PerformCARE®	Policy and Procedure

Name of Policy:	Credentialing Committee
Policy Number:	QI-CR-005
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Quality Management Department
Related Stakeholder(s):	All Departments
Applies to:	Associates
Original Effective Date:	03/15/12
Last Revision Date:	10/30/24
Last Review Date:	04/03/25
OMHSAS Approval Date:	04/03/25
Next Review Date:	04/01/26

Policy: The Credentialing Committee includes the use of peer review to make decisions regarding Initial Credentialing and Re-Credentialing decisions as well as disciplinary actions for credentialed providers. The Credentialing Committee also provides clinical consultation on clinical practice guidelines and select PerformCare Policies and Procedures.

Purpose: To establish composition, responsibilities and voting structure of the Credentialing Committee.

Definitions: **Credentialing:** The process by which a health care organization reviews and evaluates qualifications of licensed independent practitioners and licensed facility providers to provide services to its Members.
Paneled: A Provider that is contracted and credentialed to provide services in the PerformCare Provider Network.
Peer Review: Evaluation or review of colleague performance by professionals with similar types and degrees of expertise; the evaluation of one practitioner's credentials and practice by another like clinician.
Provider: This term may be used interchangeably to represent an individual practitioner or facility.

Acronyms: **OMHSAS:** Office of Mental Health and Substance Abuse Services
QI/UM: Quality Improvement and Utilization Management
QM: Quality Management

Procedure: 1. Primary Responsibilities of the Credentialing Committee:

1.1. Review credentialing/re-credentialing policies and procedures and modify them as appropriate at least annually.

1.2. The PerformCare Credentialing Committee is charged with making decisions regarding all credentialing and re-credentialing of PerformCare network providers as defined in *QI-CR-001 Credentialing and Re-credentialing Criteria - Facilities* and *QI-CR-002 Credentialing and Re-credentialing Criteria - Practitioners*. The Credentialing Committee will ensure:

1.2.1. The provider network consists of qualified behavioral health care providers that meet PerformCare credentialing criteria.

1.2.2. The network has adequate coverage to meet proximity, timeliness, and promptness standards for accessibility within each geographic area.

1.2.3. The quality of care provided meets PerformCare performance standards.

1.3. The Credentialing Committee functions include:

1.3.1. Applying credentialing and re-credentialing criteria processes in a consistent, critical, and objective manner with the assistance of the Medical Director or designee.

1.3.2. Communicates Credentialing Committee decisions regarding the disposition of each behavioral health provider's network status to the QI/UM Committee, Executive Management, and other Departments, as needed.

1.3.3. Ensuring all network providers are credentialed/ re-credentialed to provide clinical care and services as outlined in *QI-CR-001 Credentialing and Re-credentialing Criteria - Facilities* and *QI-CR-002 Credentialing and Re-credentialing Criteria - Practitioners*.

1.3.4. Evaluation of new provider applicants.

1.3.5. Making decisions for acceptance, denial and/or retention of providers in the network.

1.3.6. Timely re-credentialing of providers.

1.3.7. Regular review of Medicheck to be aware of providers under sanctions.

1.3.8. Presenting standards for credentialing and retaining providers to the QI/UM Committee.

1.3.9. Identifying process improvement opportunities, prioritizing them, and devising a plan and schedule

for improvement based on data generated from the following sources:

1.3.9.1. Site Visit Ratings
1.3.9.2. Treatment Record Audits
1.3.9.3. Member Satisfaction Surveys
1.3.9.4. Accessibility monitoring reports for emergent, urgent, routine care
1.3.9.5. Provider Surveys

1.3.10. Determining and monitoring disciplinary actions per *QI-CR-003 Credentialing Progressive Disciplinary Actions for Providers*.

1.3.11. Removing providers from the network based on failure to meet credentialing criteria or substantiated quality concerns.

1.3.12. Providing clinical consultation for the following:

1.3.12.1. Clinical practice guidelines (CPGs)
1.3.12.2. PerformCare Policies and Procedures, as applicable

2. Committee Structure

2.1. The Committee may include representation from the full range of participating practitioners including psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists and /or certified addictions counselors in the Plans' network. Participants will understand and have experience with prescribing and/or recommending In-Plan services.

2.2. The Chairperson of the Credentialing Committee is the PerformCare Medical Director or equally qualified designee. The Medical Director is responsible for the Credentialing program and participates in decision-making relative to policy and process changes to the credentialing program. The Medical Director also attends the meetings, participates in discussion about applicants and signs off on all credentialing and re-credentialing files.

2.3. The Credentialing Committee has a minimum of seven (7) members that are contracted and credentialed clinicians in the PerformCare network.

2.3.1. Regional representation of the PerformCare network providers to include a mix of traditional and non-traditional providers such as PerformCare Paneled psychiatrist, psychologist, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist or certified addictions counselor.

2.3.2. PerformCare will collaborate with the Primary Contractor(s) to identify the appropriate representatives.

2.3.3. Each committee member that is paneled with PerformCare receives one vote. To give adequate weight to the clinical opinion of such participants, their votes will be weighted at 100%.

2.4. The Credentialing Committee also includes HealthChoices Primary Contractor Representative(s).

2.4.1. Each HealthChoices Primary Contractor will have one (1) vote. To give adequate weight to the clinical opinion of PerformCare Paneled participants, the HealthChoices Primary Contractor votes will be weighted at 50%.

2.5. Regularly attending, Non-Voting PerformCare associates include Quality Manager of QM, Director of QM, Clinical Services Director or designee, Director of Operations or designee, and Representatives from other departments as needed.

3. Meetings - Frequency, Attendance and Minutes

3.1. Meetings will be held at a time convenient for voting Members.

3.2. The Credentialing Committee meets bi-monthly or as necessary, a minimum of six times per year.

3.2.1. For the months that the Credentialing Committee is not scheduled to meet, clean files will be reviewed and approved electronically by the voting members via secured email.

3.2.2. Any referrals to the Credentialing Committee per *QI-CR-003 Credentialing Progressive Disciplinary Actions for Providers* identified during a non-meeting month will be addressed by the voting members via an electronic vote or an ad hoc meeting as necessary and according to the severity of the issues.

3.3. Minutes are recorded for each meeting. Following approval by the Committee, all meeting minutes will be reviewed and electronically signed by the PerformCare Medical Director or designee, who is the committee chair.

3.4. Regular attendance is expected. Membership is evaluated annually. Members who attend less than fifty percent (50%) of meetings during the evaluation period are counseled by the chairperson and nominating County. The Committee can vote to remove members whose attendance does not meet the benchmark.

4. Voting and Quorum
    4.1. Voting Members may participate and cast their vote via video, teleconference and/or electronically.
    4.2. A Voting Member will recuse themselves from voting if the vote is related to an affiliated entity or if they are perceived as having an association and could stand to benefit from a decision.
    4.3. A quorum is required for voting. Sixty percent (60%) of the voting membership constitutes a quorum.
    4.4. A quorum is achieved if at least 60% of the paneled voting membership casts their votes. If a quorum is achieved and a Voting Member recuses, the quorum will not be affected, and a simple majority will pass a motion.
    4.5. In the event of a tie, the Chairperson of the Credentialing Committee will cast the deciding vote.
5. Compensation
    5.1. PerformCare will compensate Network Provider Voting Members for their time and thoughtful participation.
6. Confidentiality
    6.1. All information regarding the credentialing of providers is confidential and shall not be disclosed to any unauthorized persons except as required by law. All documents, reports, committee minutes and communication pertaining to credentialing of a provider are kept in a secured file. Access to the information is limited to the PerformCare Executive Director, Network Operations, Credentialing Staff, PerformCare Medical Director, PerformCare Director of QM, and Credentialing Committee members. Committee members are informed of the confidential nature of the information under review and sign a confidentiality statement annually.
7. Commitment to Non-Discriminatory Credentialing and Re-Credentialing Decisions
    7.1. PerformCare does not make credentialing and re-credentialing decisions based solely on the applicants' race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients (e.g., Medicaid) in which the provider specializes. PerformCare may include in its network providers who meet certain demographic or specialty needs for example, to meet the cultural needs of its enrollees.
    7.2. PerformCare takes specific steps during the credentialing and re-credentialing processes to monitor for and prevent discriminatory practices. Applications reviewed by the Credentialing Committee do not include information regarding the applicants' race, ethnic/national identity,

gender, age, or sexual orientation. The PerformCare QI/UM Committee monitors the decisions made by the Credentialing Committee and obtains a summary report of the rationale for credentialing decisions. Once per year, the QI/UM Committee will receive a list of providers /practitioners that were denied credentialing as well as the reason for the denial. QI/UM Committee will evaluate reasons for denied participation and determine if follow-up actions are required.

7.3. The following text appears on the Credentialing Committee Non-Discrimination Statement, which is signed by all panel members annually. All panel members must agree to keep discussions confidential and to not permit factors included below to affect decision-making:

"Members of the PerformCare Credentialing Committee, in accordance with PerformCare business practices, do not make credentialing decisions based on an applicant's type of procedures performed, or a Practitioner's specialty, marital status, race, color, religion, ethnic/national origin, gender, age, sexual orientation, or disability. Credentialing decisions are based on meeting PerformCare credentialing procedures and standards. PerformCare Credentialing Committee understands and abides by the Federal Regulation of the Americans with Disabilities Act whereby no individual with a disability shall, based on the disability, be excluded from participation."

PerformCare Staff participating in the Credentialing Committee meetings complete mandatory confidentiality and non-discriminatory statements annually and are not required to sign the separate Credentialing Committee statement.

8. For all applications, the Credentialing Committee may make one of the following determinations:
   8.1. Application approved.
   8.2. Application pended for additional information.
      8.2.1. If the Committee needs additional information about the application or the applicant before a decision can be made, the application may be pended to the following meeting. If this occurs, the application, including additional information, will be re-presented at the next meeting.
      8.2.2. If a provider fails to provide additional information one week prior to the next scheduled meeting, the application may be denied.

8.3. Application denied.
8.3.1. Reasons for denial may include, but are not limited to:
8.3.1.1. Lack of licensure or other credentialing criteria described in *QI-CR-001 Credentialing and Re-Credentialing Criteria-Facilities* or *QI-CR-002 Credentialing and Re-credentialing Criteria - Practitioners* is not met;
8.3.1.2. Adverse Medicare or Medicaid status;
8.3.1.3. Fraud or felony investigation;
8.3.1.4. Confirmed adverse information related to quality-of-care issues;
8.3.1.5. Incomplete application.

9. Providers have the following options if the Credentialing Committee denies a credentialing or re-credentialing application:
9.1. If a provider's initial credentialing application is denied, the provider may reapply to the Plan when all reasons for denial status have been corrected, but no sooner than one (1) year. There is no appeal process for providers who are denied for initial credentialing.
9.2. If a provider's re-credentialing application is denied, the practitioner has the right to appeal this decision as described in *Section 13 of this policy*.
9.2.1. If the decision to deny is upheld via the appeal process, the provider may reapply to the Plan when all reasons for denial status have been corrected, but no sooner than one (1) year from the date of the final appeal decision.
10. The Director of QM or Director of Operations or designee will make verbal notification of the Credentialing Committee decision to the provider within 2 business days of the decision. Formal written confirmation of the decision will be sent to the provider within 7 calendar days of the decision.
11. The appropriate HealthChoices Primary Contractor, through representation on the Credentialing Committee, receives notification of Credentialing Committee activity as it occurs including updates to the network of credentialed and denied or terminated providers.
12. Policies for Suspension, Reduction of Privileges and Termination
12.1. Providers may have their qualified provider status reduced, suspended, or terminated for failure to perform according to the clinical, quality, or other administrative criteria of the provider agreement.

Recommendations to adjust individual privileges and/or the PerformCare network status of a provider are rendered on behalf of the PerformCare by the Credentialing Committee.

12.2. As noted in Section 10, the provider is notified of the Credentialing Committee's decision verbally and in writing. The written notice to the provider states the circumstances warranting the adjustment and, at the discretion of the PerformCare Credentialing Committee, may specify a reasonable period within which the professional provider may remedy the failure to perform according to standards. The professional provider organizations, facilities and/or individual behavioral health providers are advised of the right to appeal the decision. The network status change appeals process is detailed in Section 13 of this policy.

12.3. Reporting Serious Quality Deficiencies - in any case, in which the adjustment of qualified provider status of any provider is based upon ethical, criminal, or other serious quality performance concerns, PerformCare follows established guidelines of reporting to the appropriate authorities.

13. Provider Appeals

13.1. The provider may appeal the decision to reduce, suspend, or terminate clinical privileges or change qualified provider status by formally requesting such a review within 30 days of the verbal notification of the decision. The right to appeal and procedures to follow are included in the notification of the original decision. They are also included in the *PerformCare Provider Manual*. The steps to the appeal process are:

13.1.1. The Provider must formally file an appeal in writing with the QM Department –Attention: Credentialing or designee within 30 days of the verbal notification of the decision. The request for appeal is logged and the issue is tracked in the log until resolution.

13.1.2. Written acknowledgment of the request to appeal is sent within three (3) business days of receipt of the appeal by the QM Department designee.

13.1.3. The PerformCare Medical Director or designee, who decides within ten (10) business days, conducts the initial review regarding the provider's appeal.

13.1.4. A QM Department designee sends notification

of disposition of appeal to the Provider.

13.1.5. If the Provider is dissatisfied with the decision, they may request a second and final internal level of appeal within 30 days of the receipt of the written notification of the decision. The request is made in writing to the PerformCare Executive Director or designee.

13.1.5.1. The provider appeal is presented to a panel not to exceed five members who will be chosen by the PerformCare Executive Management team. The panel may include but is not limited to PerformCare staff, County Representatives, and/or Provider Representatives. Panel members:

13.1.5.1.1. Will have not previously been involved in the decision to change the provider's network status;

13.1.5.1.2. Will not be in the county in which the appealing provider is located; and

13.1.5.1.3. Will have no conflict of interest or personal stake in the outcome of the decision.

13.1.5.2. The provider is given advance written notice of the panel's meeting to include the date, time, and place the disputed matter will be considered no less than two weeks prior to the meeting.

13.1.5.3. The provider is afforded the opportunity to present supporting statements and documentation. All supporting statements and documentation from the provider and PerformCare must be submitted to the opposing party one week prior to the panel review meeting.

13.1.5.4. The panel renders a decision within 15 calendar days of the meeting and advises PerformCare of the final decision in writing.

13.1.5.4.1. The panel has the option to uphold or overturn the

original decision with or without conditions.

13.1.5.4.2. Additional conditions suggested by the panel will be reviewed by PerformCare Executive Management to ensure compliance with PerformCare policies and procedures.

13.1.5.4.3. The decision of the panel will be reported to the Credentialing Committee.

13.1.5.4.4. The Committee will monitor the completion of any conditions imposed by the panel.

13.1.5.4.5. The Credentialing Committee may also elect to require additional actions of the provider.

13.1.5.4.6. PerformCare sends a copy of the final decision to the provider within one business day of the receipt of the panel's decision.

13.1.6. The provider contract contains a provision for arbitration of any disputes that cannot be resolved through the internal appeal process. The parties agree not to bring any judicial action against the other until all administrative remedies have been exhausted.

13.1.7. QM Department designee is responsible for coordination, facilitation, documentation and tracking of the network status appeal process. Coordination includes ongoing interface as necessary with the PerformCare Executive Director, Medical Director or designee, QI/UM, and any entity having authority and/or responsibility for the network status appeals process.

13.1.8. A quarterly summary report of provider appeals including final dispositions as applicable is prepared by the QM Department designee. The report is presented to the QI/UM Committee and other entities as needed.

14. Reporting
    14.1. The QI/UM Committee will receive from the Credentialing Committee a summary of meetings and activities to include summaries of recommendations and actions. The QI/UM Committee is also held to the same confidentiality standards and requirements.
    14.2. Rosters and reports are provided to the appropriate designated HealthChoices Primary Contractors, and other entities as required.
    14.3. When a provider is suspended or terminated from the network, PerformCare will simultaneously notify the appropriate HealthChoices Primary Contractors and OMHSAS of this termination and the effect it has on maintaining provider network capacity.

Related Policies: *PR-003 Ongoing Monitoring of Quality, Sanctions and Complaints*
QI-CR-001 Credentialing and Re-Credentialing Criteria-Facilities
QI-CR-002 Credentialing and Re-credentialing Criteria-Practitioners
QI-CR-003 Credentialing Progressive Disciplinary Actions for Providers

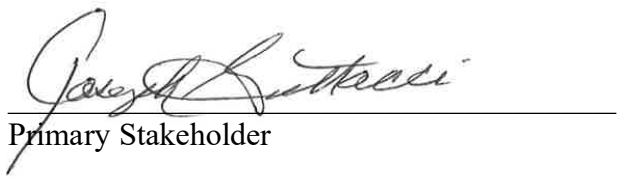
Related Reports: None

Source Documents and References: None

Superseded Policies and/or Procedures: *PR-030 Credentialing Committee*

Attachments: *Attachment 1 Credentialing Committee Confidentiality and Non-Discrimination Statements*

Approved by:



Primary Stakeholder

PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

CREDENTIALING COMMITTEE
CONFIDENTIALITY STATEMENT

During the relationship created between the Undersigned Party ("Undersigned") and PerformCare (formerly CBHNP), the parties will have access to Confidential Information, which is defined in detail below. Confidential Information is protected by state and federal laws, including HIPAA and by PerformCare policies. The Undersigned agrees to abide by the terms of this Confidentiality Statement regarding such Confidential Information.

A. Confidential Information includes both "Protected Health Information" and "Proprietary Information." Protected Health Information means information about clients, such as past, present, or future physical or mental health information, or personal or financial information, whether in written, verbal, or electronic form. Proprietary Information means information related to the operations of PerformCare and/or its affiliates, including, but not limited to business and development documents; provider performance information; concepts and care management models; software in various states of developments; research; economic and financial analysis and resources; trade services; human resources information (i.e. employment, promotions, salary and performance review); and miscellaneous copyrightable materials.

B. The Undersigned may access Confidential Information only as needed to perform legitimate duties pursuant to the relationship with PerformCare and/or its affiliates and agree not to disclose, communicate, or use any Confidential Information, except as needed to perform such duties or as required by law.

C. Confidential Information may only be released to individual outside of PerformCare and/or its affiliates upon written authorization from PerformCare.

D. The obligations contained herein will continue after termination of the relationship between the Undersigned and PerformCare.

E. Upon termination of the relationship between the Undersigned and PerformCare, the Undersigned shall delete all electronic material containing Confidential Information and shall return to PerformCare all hard copies of Confidential Information in the Undersigned's possession or control.

F. The Undersigned will be responsible for the misuse or wrongful disclosure of Confidential Information and related penalties may include termination of the Undersigned's relationship with PerformCare and/or the commencement of legal proceedings.

I have read this Confidentiality Statement and understand it.

_____
ORGANIZATION NAME (please print)

_____ _____
NAME (please print) SIGNATURE

_____ _____
TITLE (please print) DATE

Revised 09/2024

PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

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I have read this non-discrimination Statement and understand it.

_____
ORGANIZATION NAME (please print)

_____ _____
NAME (please print) SIGNATURE

_____ _____
TITLE (please print) DATE

Revised 09/2024