MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Provider Network Management		
Title:	Credentialing and Recredentialing – Organizational Providers		
Policy: ☐ Procedure: ☒ Page: 1 of 5	Review Cycle: Biennial Author: Chief Financial Officer, Contract Specialist	Adopted Date: Review Date: 03.05.2024	Related Policies: Provider Network Management Credentialing/Re-credentialing Disqualified Providers

Purpose

The purpose of this operating procedure is to detail the process for Mid-State Health Network (MSHN) and Community Mental Health Service Participants (CMHSP) to follow when conducting credentialing and recredentialing activities of organizations to ensure compliance with the Michigan Department of Health & Human Services (MDHHS) Credentialing and Recredentialing Processes for Organizational Providers contracted to provide services.

Primary Source Verification (PSV)

Organizational provider credentials must be verified by primary source. Any information found to vary from the application must be communicated to the applicant in writing within 30 days of application submission, prior to proceeding with the application process. The notice must include a timeframe for making corrections and the method/manner for submitting corrections.

Valid credentials are a condition of participation in the provider network. As applicable, the following require PSV – refer to Attachment A for PSV guidelines.:

- State Licensure, certification, and/or registration
- Accreditation status, as necessary;
- Malpractice and/or judgements within the last 5 years
- Medicare/Medicaid Exclusions

Subsequent verification(s), as applicable, must be conducted, documented, dated, and verified by the credentialing designee upon expiration/renewal of credential.

Credentialing and Recredentialing

For organizational providers included in its network, MSHN and CMHSPs must:

1. The Prepaid Inpatient Health Plan (PIHP) must validate and at least every two years that:
   a. The organizational provider completes the current credentialing application.
   b. The organizational provider is licensed or certified and in good standing as necessary to operate in the State.
   c. The organizational provider is approved by an accredited body (if a provider is not accredited, the PIHP must perform an on-site quality assessment).
   d. There are no malpractice lawsuits that resulted in conviction of criminal neglect or misconduct, settlements and/or judgements within the last five (5) years.
   e. The organizational provider is not excluded from participation in Medicare, Medicaid, or other Federal contracts.
   f. The organizational provider is not excluded from participation through the MDHHS Sanctioned Provider list.
   g. Current insurance coverage meeting contractual expectations is on file with the PIHP.
   h. For solely community-based providers (e.g., Applied Behavior Analysis (ABA) or Community

Living Supports (CLS) in private residences), an on-site review is not required; an alternative quality assessment is acceptable.
i. The contract between the PIHP and any organizational provider specifies the requirement that the organizational provider must credential and re-credential their direct employees, as well as subcontracted service providers and individual practitioners in accordance with the PIHPs credentialing/re-credentialing policies and procedures (which must conform to MDHHS credentialing process).

2. Ensure that the initial credentialing of all organizational providers applying for inclusion into the network must be completed within 90 calendar days of application submission. The start time begins when the PIHP has received a completed signed and dated credentialing application from the organizational provider. Completion time is indicated with the written communication is sent to the organizational provider notifying them of the PIHPs decision.

Suspension and Revocation

Circumstances that automatically suspend credentialing status:

- *Lack of current licensure, certification, or registration* – The organizational provider does not possess a current, valid license, certification, or registration to operate in Michigan, including because a previously valid license has expired, lapsed, or has been suspended or revoked, or otherwise ceases to meet the qualification;
- *Lack of current accreditation* – The organizational provider is not accredited by an approved accrediting body as defined by state or Federal requirement;
- *Exclusion from government programs* - The organizational provider is excluded from or limited in participation in a federal or state health care program.

Credentialing suspension/revocation decisions will not include any information regarding status related to allegations or pending investigations in process associated with licensure or registration; MSHN and its CMHSPs support due process for all organizational providers in matters pertaining to unsubstantiated allegations of misconduct.

Credentialing Committee or Designated Authority

A credentialing committee must be established and include members qualified to assess a provider's competencies and qualifications. The role of the credentialing committee is to:

- review the credentials of providers who do not meet the agency's criteria for participation in the network;
- give thoughtful consideration to credentialing information;
- document discussions about credentialing and recredentialing.

Credentialing files that meet all necessary criteria as defined throughout this procedure constitute a "clean file" and may be approved by and agency designee and do not require credentialing committee approval. Evidence of designee approval is a handwritten signature, initials or unique electronic signature if the agency has appropriate controls for ensuring that only the designee can enter the electronic signature.

Applies to:

☐All MSHN Staff

☒Selected MSHN Staff, as follows:

☒MSHN CMHSP Participants: ☐Policy Only ☒Policy and Procedure

☐Other:

Definitions:

ABA: Applied Behavior Analysis
CLS: Community Living Supports
Credentialing: The administrative process for reviewing, verifying, and evaluating the qualifications and credentials to ensure organizations meet the necessary criteria to provide healthcare services.
Credentialing Committee: A group of individuals, selected by an organization, to review the professional backgrounds and qualifications of applicants to make the determination if individual meets the criteria to provide healthcare services.
CMHSP: Community Mental Health Services Participant in the MSHN Region with delegated authority to manage a network of behavioral health providers; responsible for conducting credentialing and recredentialing activities of its provider network in accordance with this procedure. NOTE: MSHN does not credential CMHSPs; however, requires annual attestation of accreditation status.
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network, the Pre-Paid Inpatient Health Plan responsible for oversight of delegated functions, including credentialing activities
Organizational Provider: includes an agency or facility which has a contract with a CMHSP or MSHN to provide some portion of specialty support services which MSHN has agreed to perform within its contract with MDHHS. Organizational providers are required to credential and re-credential their directly employed and subcontract direct service providers in accordance with the MSHN's credentialing/re-credentialing policies and procedures (which must conform to MDHHS's credentialing process).
PIHP: Prepaid Inpatient Health Plan
Primary Source Verification: The process by which an organization/entity corroborates the accuracy and validity of an organizational provider's reported credentials and qualifications with the original source or allowable alternative source/designated equivalent source. Refer to Attachment A.
Re-credentialing: The ongoing administrative process for updating, reviewing, verifying, and evaluating the qualifications and credentials to ensure organizations meet the necessary criteria to provide healthcare services.

Other Related Materials

Provider Network Management: Background Check Procedure
Provider Network Management: Disclosure of Ownership, Control and Criminal Convictions Procedure
Provider Network Management: Provider Appeal Procedure
Human Resources: MSHN Personnel Manual

References/Legal Authority:

- MDHHS Credentialing & Re-credentialing Processes
- MDHHS Medicaid Provider Manual
- Public Act 282 of 2020
- 42 CFR 438.214
- 42 CFR 438.12

Change Log:

Date of Change	Description of Change	Responsible Party
09.2019	Annual Review – Revised procedure entirely	Director, Provider Network Management Systems
11.2021	Biennial Review	Contract Specialist
05.2023	Revised and updated language in accordance with MDHHS Credentialing and Recredentialing Processes revision 3/24/23.	Compliance Administrator/Deputy Director
12.2023	Biennial Review	PNMC, Contract Specialist

Attachment A: Primary Source Verification (PSV) Guidelines

A primary source is the original source of a specific credential that can verify the accuracy of a credential reported by an organizational provider. PSV is received directly from the issuing source. For example, if information on state licensure status is verified directly with the licensing body, this is PSV. A copy of the license is not considered PSV.

PSV can be performed in several ways:

- Electronically through agency website (i.e., State licensure, NPDB, etc.). If verified electronically, a screenshot or PDF version of the screen shall include the date the information was verified.
- Letters requesting the appropriate information are written to the primary source and responses are received directly from the primary source.
- Documentation of verification via telephone including the name of the agency called, date, the person contacted, the questions asked and responses, the name, date, and signature of the person receiving the response.

Designated Equivalent Sources: Verification of credentials through an agent that contracts with an approved source to provide credentialing information is allowed. Prior to using this method documentation must be obtained from the agent indicating that there is a contractual relationship between it and the approved source.

Verification time limit will be calculated from the date of verification to the date of the credentialing decision.

Information to Verify	Verification Source	When	Criteria	Verification Time Limit
Application	Agency Application	☒ C ☐ R ☐ E	Completed, signed, and dated application with no positively answered attestation questions	365 days
State licensure, if applicable	LARA – Department of Licensing and Regulatory Affairs	☒ C ☒ R ☒ E	Free from licensing violations and free from special state investigations in the past five (5) years for initial credentialing and two (2) years for recredentialing.	180 days
Medicaid/Medicare Exclusions	List of Excluded Individuals and Entities maintained by the OIG; SAM, and MDHHS List of Sanctioned Providers or NPDB	☒ C ☒ R ☐ E	Provider is not on the Medicaid/Medicare or MDHHS sanction provider lists.	180 days
Malpractice Claims/Professional Liability History	Any of the following: • NPDB Query • Written confirmation of past five years history of malpractice history and verify with carrier	☒ C ☒ R ☐ E	Provider attestation is not sufficient.	180 days
Accreditation, if applicable. ***Required*** **for** ***SUD Treatment Providers.*** ***CMHSPs must follow***	Copy of Survey Report	☒ C ☒ R ☒ E	Full accreditation status during the last accreditation review. For SUD providers, the following accrediting	180 days

accreditation requirements to determine which subcontracted providers must be accredited.			bodies are recognized: CARF, AOA, AAAHC, COA, JC, JCQA. Clubhouse International Accreditation required for Clubhouse programs Private Duty Nursing: CHAP, ACHC, JC (Home Health), CARF	

C = credentialing R = recredentialing E = upon expiration