SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Policy Number:	25-04
Policy Name:	Credentialing and Re-Credentialing BHRS Providers
Authority:	MHSUDS Information Notice No. 18-019; Behavioral Health Information Notice No. 22-070; 42 CFR 438.214; 42 CFR 438.608; 42 CFR.1320a-7; MH Services Compliance Plan and Program; For SUD, providers delivering covered services are defined in Title 22 of the California Code of Regulations, Section 51051
Original Policy Date:	July 29, 2025
Policy Last Revised:	N/A
Supersedes:	BHRS 19-08 Credentialing and Re-Credentialing Providers BHRS 98-05 Credentialing for Independent Contracted Providers
Attachments:	A. Credentialing Committee Member Non-Discrimination and Confidentiality Statement B. Excel Spreadsheet for Monthly Provider Verifications C. Credentialing Checklist (internal use only) D. Attestation for Providers Applying for Credentialing or Re-Credentialing E. Acknowledgment of Receipt of BHRS HIPAA Policies F. BHRS Form 700 – Contractor Agency G. MH Contractor Credentialing Termination H. AOD Contractor Credentialing Termination I. San Mateo County Health A-14 Policy — Conflict of Interest, Incompatible Activities and Outside Employment for Employees of County of San Mateo Health J. Employee Statement Regarding Conflicts of Interest, Incompatible Activities, and Outside Employment K. BHRS Attestation for Conditions of Outside Employment

Nothing in this policy is intended to supersede or amend existing related policies including, but not limited to 92-03 (Affirmative Action), 98-14 (Fingerprinting), and 96-01 (Volunteers).

PURPOSE

The purpose of this policy and procedure is to establish an internal Credentialing and Recredentialing process within San Mateo County Behavioral Health & Recovery Services (BHRS) to ensure its county-owned and operated providers and contracted organizational providers delivering Medi-Cal covered services are credentialed and recredentialed following the Department of Health Care Services' (DHCS) Statewide Uniform Provider Credentialing and Recredentialing requirements established pursuant to Title 42 of the Code of Federal Regulations (CFR), Part 438.214 for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) counties. It also establishes the internal Credentialing and Recredentialing process for Providers and aligns with the National Committee on Quality Assurance (NCQA) standards.

POLICY

Effective immediately, BHRS will ensure that each of its Network Providers are qualified in accordance with current legal, professional, and technical standards, and are appropriately licensed, registered, waivered, and/or certified.[1] These Providers must be in good standing with the Medicaid/Medi-Cal programs. Any Provider excluded from participation in Federal health care programs, including Medicare or Medicaid/Medi-Cal, may not participate in the BHRS Provider Network. For this policy's purpose, Network Providers include county-owned and operated providers (i.e., MHP and/or DMC-ODS employees) and contracted organizational providers, provider groups, and individual practitioners. The uniform Credentialing and Recredentialing requirements in this policy apply to all licensed, waivered, or registered mental health providers and licensed or certified peer support specialists and/or substance use disorder services providers employed by or contracting with BHRS to deliver Medi-Cal covered services. This includes, but is not limited to, Psychiatrists, Psychologists, Physician Assistants, Nurse Practitioners, Registered Nurses, Clinical Nurse Specialists, Clinical Social Workers, Marriage and Family Therapists, Alcohol and Other Drug Counselors, Psychiatric Technicians, Vocational Nurses, Nursing Assistants, Medical Assistants, Occupational Therapists, and Pharmacists working at County owned and/or operated behavioral health sites.

DEFINITIONS

Centers for Medicare and Medicaid Services (CMS): A federal agency that provides health coverage to more than 100 million through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. CMS works in partnership with the entire

[1] Applicable provider types include licensed, registered, or waivered mental health providers, licensed practitioners of healing arts (LPHAs), and registered or certified Alcohol or Other Drug counselors.

health care community to improve quality, equity, and outcomes in the health care system.

Credentialing: The formal process of collecting and verifying the professional credentials and qualifications of each Provider and evaluating them to determine whether the Provider meets or continues to meet the minimum and/or additional Credentialing criteria set forth by DHCS.

Credentialing Committee: The Credentialing Committee is a confidential, multi-disciplinary peer review body with members drawn from participating BHRS Providers that are representative of the types of Providers that BHRS credentials and recredentials in accordance with the policies and procedures set forth herein.

Controlled Substance Utilization Review and Evaluation System (CURES): California's prescription drug monitoring database that tracks and stores information on Schedule II, III, IV, and V controlled substances dispensed in the state. Healthcare Providers and pharmacists use CURES to monitor prescribing patterns and prevent prescription drug misuse.

Drug Medi-Cal Organized Delivery System (DMC-ODS): The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed to achieve sustainable recovery. DHCS initially received approval in August 2015 from the Centers for Medicare & Medicaid Services (CMS) to implement the DMC-ODS through the State's prior Section 1115 demonstration. DHCS received approval from CMS on December 29, 2021, to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed care, and Specialty Mental Health Services (SMHS).

Independent Contractor: Refers to independent contractors who are defined as participating in an Organized Health Care Arrangement (OHCA) with BHRS.

Ineligible Person: An individual or entity who (1) is currently excluded, suspended, debarred or otherwise ineligible to participate in federal health care programs or (2) has been convicted of a criminal offense related to the provision of health care services and has not been reinstated by the federal health care program to provide services. No manager/supervisor will make an offer of employment to an applicant whom they know is listed as an ineligible person.

Mental Health Plan (MHP): The MHP means an entity that enters into a contract with DHCS to provide directly or arrange and pay for the provision of Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries in a county. SMHS means the impact of the beneficiary's condition is severe enough to

require the services of a specialist as opposed to a generalist in the field of mental health. A MHP may be a county, counties acting jointly, or another governmental or non-governmental entity.

Medicare Opt-Out (MOO): The process by which a Provider formally withdraws from Medicare participation by submitting an opt-out affidavit and entering into private contracts with Medicare beneficiaries. Opted-out Providers agree not to bill Medicare for services and must renew their opt-out status every two years unless automatically renewed.

NCQA Credentials Verification Organization (CVO) Certification: A certification issued by NCQA that provides a framework for organizations to implement industry best practices that help them efficiently and diligently verify practitioner credentials, while focusing on consumer protection and customer service improvement.

Network Provider(s): Consists of Providers in the BHRS network, including county-owned and operated providers (i.e., MHP and/or DMC employees) and contracted organizational providers, provider groups, and individual practitioners.

Office of Foreign Assets Control (OFAC): The OFAC of the U.S. Department of the Treasury administers and enforces economic sanctions programs primarily against countries and groups of individuals, such as terrorists and narcotics traffickers. The sanctions can be either comprehensive or selective, using the blocking of assets and trade restrictions to accomplish foreign policy and national security goals.[2]

Office of the Inspector General (OIG): The OIG of the U.S. Department of Health and Human Services has the authority to exclude individuals and entities from Federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud.[3]

Peer-Review Protected Information: Refers to all records, reports, and investigative materials generated by a designated peer review committee for the purpose of monitoring, evaluating, and improving the delivery and quality of healthcare services. This includes, but is not limited to, complaint files, investigations, reports, discussions, deliberations, meeting minutes, and committee members' identities.

Primary Source: Refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.

Primary Source Verification (PSV): The process of verifying that the credentials of a healthcare Provider are legitimate by directly contacting the original source or approved agent of the source that issued the credential. It can involve checking licenses, registrations, certifications, education and

[2] https://ofac.treasury.gov/about-ofac
[3] https://oig.hhs.gov/exclusions/

employment history, sanctions, among other qualifications.

Professional Review Action: A BHRS activity or action with respect to an individual Provider that determines the Provider's ability to meet and/or maintain their status as a BHRS Provider or that affects the scope of the Provider's participation in the BHRS network (e.g., suspension, termination, inactive status). Professional Review Actions are based on the Provider's professional conduct or competence, and may be triggered by a Provider's failure to meet and/or maintain the Provider's credentials or to comply with other BHRS policies and procedures or Provider requirements.

Provider(s): Refers to clinicians and/or counselors who render direct services to BHRS beneficiaries and who possess a license, registration, certification, and/or are waivered.

Recredentialing: The formal re-verification of credentials every three (3) years to ensure that Providers continue to meet DHCS Credentialing criteria.

PROCEDURE

BHRS will work with CertifyOS, a Credentials Verification Organization (CVO) certified by the National Committee for Quality Assurance (NCQA), to centralize the following Provider Credentialing and Recredentialing activities.

I. Provider Credentialing Application and Attestation

BHRS Providers are required to submit the following documents, when applicable to the Provider type, via a link to the BHRS Provider Credentialing Application for CertifyOS to commence the PSV process:

1. Type 1 NPI Number
2. Council for Affordable Quality Healthcare® (CAQH) ID - if applicable
3. DEA Number - if applicable to the Provider type
4. Board Certification Information
5. Social Security Number (SSN)
6. Current Curriculum Vitae (CV)/Resume
7. Professional Liability Insurance
8. Signed and Dated Provider Application and Attestation

BHRS will make available to new and existing Providers the link to the CalMHSA Provider Credentialing Application and will inform Providers to expect email and/or telephone communications from CertifyOS Credentialing staff.

CertifyOS will collect the required information from the Provider via the CalMHSA Provider

Credentialing Application and will review and import the information collected to its Credentialing platform. If there is a problem with any of the information provided, such as the Provider missing any required information, CertifyOS will conduct outreach to the Provider. CertifyOS will provide BHRS with the outreach reason(s) via the dashboard module.

CertifyOS outreach to Providers will consist of a total of three (3) emails before the Provider is closed out for outreach and CertifyOS notifies BHRS that the application was not completed.

1. Initial email – sent to Provider from the CertifyOS Credentialing platform within three (3) business days after CertifyOS identifies the need for outreach.
2. Second email – sent to Provider from the CertifyOS Credentialing platform six (6) business days after initial email is sent and there is no response from Provider.
3. Final email – sent to Provider from the CertifyOS Credentialing platform nine (9) business days after initial email is sent and there is no response from Provider.

During the Recredentialing process, CertifyOS will commence Provider outreach thirty (30) days before the Recredentialing due date if Providers do not complete the Credentialing application within the first thirty (30) days after the initial email with the application link is sent. Recredentialing starts no later than sixty (60) days prior to the Recredentialing due date. Outreach during Recredentialing will consist of emails to Providers in intervals based on the Recredentialing due date.

BHRS can track the status of the outreach through the dashboard functionality embedded in the CertifyOS Credentialing Platform. Once CertifyOS has all the information needed from the Provider, the Provider will be moved to the Credentialing workflow for the automated PSV process to commence.

As part of the CalMHSA Provider Credentialing Application, each BHRS Network Provider who delivers covered services will sign and date a statement attesting to the following:

1. Any limitations or inabilities that affect the Provider's ability to perform any of the position's essential functions, with or without accommodation.[4]
2. A history of loss of license or felony conviction.[5]
3. A history of loss or limitation of privileges or disciplinary activity.
4. A lack of present illegal drug use.

[4] These attestation requirements comply with requirements of the Americans with Disabilities Act, 42 U.S.C. §§ 12101 *et seq.*

[5] A felony conviction does not automatically exclude a provider from participating in the BHRS network. However, in accordance with 42 C.F.R. §§ 438.214(d), 438.610(a) and (b), and 438.808(b), BHRS may not employ or contract with individuals excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

5. Registration with the State of California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES).[6]
6. A history of refused membership on a hospital medical staff.[7]
7. The application's accuracy and completeness.

CertifyOS will review the Provider's application and attestation prior to moving the Provider into Credentialing PSV workflow to ensure that all the required information was included. CertifyOS will verify that the Provider's application and attestation is not older than 305 calendar days prior to reporting the application information to BHRS.

Once a provider submits their Credentialing application, they will receive an email confirmation. Within seven (7) business days of submission, applicants will be notified via email and the CertifyOS Provider Portal if any additional information is needed. Providers can check the status of their application via the CertifyOS Provider Portal. Initial Credentialing decisions will be completed within sixty (60) calendar days after receiving a completed Credentialing application.

For Mental Health Services, the Quality Management staff must review and approve the Credentialing application and attestation. QM staff must be satisfied that there are no clinical concerns regarding the provider's ability to provide quality services. For Substance Use Services, the Credentialing Application must be submitted and reviewed by AOD Credentialing staff for all new and existing clinicians.

II. Provider Credentialing

CertifyOS will complete Provider Credentialing on behalf of BHRS by verifying the Provider information listed below, as applicable to the Provider type, via NCQA-approved Primary Sources.[8] When applicable to the Provider type, the information will be Primary Source verified by CertifyOS, unless CertifyOS can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

1. The appropriate license and/or board certification or registration.
2. Evidence of graduation or completion of any required education.
3. Proof of completion of any relevant medical residency and/or specialty training.
4. Satisfaction of any applicable continuing education requirements.
5. Work history.
6. Hospital and clinical privileges in good standing.

[6] Applicable only to MDs, DOs, NPs provider types.

[7] Applicable only to MDs, DOs, NPs provider types.

[8] "Primary Source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.

7. History of any suspension or curtailment of hospital and/or clinic privileges.
8. Current Drug Enforcement Administration (DEA) identification number.
9. National Provider Identifier (NPI) number.
10. Current malpractice insurance in an adequate amount.
11. History of liability claims against the Provider.
12. Provider information, if any, entered in the National Practitioner Data Bank (NPDB), when applicable.
13. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: Providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the BHRS Provider network.
14. History of sanctions or limitations on the Provider's licensure issued by any state agencies or licensing boards.

A. Documentation and Reporting of Credentialing Verifications

CertifyOS will conduct PSVs using web crawlers, databases, or by directly querying the source to extract information from a NCQA-approved source for each Provider to verify and monitor credentials.

Once the PSV process is complete, a CertifyOS verifier staff will document sources used, date of verification, unique electronic signature of the verifier by source, and the report date, if applicable. CertifyOS uses an electronic signature that is unique to each staff member and can only be entered by the corresponding staff member.

Once the CertifyOS verifier completes verification of the credentials as indicated by documenting verification in the Provider's file, the platform immediately makes the Provider's Credentialing file or Provider's PSV file available to BHRS via the CertifyOS Credentialing Platform.

If at any time during the verification process CertifyOS becomes aware of any mistakes or discrepancies in the data or discovers that Credentialing information obtained through the verification process varies substantially from that supplied by the Provider, CertifyOS staff will notify the Provider and BHRS via email. CertifyOS will notify BHRS of any mistakes or discrepancies prior to completing PSV and remediate, if possible. If CertifyOS identifies any mistakes or discrepancies after completing PSV, then CertifyOS would revalidate and verify the file and provide the corrected file to BHRS immediately upon identifying the issue.

BHRS can generate a PSV file containing all the data derived from PSVs and all other applicable verifications, including annotations containing the name of the staff that worked on such verifications from the platform at any time during the period of the agreement. BHRS has the option to download and save each Provider PSV file or use the CertifyOS Cr00edentialing

Platform as the single source of truth for Provider Credentialing/Recredentialing data.

The following BHRS staff are authorized to modify credentialing information: Medical Office Specialist, Quality Management Unit Chief, Quality Manager, and Quality Management Program Specialists. All credentialing information modifications will be tracked in CertifyOS, including the time and date of modification, changed information, reason behind the update, and the staff who made the modification. Circumstances when modifying credentialing information are appropriate include:

- Corrections to data entry errors
- Changes/updates to contact data
- Updates to expired credentials
- Changes/updates to practice or billing location demographic data
- Updating credentialing approval dates following recredentialing
- To move documents attached to the wrong provider file

Circumstances when modifying credentialing information are inappropriate include:

- Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates)
- Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as a new credential)
- Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports)
- Attributing verification or review to an individual who did not perform the activity
- Modifications to information by unauthorized individuals

The Quality Management Unit Chief is responsible for overseeing audits on credentialing staff documentation and updates. These audits shall be conducted annually, and all results shall be documented in a report. If there are any findings related to inappropriate modifications, the Quality Management Unit Chief, or their designee, shall conduct a qualitative root cause analysis. Once the audit is complete, the report will be reviewed by the Credentialing Committee for oversight of credentialing information integrity and the audit process for further action, as needed. Any audit findings shall require a corrective action plan. Inappropriate documentation and updates will be reported to the Quality Manager, and NCQA if any fraud or misconduct is identified.

III. Provider Recredentialing

CertifyOS will complete Provider Recredentialing on behalf of BHRS, at a minimum of every three (3) years, to ensure that each Network Provider delivering covered services continues to possess valid credentials, including verification of each of the Credentialing requirements listed under

Section II. Provider Credentialing, as applicable to the Provider type. When applicable to the Provider type, the information will be Primary Source verified by CertifyOS, unless CertifyOS can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

BHRS will require each Provider to submit any updated information needed to complete the Recredentialing process using the CalMHSA Provider Credentialing Application link. Providers due for Recredentialing will receive an email notification with a link to the application sixty (60) days prior to their Recredentialing due date. Providers will be required to sign and date a new Credentialing application and attestation during Recredentialing events.

As part of Provider Recredentialing, BHRS includes documentation considered from other sources pertinent to the Recredentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews. The CertifyOS Credentialing Platform provides a section under the "Performance Indicator" tab that BHRS can utilize to track discrete number of complaints found for Providers in various categories. The categories include clinical service, benefit, claim, and access. The platform allows BHRS to attach supporting documentation related to tracked issues. Credentialing Committee members can access this information and take it into consideration when making Provider Recredentialing decisions.

BHRS will follow its established policies and procedures (i.e., BHRS Policy 98-10: Concerns/Complaints about MHP Individual and Organizational Contract Providers) for disciplinary actions, including reducing, suspending, or terminating a Provider's privileges.

IV. Credentialing / Recredentialing Decision Making

It remains the sole responsibility of BHRS to make final Credentialing and Recredentialing decisions for all Providers delivering services for BHRS. New Providers will be credentialed by CertifyOS before they can start providing services to beneficiaries. Established Providers will be credentialed/recredentialed by CertifyOS immediately and/or before they are due for Recredentialing.

Once CertifyOS conducts all required PSVs for a Provider, the Provider's PSV file will be marked "PSV Ready." This means that the PSV file is ready for adjudication. Each Provider's "PSV Ready" file will include a determination of "clean" or "non-clean."

The CertifyOS Credentialing Platform will automatically flag Provider PSV ready files as "clean" and "non-clean" based on the information gathered during the verification process. A PSV file will be designated as "clean" if it meets all the following conditions:

1. NPDB: If no action is found.

2. Licensure Actions: If there are no actions.
3. Sanctions (MOO, OIG, GSA/SAM/OFAC): If all three sources return "No Match Found."

A PSV file will be designated as "non-clean" if it meets any of the following conditions:

1. NPDB: If there is no information or if any NPDB report actions are found.
2. Licensure Actions: If there are any licensure board actions.
3. Sanctions (MOO, OIG, GSA/SAM/OFAC): If any sanctions results are found.

The BHRS Medical Director, or the Medical Director's designee (e.g., a qualified physician), shall have direct responsibility for and participation in the Credentialing program. The BHRS Medical Director or Medical Director's designee (e.g., a qualified physician) is the ultimate decision maker of Provider Primary Source verified Credentialing and Recredentialing "clean" files and can delegate the administrative responsibility of approving clean files, as needed. The "clean" file review process is as follows:

1. CertifyOS marks the Provider Credentialing or Recredentialing file as "PSV Ready" in the Credentialing platform.
2. Medical Director or designee (e.g., a qualified physician) reviews and approves the PSV "clean" file. If there are multiple clean files, the approval can be completed in a batch.
3. Automatic notification of Credentialing or Recredentialing approval is sent to the Provider and/or the BHRS Medical Office Specialist.
4. Provider file is automatically flagged in the Credentialing platform for three-year Recredentialing and for ongoing monitoring, if applicable.
5. A list of all approved clean files is shared at the next Credentialing Committee meeting.

The Credentialing Committee is the ultimate decision maker of Provider "PSV Ready" Credentialing and Recredentialing "non-clean" files. The BHRS Medical Director or the Medical Director's designee (e.g., a qualified physician) will fairly review and adjudicate all "non-clean" files with the Credentialing Committee members. The "non-clean" file review process is as follows:

1. CertifyOS marks the Provider Credentialing or Recredentialing file as "PSV Ready" in the Credentialing platform.
2. PSV file is manually sent to the CertifyOS Credentialing Committee module. The BHRS Medical Office Specialist will click the corresponding button to complete this step.
3. In preparation for committee meetings, members are notified about an available PSV file summary for each Provider that resulted in meeting the non-clean file criteria.
4. The Medical Director or designee (e.g., a qualified physician) and Credentialing Committee members convene as per agreed committee meeting schedule and may choose to utilize the CertifyOS Credentialing Committee module, to review and adjudicate Provider non-clean files.

5. The Credentialing Committee will vote to approve, approve with monitoring, or deny Credentialing or Recredentialing for each provider. Votes of the committee on credentialing are only valid if the voting quorum includes a majority of licensed members.
6. The BHRS Medical Director or designee marks PSV Provider files as approved or denied in the CertifyOS platform per the Credentialing Committee's vote.
7. If Credentialing/Recredentialing is approved or approved with monitoring, the PSV file is marked as "approved" in the platform and an automatic email notification is sent to the Provider and/or the BHRS Medical Office Specialist. Simultaneously, the Provider file is flagged in the Credentialing platform for three-year Recredentialing and if it was approved with monitoring, it is also flagged for ongoing monitoring.
8. If Credentialing/Recredentialing is denied, the committee generates a summary of the reason(s) the Provider's credentials were not approved. This information can be gathered via meeting minutes. The PSV file is marked as "denied" in the platform and a Credentialing Committee member or appointed individual notifies the Provider in writing of the denied Credentialing/Recredentialing decision, as well as any Professional Review Action BHRS is taking as a result of the Provider's denial. The written notification contains information about Provider appeal rights. This step is completed outside of the CertifyOS Credentialing Platform.
9. BHRS follows the appeal process in Section VI if the Provider appeals the decision. BHRS retains the right to approve, suspend and terminate Providers.

Committee decisions will be made during in-person meetings, videoconferences, or telephone conferences. The committee will not make decisions via email or by facsimile. Providers will be notified of the committee's Credentialing/Recredentialing decision within seven (7) business days from the date the Credentialing Committee decides.

A. Voting Procedures and Meeting Minute Recording

All recommendations made by the BHRS Credentialing Committee will pass by simple majority, which is 50% plus one of the members present at a meeting voting in the same manner. Prior to voting on credentialing, recredentialing, or a Hearing Panel decision, a quorum will be established. A quorum exists if A) at least one half of the members of the committee plus one is present at the committee meeting; and B) at least half of the committee members present plus one are licensed in a discipline practiced under BHRS. The Medical Director, or in their absence, their designee, when there is a tie vote, makes the decision that will break the tie.

The committee's discussions will be documented within its meeting minutes. Meeting minutes must be recorded during every committee meeting and must include the date, time, location of meeting, attendees, and absent committee members. In brief narrative, meeting minutes will also incorporate the following: topics discussed, significant decisions, follow-up issues, and next meeting date and time. Quality Management staff will maintain agendas and minutes of BHRS

Credentialing Committee meetings and ensure that the materials are kept confidential.

B. Emergency Decision Making

If BHRS is to make an emergency Provider Credentialing decision, it will be made by the BHRS Medical Director, or the Medical Director's designee. An emergency decision may be made when reasonable information has been identified by BHRS that a beneficiary may be endangered by potentially unsafe or unethical care or treatment by a BHRS Network Provider.

When an emergency decision is made, the Provider may be suspended immediately with written notice sent to the Provider. Within ten (10) business days of the notification of suspension, all pertinent facts must be gathered for review by an ad hoc peer review committee consisting of at least three (3) Provider members of the BHRS Credentialing Committee. These members will make a final determination on whether to terminate or recommend full committee review.

V. Credentialing Committee Roles and Responsibilities

The Credentialing Committee is a confidential peer review body with members drawn from Providers participating in the BHRS network. The BHRS Credentialing Committee assures that beneficiaries receive care from a highly qualified, community-based, multi-disciplinary panel of Providers. All credentialing records and processes are confidential and protected to the fullest extent allowed by Section 1157 of California Evidence Code, and any other applicable law.

BHRS will establish and maintain a diverse Credentialing Committee, ensuring representation from different types of Providers being Credentialed/Recredentialed within the network. The Committee will have at least the following membership:

- Medical Director and/or Deputy Medical Director
- Compliance Officer
- Deputy Director for Youth & Family Services
- Deputy Director for Adult & Older Adult Services
- Deputy Director for Alcohol & Other Drugs Services
- Quality Manager
- Contracts Manager
- Call Center Manager
- Specialty Mental Health Private Provider Network (SPPN) Provider Relations Coordinator
- Representative of Management Information System (MIS)
- Representative of Personnel

If any discipline serving within BHRS, a BHRS contracted agency, or the Private Provider Network is

not represented by any of the above, a representative shall be appointed to the Credentialing Committee in a similar manner as above.

The Committee shall be appointed by the BHRS Director, Medical Director, and the Compliance Officer. Members serve until they request to leave the Committee. Membership may be revoked by the Medical Director if a member is found to be unable to attend scheduled meetings and/or perform the defined functions of the Committee.

The members in attendance at a regularly scheduled meeting of the Credentialing Committee will select one member as chairperson for a two-year term. The responsibilities of the chairperson are:

- Facilitate the meeting schedule and preside over committee meetings.
- Review drafts of committee minutes prior to full committee review and approval.
- Approve, as the representative of the Committee, any correspondence or other documents written by the Committee.
- Participate in discussion with BHRS management about findings of the Committee, participation of Committee members, and other issues at the request of any BHRS staff or of the Committee.

Committee members as a whole will possess broad clinical experience and expertise in the California Behavioral Health County Plan arena and ensure that Providers rendering services for BHRS members are credentialed and recredentialed in accordance with DHCS and NCQA standards, as well as provide meaningful advice and expertise when reviewing and making Provider Credentialing and Recredentialing decisions and taking Professional Review Actions. All professional members of the Credentialing Committee shall have a minimum of three years of independent practice, post Board Certification in the case of psychiatrists, and post licensure in the case of psychologists.

BHRS Credentialing Committee members will not base Credentialing decisions or Professional Review Actions on a Provider's race, ethnicity, national identity, gender, age, sexual orientation, or on the type of population the Provider renders services to/specializes in. To prevent discrimination in Credentialing decision making, Credentialing Committee members will sign the Credentialing Committee Member Non-Discrimination & Confidentiality Statement (Attachment A) affirming that they do not discriminate. Similarly, the committee will continuously monitor Credentialing and Recredentialing activities to remain cognizant of any bias to proactively identify discrimination.

By signing Attachment A, Credentialing Committee members will also agree to maintaining the

confidentiality of all aspects of the Credentialing and Recredentialing process, including during committee Provider file reviews and decision making. BHRS Credentialing records, including the practitioner application and attestation, any documents received, documentation of credentialing activities (e.g., verification dates, report dates, credentialing decisions, credentialing decision dates, signature or initials of the verifier/reviewer), credentialing checklist, documentation of clean file approval if applicable, and committee meeting minutes will be kept confidential and access to this information is restricted to committee members and specific staff designated by the committee. Records related to Credentialing will be stored for a minimum of ten (10) years.

No member of the Committee will participate in any review of their own compliance with Credentialing standards, nor shall any member review the credentials of any practitioner with whom they share membership in a professional legal entity. In such cases, an alternate member, representing the specific discipline and specialty under discussion, will be selected by the Medical Director, or their designee, to serve on the Committee during that deliberation.

The Credentialing Committee shall be scheduled to meet on a regular basis (e.g., bi-monthly, monthly, or quarterly), with sufficient frequency to review Provider "PSV Ready" files before Credentialing expiration. If there are no Provider applications or issues that require review and/or adjudication, the meeting may be cancelled. Committee meetings may be conducted via a web conferencing platform or in person. The committee module embedded in the Credentialing platform could be used by committee members to review and adjudicate "PSV Ready" files.

VI. Provider Rights and Appeal Process

BHRS Providers are afforded certain rights and protections during the Credentialing and Recredentialing process, including with respect to any Professional Review Actions BHRS takes arising from the Credentialing and Recredentialing process. BHRS will notify practitioners of their rights to review information obtained from outside sources to support their Credentialing application (e.g., malpractice insurance carriers, state licensing boards), correct erroneous information by submitting a request in writing via email to HS_BHRS_QM@smcgov.org within ten (10) calendar days of receiving a decision notification, be informed of the status of their application upon request, and to appeal Credentialing/Recredentialing decisions and Professional Review Actions. Additionally, BHRS will inform Providers on its process for responding to requests for application status and the information that BHRS is allowed to share with practitioners. BHRS is not required to make available references, recommendations, and/or peer-review protected information to Providers. These rights apply to new and established Providers at the time of initial and subsequent Credentialing. Providers can send an email to HS_BHRS_QM@smcgov.org to request any of this information.

The BHRS Credentialing Committee will notify Providers in writing, within fifteen (15) business days of all initial Credentialing decisions and/or Professional Review Actions that have been brought against them. The notice will include reasons for the action and a summary of the Provider's appeal rights, including an opportunity for a hearing.

Independent contracted providers will be required to respond to the notification within ten (10) business days with an explanation and/or plan of correction to resolve the issue. Failure to respond to the notification or implement a plan of correction may result in suspension or termination. A letter giving the provider a thirty (30) day notice of termination may be issued and any existing clients will be transferred to another provider as needed.

For BHRS providers, any Credentialing decisions and/or Professional Review Actions that have been brought against them will be handled by their direct supervisor and/or manager in addition to an Employee and Labor Relations Analyst from the Human Resources Department. Any corrective action plan or Professional Review Action must be handled by the Human Resources Department and the provider's direct supervisor, and updates must be provided to the Credentialing Committee.

BHRS Providers may request a hearing to appeal a Credentialing/Recredentialing decision, including any resulting Professional Review Action, such as denials of a Provider's Credentialing application, or suspension or termination of a previously approved Credentialing approval, by submitting a written appeal letter to BHRS within fifteen (15) business days after the notification of BHRS's decision was sent. The appeal letter can be submitted via email to HS_BHRS_QM@smcgov.org.

Upon receipt of the appeal letter, the BHRS Medical Director, or in their absence, their designee, will appoint members to the Hearing Panel within twenty (20) business days from when the appeal letter was received. The Hearing Panel shall be composed of three (3) Providers professionally qualified to evaluate the standards applicable to the Provider. Whenever reasonably possible, the majority of the Hearing Panel members will be Providers with the same professional degree or higher than the appealing Provider. Within thirty (30) calendar days from when the Hearing Panel members have been appointed, the hearing will be scheduled and held. The hearing will be completed, and a determination shall be made within ninety (90) calendar days from the date the appeal letter was submitted. If warranted, BHRS may allow the Provider to submit additional documentation to be considered during the hearing.

The Provider will be notified in writing of the Hearing Panel's decision within fifteen (15) business days of the decision. In the event the Hearing Panel upholds a Provider's appeal requesting full Credentialing, the Provider will be Credentialed/Recredentialed without further action. In the event the Hearing Panel's determination imposes conditions under which the Credentialing decision

and/or Professional Review Action will be upheld or denied, those conditions will be put into effect without any additional hearing. If the Hearing Panel denies the Provider's appeal, no further appeal process is available.

Any required report regarding Credentialing, Professional Review Action, participation, or quality of patient care will be made to the NPDB, DHCS, and other licensing agencies as prescribed by law and established policies and procedures will be followed, which may result in the Provider's suspension and/or termination.

VII. Inactive / Terminated Providers

BHRS Providers may become inactive and/or terminated by choice, or if determined that the Provider no longer meets the DHCS Credentialing/Recredentialing criteria outlined in this policy. If a Provider becomes inactive and/or terminated, BHRS will update the status of that Provider in the CertifyOS Credentialing Platform to inform CertifyOS about the Provider change.

For terminated contractors, contractor agency staff must fill out the appropriate Contractor Credentialing Termination form (Attachment G or H) with the effective date of termination. Forms must be emailed to HS_BHRS_MISCredentialing@smcgov.org within one business day of termination.

For terminated BHRS staff, the following process will be initiated:

1. All supervisors are required to inform payroll/personnel within 24 hours of an employee's notice of termination.
2. BHRS payroll/personnel will inform QM within 24 hours of the notice from the supervisor and provide the effective date of termination.
3. QM will inform MIS of the employee's termination date.
4. MIS will terminate the practitioner's enrollment and inform the BHRS IT Team.
5. BHRS IT will terminate the computer and EHR accounts and disable the badge for the terminated employee.

VIII. Provider Ongoing Monitoring

CertifyOS will conduct monthly ongoing monitoring checks on behalf of BHRS after initial Credentialing and in between Recredentialing cycles to continuously verify Providers' information. This ensures quality and safety of care to BHRS beneficiaries. Providers loaded to the CertifyOS Credentialing Platform with an active status will be included in ongoing monitoring checks. During the ongoing monitoring process, CertifyOS will document methods used to access and verify credentials information and will report any discrepancies found to BHRS via the Dashboard functionality embedded into the platform. Additionally, CertifyOS will send BHRS a monthly report

with a summary of any discrepancies found.

CertifyOS ongoing monitoring checks include querying the following sources:

1. National Practitioner Data Bank (NPDB)
2. DHCS Suspended and Ineligible Provider List (S&I List)
3. Centers for Medicare (CMS) Medicare Exclusion Database (MED)
4. U.S. General Services Administration (GSA) - System for Award Management (SAM)
5. Health and Human Services (HHS) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
6. Social Security Administration (SSA) Death Master File
7. U.S. Department of Justice Drug Enforcement Administration (DEA) Official List
8. State Licensing Board Websites

CertifyOS will conduct ongoing monitoring using approved sources within thirty (30) days of release by the reporting entity. If the reporting entity does not publish sanction information on a set schedule, CertifyOS will query the source for information at least every six (6) months. If the reporting entity does not release sanction information reports, CertifyOS will directly query the source for credentialed Providers every twelve (12) to eighteen (18) months. CertifyOS will review information within thirty (30) calendar days of a new alert for all sanction alerts. This information will be available to BHRS via the CertifyOS Credentialing Platform, specifically the ongoing reporting dashboard, at least monthly.

Contract agencies (Mental Health & AOD/SUD) are required to fully complete the Contractor Monthly Credentialing Verification Spreadsheet (Attachment B) and submit it to BHRS by the first day of the month, every month. The following data elements must be entered into Attachment B by the contractor, encrypted and emailed to BHRS Quality Management at HS_BHRS_QM@smcgov.org, or delivered to Quality Management in another secure electronic format:

1. First name
2. Middle name
3. Last name
4. Date of birth
5. Social Security number
6. License number (if applicable)

The information submitted to Quality Management in the Contractor Monthly Credentialing Verification Spreadsheet (Attachment B) will be utilized to check the exclusion lists above, aside from the DEA official list and NPDB, in a monthly Streamline Verify review.

Additionally, BHRS will investigate practitioner-specific member complaints upon their receipt and evaluate the practitioner's history of complaints, if applicable. The history of complaints for all practitioners will be evaluated at least every six months. The Grievance and Appeals Team (GAT) manages the resolution of grievances and appeals. The GAT will commence reporting on all practitioners every six months, by submitting a report to the Credentialing Committee which will be analyzed for trends by both the GAT and Credentialing Committee. The Grievances Coordinator participates in the GAT and the Quality Manager participates in the Credentialing Committee to ensure accurate review of practitioners' complaint history. The Grievances Coordinator and Quality Manager will serve as resources for better understanding of complaints and provider quality issues and concerns that may affect member experience and health, and the Credentialing Committee will recommend appropriate interventions as needed.

Furthermore, before contracting and for at least every 36 months thereafter, BHRS will confirm that an organizational provider is in good standing with state and federal requirements by obtaining copies of credentials (e.g., state licensure) from the provider. BHRS will also confirm a contracted provider's accreditation status via the applicable accrediting body for each type of organizational provider (e.g., Commission on Accreditation of Rehabilitation Facilities [CARF]) and any copies of credentials from the provider before contracting initially and at least every 36 months thereafter. If a contracted organizational provider is not accredited, BHRS will conduct an onsite quality assessment per BHRS Policy 98-12. BHRS may substitute a CMS or state quality review in lieu of a site visit under the following circumstances:

- The CMS or state review is no more than 3 years old.
- If BHRS obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection.

BHRS reviews participation of practitioners whose conduct could adversely affect members' health or welfare. BHRS continuously monitors for and reviews adverse events in accordance with BHRS Policy 05-08: Adverse Event Reporting. BHRS conducts regular and periodic review of providers' documentation, grievances and complaints, critical incident reports, outcomes of clinical supervision, and satisfaction surveys. If any query, at any time, discovers information concerning competency, malpractice, limitations of privileges, ongoing ethical investigations, or other such factors presenting potential risk to BHRS clients, the information will be further reviewed and investigated by the BHRS Assistant Director, QM Manager, Provider Relations Coordinator, Medical Director, and may also include County Counsel.

BHRS will implement interventions if there is evidence of poor quality that could affect the health and safety of its members. BHRS will not hire or contract with any individual, entity or independent contractor that is deemed ineligible. Providers who are deemed ineligible during

employment will not be permitted to provide SMHS or DMC-ODS services. The BHRS Quality Management staff will notify the Compliance Officer and Credentialing Committee immediately if any current employee is found to be ineligible during monthly ongoing monitoring checks. Any findings from the monthly ongoing monitoring checks will be reviewed at the next Credentialing Committee meeting. Additionally, if a BHRS Provider is found to be on any of the exclusion lists above, Quality Management will immediately notify MIS to block the individual(s) from billing to any payer. Any billing submitted after the date of exclusion will be voided. Blocks on claiming or providing services will not be lifted until the Provider's name no longer appears on the exclusion list.

If an independent contracted provider is found to be on any of the exclusion lists above, the following process will be initiated:

1. The Provider will immediately be informed of their status and stopped from providing services, and billing will not be submitted to BHRS or Health Plan of San Mateo (HPSM) for reimbursement for any services delivered on or after the date of exclusion. Any claims to Federal and State funds will be blocked by BHRS program administration.
2. Quality Management will immediately notify the Contracts Manager and the Provider Relations Coordinator that the individual had a finding on their monthly screening.
3. Quality Management will immediately notify MIS and the BHRS Contracts department to block the individual(s) from billing to any payer. Any billing submitted after the date of exclusion will be voided. The excluded Provider will not submit for reimbursement for any service from the date of exclusion and may not submit billing until any discrepancies are resolved and it is evident that the individual is not and will not be excluded or debarred.
4. Blocks on claiming or providing services will not be lifted until the Provider's name no longer appears on the exclusion list.
5. Quality Management will notify the Compliance Officer, who will initiate an investigation and report the results to the Compliance Committee.

The BHRS Compliance Committee will report notification of action to the appropriate Board of California, National Practitioner Data Bank, contracted health plans, and the Medical Board of California within fifteen (15) business days.

IX. Oversight of Credentialing/Re-Credentialing Activities

BHRS delegates oversight of CertifyOS Credentialing and Recredentialing activities to California Mental Health Services Authority (CalMHSA). An executed agreement between CalMHSA and CertifyOS is in place, as well as an executed agreement between BHRS and CalMHSA.

To ensure accountability for CertifyOS Credentialing and Recredentialing activities, CalMHSA has established a system to:

- Ensure that CertifyOS meets BHRS, DHCS, and NCQA Credentialing standards.
- Continuously monitors and evaluates the Credentialing functions performed by CertifyOS on behalf of BHRS.

Nonetheless, BHRS remains contractually responsible for the completeness and accuracy of Provider Credentialing and Recredentialing activities as established by DHCS.

BHRS retains the responsibility for ensuring that Providers' information published in beneficiary informing materials, including Provider directories, is consistent with the information obtained during the Credentialing and Recredentialing verification process. BHRS follows the process outlined in Policy 19-06: Provider Directory for maintaining and updating provider information in the Provider Directory.

X. Orientation and Training of New Providers

Offers of employment from personnel within BHRS are contingent upon completing an application and a background investigation through the County of San Mateo's Human Resources Department and the BHRS Quality Management (QM) Department. Conditional job offers may be made but are not finalized until screening and background checks are successfully completed. For all potential BHRS employees, a background check is conducted by San Mateo County to ensure that the individual is cleared for employment by the U.S. Department of Justice (DOJ). Contractor agencies are required to comply with finger printing requirements and background checks as specified in their contract with BHRS.

New BHRS employees and new contractors will receive written materials and will be trained in policies related to compliance during their initial orientation to BHRS. Training and materials presented during staff orientation will emphasize the elements of the compliance plan and the related Code of Conduct.

- Immediately upon hire, the Payroll/Personnel Specialist will give the employee several County Health and BHRS policies to read and acknowledge (Attachment E). All staff shall acknowledge in writing that they have received and read the policies listed in Attachment E, and any others deemed necessary. Evidence of compliance will be maintained in the employee's personnel file.
- Additional training, if needed for the individual's work assignment will be completed within 90 days of hire.
- New staff, trainees and psychiatric residents shall be directed to take the mandatory self-administered web-based confidentiality and privacy courses. HIPAA Confidentiality Training and Compliance Training must be completed before access is granted to the EMR or any client PHI.

- Failure to attend or complete mandatory training will result in progressive discipline, up to and including termination of employment. All staff and independent contractors will complete the online BHRS compliance and confidentiality trainings at initial hire and annually thereafter.
- As appropriate, the new staff will be scheduled by supervisors to attend documentation training and other training specific to their assignment.

XI. Prescriber Malpractice Insurance

A. BHRS Employees

During the onboarding process for BHRS Prescribers (MDs, NPs, DOs), QM will notify the County's Risk Management Office and Insurance Broker via email. Once the Prescriber has been added to the County's Malpractice Insurance, confirmation will be provided through a certificate sent to QM. QM will save all certificates for Prescribers. Since certificates are valid for only one year, at the start of each fiscal year, QM will request updated certificates for all current BHRS Prescribers. QM shall request and review a list of covered providers monthly. This serves as QM's quality check to ensure all BHRS Prescribers are covered by the County's Malpractice Insurance.

B. BHRS Independent Contractors

A BHRS Prescriber Independent Contractor (MDs, NPs, DOs) must secure their own malpractice insurance, which will name the County as an additional insurer and send QM a copy of the malpractice insurance to QM on a yearly basis. If the County has other insurance that may be applicable to a loss or claim, it will be considered excess coverage for the County, with the Contractor's malpractice insurance as the primary coverage for the County. Independent Prescriber Contractors will not be added to the County's malpractice insurance and therefore will not receive a certificate of insurance for the County's malpractice insurance.

XII. Providers' Responsibility to Maintain License

All staff providing services for which a license is required must maintain and provide evidence of current licensure:

- It is the sole responsibility of the professional staff member to meet all conditions, including completion of Continuing Education Units, which are required to maintain licensure.
- A staff member must notify their licensing board within thirty (30) days of a legal name change; the reissued license with correct legal name should be submitted to BHRS as soon as available to the staff member.
- BHRS staff whose license has expired may be reassigned to a position not requiring a license or may be placed on leave, until evidence of license renewal is submitted. The following action may be taken:

- The Director of BHRS or designee will determine the action to be taken.
- The immediate service needs of the division will frame this decision. There is no obligation incumbent upon the division to find an alternate work site.
- If no alternate appropriate assignment is identified, the staff member shall be placed on leave without pay. Failure to obtain evidence of renewal licensure within 30 days from expiration may result in permanent reassignment, demotion or termination.

- Contractors who cannot show evidence of licensure after the expiration date must notify the Provider Relations Coordinator and Contract Administrator immediately. Providers whose license has expired will be barred from providing services to existing clients and will not receive any new referrals until evidence of license renewal is submitted. Failure to obtain evidence of renewal licensure within 30 days from expiration may result in termination of the contract.

XIII. Conflict of Interest, Incompatible Activities and Outside Employment for Employees of San Mateo County

San Mateo County Health maintains Health Policy A-14: Conflict of Interest, Incompatible Activities and Outside Employment for Employees of San Mateo County. New and existing BHRS employees are required upon hire and on an annual basis to complete the Employee Statement Regarding Conflicts of Interest, Incompatible Activities, and Outside Employment. If the employee identifies a potential conflict, incompatible activity, or reports they are involved with outside employment then the statement requires the approval of their supervisor, director, and potentially the Health Chief.

Often, outside employment is related to mental health or substance use treatment because of the nature of the work that is done at BHRS. In those cases, the employee's outside employment may be approved, but would be conditioned to assure there is no self-referral and that the employee in the course of their outside work does not serve BHRS or HPSM clients. The A-14 Policy (Attachment I), the Employee Statement (Attachment J), and BHRS Attestation for Conditions of Outside Employment (Attachment K), are incorporated into the Credentialing and Re-Credentialing process.

BHRS collects disclosures of ownership, control, and relationship information for persons who have an ownership or control interest in the San Mateo County Contracted or Subcontracted entities, if applicable, and ensures its subcontractors and network providers submit disclosures to BHRS regarding the network provider's (disclosing entities) ownership and control (42 C.F.R. Section 455.101 and 104). BHRS requires providers, or any person with a 5% or more direct or indirect ownership interest in the provider, to submit fingerprints when applicable (42 C.F.R. § 455.434(b)(1) and (2)). BHRS ensures that its subcontractors and network providers submit the disclosures below to BHRS regarding the network providers' (disclosing entities') ownership and control. BHRS network providers are required to submit updated disclosures to BHRS upon submitting the provider application, before entering into or renewing the network providers'

contracts, within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the revalidation of enrollment process under 42 C.F.R. §455.104 (MHP Contract, Ex. A, Att. 13). BHRS complies with all mandatory reporting requirements for submitting disclosures and updated disclosures (42 C.F.R. § 455.106(a)(1), (2)).

SIGNATURES

Approved: *Signature on File*
Dr. Jei Africa, PsyD, FACHE
BHRS Director

Approved: *Signature on File*
Scott Gruendl, MPA, CPCO
Compliance Officer

Approved: *Signature on File*
Tasha Souter, MD
Medical Director

REVISION HISTORY

Date of Revision	Type of Revision	Revision Description
08/04/25	Tech Edit	**Attachment E:** Revisions made to the list of Behavioral Health Confidentiality Policies (added policies 22-06 & 22-07 and removed superseded Policy 03-11; added policy 22-04 and removed superseded Policy 91-05). **Attachment K:** Correction made to title

COMPLIANCE REVIEW HISTORY

Date of Review	Reviewer Name and Job Title
7/29/25	Scott Gruendl, Compliance Officer