporary or provisional status may be considered for organizational providers that are not yet enrolled in CHAMPS, only with written permission from MDHHS and SWMBH.
 - a. If temporary or provisional credentialing status is approved for an organization provider who is not yet enrolled in CHAMPS, contracts with that organizational provider may not exceed 120 days, and must terminate immediately after the 120-day time period, unless either of the following occurs:
 - Written permission by MDHHS to extend the contract beyond the 120-day limit; or
 - Verification of the organizational provider's enrollment in CHAMPS
- 4. Van Buren shall follow the same process for presenting provisional credentialing files to the Credentialing Committee as it does for its regular credentialing process. Temporary/Provisional credentialing decisions shall be made by the applicable entity's Credentialing Committee and not through the clean file process.

D. Credentialing Reciprocity (Deemed Status)

- 1. **Out of Region.** Van Buren may accept credentialing activities conducted by any other Michigan PIHP or CMH outside of the SWMBH region in lieu of completing its own credentialing activities. If Van Buren chooses to accept the credentialing activities of another Region, copies of the credentialing Region's decision shall be maintained in the Van Buren credentialing file.
- 2. **Within the SWMBH Region (also known as Region 4).** Van Buren shall work collaboratively to reduce the burden on shared network providers (providers that contract with two or more participant CMHSPs) by coordinating credentialing/recredentialing activities to ensure, to the extent practicable, that shared providers in the SWMBH network only complete credentialing/re-credentialing through a single participant. CMHSP or SWMBH, and that those credentialing/re-credentialing results are shared with the Region.

3. **Reciprocity Procedure:** When accepting credentialing activities performed by another Region or another in-Region entity, VBCMh shall follow the SWMBH Procedure 02.03.01 Credentialing Reciprocity.

E. Network Provider Credentialing of Its Direct Employees and Contractors

1. Network providers may be held responsible for credentialing and re-credentialing their direct employees and subcontracted professional service providers per SWMBH or VBCMh contractual requirements.
2. Network providers shall maintain written credentialing/re-credentialing policies and procedures consistent with SWMBH and MDHHS credentialing policies and any other applicable requirements.
3. Network providers shall perform credentialing/re-credentialing activities in accordance with applicable contractual requirements, SWMBH policies and procedures, MDHHS policies and procedures, and any other applicable requirements.
4. Van Buren shall verify through annual on-site reviews and other means as necessary that the organizational provider's credentialing practices meet applicable policies and requirements.

F. Reporting Requirements

1. **Routine**
 - a. VBCMh shall submit a monthly credentialing report to SWMBH, utilizing the MDHHS credentialing report template.
 - b. SWMBH shall submit quarterly reports to MDHHS at the timeframes referenced in the MDHHS PIHP Master Contract Schedule E, utilizing the MDHHS credentialing report template.
2. **Ad hoc**
 - a. VBCMh shall promptly report to SWMBH's Director of Provider Network information about a network provider which could result in suspension or termination from the SWMBH network, including but not limited to:
 1. Known improper conduct (e.g. fraud, threats to member health and safety, etc.).
 2. Positive sanctions/exclusions screening results, in accordance with SWMBH Procedure 10.13.
 3. Any other information that may affect the network provider's status as a SWMBH network provider.
 - b. SWMBH shall report any known improper conduct of a network provider which could result in suspension or termination from the SWMBH network in accordance with applicable SWMBH policies and to the applicable regulatory authority (MDHHS, MI OIG, MI AG, provider's governing board, etc.)

Related Forms:

SWMBH Operating Procedure 2.03.01 Credentialing Reciprocity

References:

MDHHS-PIHP Contract Schedule A, Section 1(ON)(1), MDHHS BPHASA Credentialing and Re-Credentialing Processes, BBA 438.214, SWMBH Policy 2.18, SWMBH Policy 2.04, SWMBH Policy 2.05, SWMBH Procedure 10.13

Attachments:

2.03A SWMBH Organizational Credentialing Application
2.03B SWMBH Organizational Credentialing Checklist