CREDENTIALING

Based on standards set forth by the National Committee for Quality Assurance (NCQA) all Providers listed in literature for Molina Healthcare will be credentialed.

All designated practitioners, including physicians (DO's and MD's), podiatrists (DPM's), dentists (DMD's),Oral Surgeons and chiropractors (DC's), as well as mid-level professionals such as Physician Assistants (PA's), Nurse Practitioners (NP's), and Certified Nurse Midwives (CNM's) will have their credentials reviewed in a manner that is non-discriminatory, objective and uniform. This will assure that care is rendered to Molina Healthcare members by qualified practitioners. This also includes behavioral health practitioners, such as Psychologists, Psychiatrists, Social Workers and Counselors who are credentialed by CompCare, an NCQA accredited Managed Behavioral Health Organization delegate.

Molina Healthcare will credential designated Practitioners prior to granting Provider status. All mid-level professionals, as defined above, must be credentialed prior to allowing them to provide services to Molina Healthcare members. The plan requires initial credentialing of all practitioners and mid-level professionals who seek reinstatement after having a break in service beyond 30 calendar days.

Molina Healthcare does not make credentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients the practitioner discipline of care.

Who Should Be Credentialed
Credentialing standards must apply to all licensed independent practitioners or groups of practitioners who provide care for Molina Healthcare members. NCQA standards do not address the types of practitioners with whom Molina Healthcare may contract.

Practitioners who must be credentialed
NCQA required Molina Healthcare to credential the following types of practitioners:

- Practitioners who have an independent relationship with the organization. An independent relationship exists when the organization selects and directs its members to see a specific practitioner or group of practitioners.
- Practitioners who see members outside the inpatient hospital setting or outside ambulatory freestanding facilities.
- Practitioners who are hospital based, but see Molina Healthcare's members as a result of their independent relationship with the organization.
- Pharmacists who work for a pharmacy benefit manager (PBM) to which the organization delegates utilization management.
- Covering practitioners (e.g. locum tenens)
- Practitioners who do not provide care for members in a treatment setting (e.g. board certified consultants)

Documents Required For Credentialing
Molina Healthcare must verify that the following elements are present and within the prescribed time limits:

- A valid Drug Enforcement Agency (DEA) certificate
- Verification of education
- Verification of training
- If a provider states on the application that he or she is Board Certified, verification of board certification.
- Verification of work history
- A history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioners
- Verification of license
- Disclosure form

Credentialing Application
The applicant will have the responsibility of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and ability to provide services without limitations including physical and mental health status as allowed by law, and the responsibility of resolving any doubts about these or any of the other basic qualifications required by Molina Healthcare.

Network Development sends an unsigned contract and an application packet to each requesting practitioner, mid-level professional, and/or IPS/medical group with whom Molina Healthcare has chosen to pursue a business relationship.

The application packet will contain the application form, release and consent forms and instructions for completing and submitting credentialing information to Molina Healthcare. Although the applicant's contracted medical group or IPA may return the completed application to the Credentialing Coordinator, the applicant is responsible for completing all of the information and providing the supporting documentation. The contract is fully executed once the applicant has completed the Peer Review/Credentialing Review process.

Application Form
The applicant shall complete the Application (see attachment A at the end of this section). Each application for Molina Healthcare Provider or mid-level professional status shall provide current information, be submitted on the written application form prescribed by the Governing Board and be signed by the applicant. The application shall request at least the following:

- A current, valid Michigan license or certificate to practice his/her profession, including a copy of such license or certificate.
- A current, valid DEA certificate, including a copy of such certificate, as applicable.
- Documentation of professional liability insurance at a minimum amount of $100,000 per occurrence and $300,000 aggregate coverage appropriate to the medical practice under contractual consideration. This coverage shall extend to Molina Healthcare members and the applicant's activities on Molina Healthcare's behalf. The name of the insurance carrier and date of expiration must be included.
- A list of all malpractice actions for at least the last ten (10) years, with explanations of the actions and current status.
- Education.
- Board Certification status, if applicable.
- Educational background, including professional school, graduation date and degree.

The credentialing process will be completed with 45 working days of application submission unless extenuating circumstances exist (i.e. Verification of education is delayed), assuming the information submitted by the applicant is determined by the Peer Review/Credentialing Committee to be sufficient to make a determination of the mid-level professional's qualifications or current competence, If any time sensitive application information and/or verification, as defined by current NCQA guidelines, becomes over one hundred and eighty (180) calendar days old prior to a final decision by the Peer Review/Credentialing Committee regarding the applicant, updated information must be obtained and included in the review of the application.

Provider Disclosure Information (FY2010)
The Medicaid Managed Health Plans are expected to solicit the following information from their providers/contractors:

1. Ownership information. For specifics see **42 CFR §455.104.**
2. Managing employee, including name and social security number. For specifics see **42 CFR §455.106.**
   Once the ownership and managing employee information are obtained, the Medicaid health plan must check the EPLS on these individuals.
3. Information on criminal conviction by querying: Has any person who has ownership or control interest in the provider or is an agent or managing employee of the provider ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the title XX services program since the inception of those programs? For specifics see **42 CFR §455.106.** If the answer is "yes," to this question the provider/disclosing entity, must list these individuals. Then, the plan must report these individuals to the HHS/Office of Inspector General (OIG) within 20 days of disclosure and also to our department. Please See **42 CFR §455.106.**

For definitions, including definition of Managing Employee, please see **42 CFR §455.101.**

Credentialing Site Visits
As part of the credentialing process, Molina Healthcare may assess the quality, safety and accessibility of the office sites where care is delivered. In addition Molina Healthcare sets standards for medical/treatment record practice. Molina Healthcare contracts with Medical Site Reviewers (MSR) to conduct office site visits.

1. A standard site visit survey form that is completed at the time of the site visit (See attachment B at the end of this section)

2. A set of criteria for the office review, which include an assessment of:
   - Physical accessibility
   - Physical appearance
   - Adequacy of waiting and exam room space
   - Availability of appointments
   - Adequacy of medical/treatment record keeping
   - Standards and thresholds for acceptable performance

Practitioner office sites must pass with an 80% in order to be considered to enter the Molina Healthcare network.

Practitioner Appeal Rights
Procedural rights provided to Molina Healthcare practitioners when an action or recommendation of a Quality Improvement Committee, Peer Review/Credentialing Committee or the Board will, if it becomes a final action, result in a report to the Michigan State Board of

Medicine. This applies to practitioners with Molina Healthcare active status as well as those who are applicants for Molina Healthcare.

Grounds for a Hearing

Grounds for a Hearing exist whenever the Molina Healthcare Quality Improvement Committee or Peer Review/Credentialing Committee take or recommend any of the following Adverse Actions:

- Denial of initial application for Molina Healthcare Provider status;
- Revocation or termination of, or expulsion from Molina Healthcare participation;
- Reduction or revocation of authority to provide care to Molina Healthcare patients;
- Suspension or restriction of authority to provide care to Molina Healthcare patients for a cumulative period of more than thirty (30) days in any twelve (12) month period;
- Summary suspension of authority to provide care to Molina Healthcare patients for more than fourteen (14) consecutive days.

Notice of Action

If the Molina Healthcare Quality Improvement Committee or Peer Review/Credentialing Committee has recommended an Adverse Action as defined above, the Committee taking or recommending the adverse action shall give written notice to the Provider by certified mail with appropriate return receipt. This notice shall:

- Describe the nature of the proposed action or recommendation; and
- State that the proposed action or recommendation, if adopted, must be reported to the National Practitioners Data Bank; and the State Licensing Board within fifteen (15) days from the date the adverse action is taken.
- Advise the Provider that he/she has the right to request a Hearing on the proposed action or recommendation; and
- Inform the Provider that any request for Hearing must be made in writing within thirty (30) days following receipt of the Notice of Action and must be sent to the Medical Director; and
- Contain a summary of the Provider's hearing rights.

Request for a Hearing

If the Provider has not requested a Hearing within the time and manner described above, the Provider shall be deemed to have accepted the action or recommendation, and such action or recommendation shall become the Molina Healthcare Quality Improvement Committee's or Peer Review/Credentialing Committee's final action or recommendation, which shall be forwarded to the Board for their information. In the event that a timely written request for a Hearing is received, a Hearing Panel shall be appointed and the practitioner shall be provided a Notice of Hearing and Statement of Charges consistent with this policy.