Policy and Procedures
Operating Manual

Policy Title:	Behavioral Health Services Department Credentialing & Recredentialing Policy	**Policy No.:**	CR 4.0
Replaces Policy Title *(if applicable)*	N/A	**Replaces Policy No.** *(if applicable)*	
Department Owner	VHP Credentialing	**Policy Review Frequency:**	
Department Applicability			
Lines of Business *(check all that apply)*	Commercial ☒ Medi-Cal ☒ Covered CA ☒ IFP		
Accreditations *(check all that apply)*	☐NCQA	☐AAAHC	☐ ______________

I. POLICY

It is BHSD's policy to make every reasonable effort to ensure that the health care providers and practitioners that participate in the Plan undergo a credentialing process. The process involves a completion of a The Council for Affordable Quality Healthcare (CAQH) or County of Santa Clara Participating Practitioner Application (CSCPPA) as applicable, primary source verification, medical malpractice review, and approval by the applicable credentialing committee or Chief Medical Officer or designee before the provider can be listed as a provider in the applicable Provider Directory.

The BHSD has delegated its credentialing and re-credentialing activities to Valley Health Plan (VHP), which is licensed as a full-service health plan under the Knox-Keene Health Care Service Plan Act of 1975 and a department within the County of Santa Clara. Integral in this delegated credentialing function is the formal process by which VHP will confirm a practitioner's credentials and qualifications through primary source verification, or through verifications conducted by a California licensing, certification, or registration Board, to ensure that a practitioner has met all the education, training, and experience requirements to join the BHSD network. Valley Health Plan (VHP) responsible to perform credentialing, on-going monitoring and recredentialing activities in accordance with the regulatory and accrediting standards relevant to each organization.

The credentialing process will be performed in an objective, non-discriminatory and unbiased manner. No provider will be denied an agreement with the Plan or to serve BHSD's clients, have any sanctions imposed, or have their agreement terminated on the basis of age, race, creed, color, national origin, ethnic identity, sexual orientation, sex/gender, ancestry, mental/physical disability, medical condition, political beliefs, organization affiliations, marital status, or based on type of procedures or source of payment. An annual audit is performed by the County of Santa Clara's Compliance Department of providers denied for participation for reasons not related to failing to complete the credentialing/re-credentialing process to ensure discriminatory practices are not conducted. The results of the audit will be reported to the appropriate credentialing committee and BHSD Quality Management Dir.

II. PURPOSE

Credentialing policy establishes the procedures for evaluating and determining a provider's acceptance for initial and continued participation in the Plan or in the BHSD's participating provider network or employed by BHSD. Through this policy, the Plan ensures that providers meet basic qualifications before delivering care to Plan participants or individuals served either directly by the BHSD or through a contractual relationship between a community-based organization and the BHSD. VHP re-verifies the qualifications of participating providers on an every three-year (36-months) basis. The credentialing/recredentialing policy is one aspect of the Plan's and the BHSD's Quality Improvement Program.

This policy governs the credentialing/re-credentialing and on-going monitoring of the following providers, including, but not limited to:

Medical	Mental Health	Substance Use
Physicians (MD)	Physicians/Psychiatrists (MD)	Licensed Marriage & Family Therapists (LMFT)
Nurse Practitioners (NP)	Psychologists (PhD/PsyD, including interns)	Associate Marriage & Family Therapists (AMFT)
	Doctor of Osteopathic Medicine (DO)	Licensed Clinical Social Workers (LCSW)
	Clinical Psychologists (licensed or waivered)	Associated Clinical Social Workers (ASW)
	Licensed Clinical Social Workers (LCSW)	Nurse Practitioner (NP)
	Associate Social Workers (ASW)	Medical Doctor (MD)
	Masters Social Worker Interns (MSWI)	Licensed Professional Clinical Counselors (LPCC)
	Licensed Marriage Family Therapists (LMFT)	Associate Professional Clinical Counselor (APCC)
	Associate Marriage and Family Therapists (AMFT)	Registered Psychologists (REG PSY)
	Licensed Professional Clinical Counselors + (LPCC+)	Licensed Psychologists (LIC PSY)
	Licensed Professional Clinical Counselors (LPCC)	Licensed Technicians (PSY TECH)
	Associate Professional Clinical Counselor (APCC)	Licensed Vocational Nurses (LVN)
	Registered Nurses (RN)	Registered Nurses (RN)
	Psychiatric Mental Health Nurse Practitioners (PMHNP)	Registered Alcohol and Drug Technicians (RADT)
	Licensed Vocational Nurses (LVN)	Registered Alcohol and Drug Trainee IIs (RADTII)
	Licensed Psychiatric Technicians (LPT)	Certified Alcohol and Drug Counselor Is (CADCI)
	Pharmacists (RPh)	Certified Alcohol and Drug Counselor IIs (CADCII)
	Occupational Therapists (OTR/L)	Certified Alcohol and Drug Counselor Clinical Supervisors (CADC-CS)

Medical	Mental Health	Substance Use
	Mental Health Rehabilitation Specialists (MHRS)	Licensed Advanced Alcohol and Drug Counselors (LAADC)
	Paraprofessionals >2 yrs./<2 yrs.	Licensed Advanced Alcohol and Drug Counselor-Supervisors (LAADC-S)
		Certified Addictions Treatment Counselors (CATC)
		Certified Addictions Treatment Counselors (CATC-I)
		Certified Addictions Treatment Counselors-AA (CATC-II)
		Certified Addictions Treatment Counselors-BA (CATC-III)
		Certified Addictions Treatment Counselors-MA (CATC-IV
		Certified Addictions Treatment Counselors-DR (CATC-V)
		Certified Addictions Treatment Counselors-Nurse (CATC-N)
		Substance Use Disorder Certified Counselors (SUDCC)
		Substance Use Disorder Certified Counselors – Advanced Experience (SUDCC II)
		Substance Use Disorder Certified Counselors – Advanced Experience & Bachelor’s Level Education (SUDCC III)
		Substance Use Disorder Certified Counselor Clinical Supervisors (SUDCC III CS)
		Substance Use Disorder Certified Counselors – Advanced Experience & Master’s Level Education (SUDCC IV)
		Substance Use Disorder Certified Counselor Clinical Supervisors (SUDCC IV CS)
		Substance Use Disorder Registered Counselors (SUDRC)
		Certified Alcohol & other Drug Counselors (CAODC)
		Certified Alcohol & other Drug Counselor Associates (CAODC-A)
		Certified Alcohol & other Drug Counselor Clinical Supervisors (CAODC-CS)

III. DEFINITIONS

N/A

IV. RESPONSIBILITIES

A. The Management Oversight Committee (MOC) is ultimately responsible for the quality of care delivered to BHSD members. The MOC has the final authority to approve/disapprove credentialing/re-credentialing decisions and to delegate roles and responsibilities for the process to the following:

1. Quality Management Committee (QMC)

    a. The QMC is responsible and accountable for the continuous quality of care and service for all Plan members. Quality management involves assessment and establishing goals for improvement and evaluation of the process. The QMC makes determinations on provider issues, reviews activities, reports, and makes recommendations to the MOC.

2. Credentialing Committee (CC)

3. Credentialing Manager; Credentialing Supervisor

4. Chief Medical Officer or designee is the Chair of the CC

B. The Credentialing Committee (CC) is a multidisciplinary team of physicians, mid-levels and behavioral health practitioners who monitor and review the quality-of-care findings from credentialing and quality activities of the Utilization Management, Quality Management and Credentialing departments. The CC make determinations and hear provider appeals regarding initial and subsequent credentialing decisions based on clinical competency and/or professional conduct. The committee members are required to sign a statement that affirms that members will not discriminate and will maintain confidentiality during the credentialing/recredentialing process and/or meeting. The CC report credentialing action items to the QMC on at least a quarterly basis.

1. Committee Membership: The CC will consist of at least three participating providers. The CC represent surgical and medical specialties, primary care, mid-level providers and behavioral health practitioners. The CC will maintain a list of providers in specialties not represented on the committees to advise the Chief Medical Officer, or designee, on applicants with adverse information that may require specialty review. The CC meet at a minimum of six times per year. Meetings may be held either in person, by teleconferencing or video conferencing.

2. Quorum: A quorum consists of one-half of the voting members of the committees, but in no event less than two voting physician members, including the Committee Chair. The Plan Chief Medical Officer or designee serves as Chair to the CC.

3. Committee Records: The committees maintain permanent and confidential records of their proceedings, of the persons attending each meeting, and the results of the vote on each matter upon which a vote is taken.

4. Routine Committee Meetings: All credentials presented to the CC for review must be updated, and the attestation questionnaire and release of information page must be signed within a minimum of 180 days prior to the meeting at which an applicant for credentialing/re-credentialing is brought before the committee.

5. The CC reviews credentials of providers who do not meet criteria and may make recommendations to approve with and action plan or shorter renewal timeframes. The committees may also defer a decision and request further explanation and documentation or deny an application.

C. The Plan Chief Medical Officer (or designee) is responsible for professional and clinical oversight of the activities of the Credentialing Department, CC and QMC.

1. Serves as Chair for QMC and CC.

2. The CC under the direction of the Plan Chief Medical Officer makes final recommendations regarding provider participation and/or appeals regarding credentialing decisions based on clinical competency and/or professional conduct if an expedited decision is required due to extenuating circumstances and there is insufficient time to convene a committee meeting.

3. Or designee, has the authority to approve a “clean file” outside of the CC as needed.

D. The Behavioral Health Medical Director and the BHSD Utilization Review Manager are responsible for the professional and clinical oversight of the BHSD activities.

1. Reviews findings of credentialed BHSD providers and makes recommendations based on providers’ competency and professional conduct to the Credentialing Committee

2. Or, designed, has the authority to approve a “clean file” outside of the CC as needed.

3. Reviews BHSD’s Credentialing Policy at least annually and presents Plan’s policy to the for possible updates and/or revisions.

E. The Credentialing Manager and Credentialing Supervisor are responsible for implementation of the credentialing policy and procedures.

1. Reviews and evaluates the qualifications of each provider applying to become a participating provider or seeking continued participation with the Plan or the BHSD and each BHSD employee rendering direct client services, and documents relevant findings and transmits such findings to the Chief Medical Officer or designee for presentation to the CC.

2. The Credentialing Specialists are trained, at time of new hire orientation, using the National Committee for Quality Assurance (NCQA) and Department of Health Care Services (DHCS)

V. PROCEDURES

A. Credentialing Process

1. Application process for initial credentialing & recredentialing:

   a. The Credentialing staff is notified of interested applicants from County Contracted Providers (CCP) and County of Santa Clara providers. To initiate the process, the CAQH number is requested from providers who are eligible to use the CAQH application process.

      i. BHSD Licensed professionals must complete the CAQH application process and provide their CAQH number. Paraprofessionals, Interns and Trainees are required to complete the (CSCPPA).

2. **Minimum Qualifications for Provider Participation**

   A provider must meet the following minimum qualifications:

   a. The provider must supply a completed/signed application and attestation questionnaire attesting to the correctness and completeness of information included in the application, and provide all requested attachments, which are part of the application. In addition, a copy of a current Curriculum Vitae or complete work history must be included with the application packet. The attestation questionnaire includes:

      i. A minimum of five years' work history for new providers. Gaps of six months or longer are researched and an explanation is required of a provider, and then documented in the file by provider or credentialing staff. Gaps of one year or longer must be explained by the applicant in writing.

      ii. Reasons for inability to perform the essential functions of the position, with or without accommodation.

      iii. Absence of current illegal drug use.

      iv. History of loss of license, medical malpractice issues, or felony convictions.

   b. History of loss or limitation of privileges or disciplinary actions, meaning, all providers must possess a current, unrestricted, and valid license to practice and/or provide covered services in California. License must have been obtained from the State of California from the appropriate licensing board.

   c. License verifications for behavioral health providers are verified through the Board of Behavioral Sciences (BBS) or the California Board of Psychology, utilizing the Department of Consumer Affairs (DCA) license search. SUD counselors must be certified through the Addiction Counselor Certification Board of California (ACCBC) and continued education maintained through the California Association for Drug/Alcohol Educators (CAADE).

d. If applicable, must have current medical staff appointment at one or more of the BHSD's participating facilities or clinics, provide services in a County of Santa Clara operated site or community-based organization contracted directly with the BHSD, with clinical privileges commensurate with the services to be performed as a participating provider.

   i. Physicians who demonstrate arrangements for admission through other participating physicians are also acceptable.

   Ii Psychiatrists must have a current medical staff appointment at one or more of the BHSD's participating facilities for services to be performed at these facilities.

e. Eligible providers must be enrolled through a state-level enrollment process, Provider Enrollment Division (PED) for Medi-Cal FFS using the Provider Application and Validation for Enrollment (PAVE) or a Managed Care Plan. Providers' enrollment status will be verified on the California Health and Human Services' (CHHS) Open Data Portal, by accessing the Enrolled Medi-Cal Fee for Service Provider report.

f. Providers must be in good standing to provide services under the California State Medi-Cal and Federal Medicare programs. VHP prohibits employment or contracting with providers who have been excluded or sanctioned from participation with Medicare and Medicaid programs.

g. Physicians: Must maintain American Board Medical Specialties (ABMS) certification or for initial credentialing, have completed a residency program in their specialty, be approved by the American College of Medical Examiners (ACME); American Osteopathic Association (AOA); or other acceptable accrediting body.

h. For physicians who are initially credentialed and not board certified (NBC), at the physician's next credentialing cycle, they must be Board certified or provide a written explanation to the CC explaining why boards have not been taken.

   i. Board certified physicians will be distinguished from physicians who do not have board certification in the Plan's Provider Directory.

   ii. A primary care provider who was initially credentialed before 2007 who has not completed a Residency in a primary care area will be designated as a General Practitioner in Plan's Provider Directory and will not be obligated to have completed a residency or maintain ABMS certification for recredentialing. PCP's are Family Medicine, Internal Medicine and Pediatric physicians.

1. Behavioral Health Paraprofessionals, Mental Health Rehabilitation Specialists (MHRS), Interns and Trainees: Must be credentialed prior to providing services to the Behavioral Health Services Department (BHSD) clients and meet the following standards:

   a. Complete the CSCPPA and submit to BHSDCredentialing@vhp.sccgov.org for Credentialing committee review.

i. The application for the paraprofessional must include their supervisor's name. The supervisor must be a qualified service provider or qualified service professional at a level of clinical supervisor that meets professionally recognized standards of practice. licensed, have immediate responsibility and oversight for all client contact by the paraprofessional. The supervisor's license will be verified during the credentialing of the paraprofessional and updated in the Credentialing Database.

b. Paraprofessionals must also meet the following education and training requirements:

   i. PP> 2 years: An individual who provides mental health services but does not hold a license/waiver/registration as a physician, psychologist, social worker, marriage and family therapist, professional clinical counselor, registered nurse, licensed psychiatric technician, or occupational therapist, but has more than two years of mental health experience.

   ii. PP< 2 years: If the individual does not have a bachelor's degree in a mental health field and does not have at least two years of mental health experience.

2. An MHRS must have the combined education and mental health experience required by state law. In all cases the experience must be: "in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment."

   In order to qualify, an individual must have one of the following:

   a. A master's degree in a mental health related field plus two years of clinical experience in a mental health setting;

   b. A bachelor's degree plus four years of clinical experience in a mental health setting. Up to two years of graduate professional education in a mental health or related field may be substituted for the experience requirement on a year-for-year basis; or

   c. An associate degree and six years of clinical experience in a mental health setting. Two of the six years required work experience must be completed after being awarded the Associate's degree

Clinical experience includes but is not limited to, the following activities: case management, counseling, psychotherapy and crisis intervention. Practicum and internship experience that is part of the requirement for the bachelor or graduate degree will not be counted as clinical experience.

Completed form and supporting documentation may be submitted to: BHSDBusinessOffice@hhs.sccgov.org If the individual satisfies the MHRS requirements, a certificate will be issued. The requestor will be notified and can attach the certificate to the credentialing application packets submitted to the Credentialing Team at VHP.

3. Those providers required to have a Drug Enforcement Administration (DEA) number to perform their contractual functions must possess a verified current Federal Drug Enforcement Agency Certificate.

4. All providers must have a current sanction-free status with applicable state professional licensing boards, or Medicare or Medi-Cal programs, and must have had no previous criminal history, felony, or specified misdemeanor convictions. All providers must never have had a professional license revoked (even if the revocation was stayed) or suspended. All providers must never have had clinical privileges revoked or suspended. A California licensing board probationary status is considered a sanction, therefore a provider who is placed on probation may be terminated from BHSD.

5. Providers with any current or past limitations imposed upon their exercise of clinical privileges, or any change in appointment of clinical privileges during their participation with the Plan, must supply information to the Plan regarding such limitations. Exceptions are considered based on the following criteria, which requires a special review by the CC.

At any time before the five-year period preceding the date of provider's application, the provider:

a Has ever had their medical professional or business licenses revoked or suspended by a state licensing board.

b Been convicted of a criminal felony or of any criminal misdemeanor relating to the practice of their profession, other health care related matters, third-party reimbursement, controlled substances violations, child/adult abuse charges, or any other matter that, in the opinion of the Plan, would adversely affect the ability of the provider to participate with the Plan or BHSD.

c Been excluded or precluded from participation in the Medicare or Medicaid programs and never have been convicted of Medicare, Medicaid, or other governmental or private third-party payer fraud or program abuse or have been required to pay civil penalties for the same.

d Has had their medical staff appointment or clinical privileges denied, revoked, or terminated by any health care facility.

i. All providers must furnish evidence of professional liability insurance coverage in the minimum amounts required by the Plan or BHSD.

j. BHSD uses a third-party vendor to track and maintain contractual insurance compliance, currently Ebix, Inc.

k. Malpractice Liability Coverage in amounts equal to a minimum of $1 million per occurrence/$3 million aggregate.

l. All providers must possess malpractice liability history acceptable to the credentialing committee. Malpractice liability history includes all legal actions involving claims of medical malpractice which have ever been commenced against the provider. Any provider with a malpractice history shall be subject to review and approval by the CC. Acceptance of malpractice history is based on the following guidelines:

During the five-year period preceding the date of the provider's application, no more than two legal actions have been commenced and the aggregate amount of the resulting judgments and/or settlements was:

i. $100,000 or less for other specialty physicians and primary care physicians will be subject to review and approval by the CC.

All providers must demonstrate to the satisfaction of the Plan that they can provide health care services that meet the standards established by the Plan.

All providers must be responsible for organizing a pattern of supportive medical resources so that Plan members and the BHSD clients may be appropriately served by clinical advice and supervision seven days a week and 24 hours a day.
In addition to meeting the above listed minimum requirements, all Plan and BHSD participating providers shall:

i. Agree to actively participate in and comply with utilization review and quality improvement activities of the Plan or the BHSD and permit Plan or BHSD representatives to have access to their private office for the purpose of conducting on-site audits.

ii. Agree to comply with Plan or BHSD standards, protocol, policies, and provisions specified in the relevant Provider Agreement.
Supply, upon request, such information regarding the aspects of their private practice related to Plan or the BHSD participation.

3. Verification Process

a. Primary source verification of applicant qualifications and information is performed by the Credentialing Specialists. Verifications will adhere to the current National Committee for Quality Assurance (NCQA) standards. BHSD acknowledges that the NCQA standards for credentialing are dynamic and shall implement new standards during annual review of the credentialing and Peer Review policy.

4. Protection of Providers’ Rights

a. Applicants have the following rights:

i. Review information submitted to support their credentialing application. The request to review must be made in advance to the Credentialing Department. The application, including primary source verification, will be made available for review at a Plan determined location. The applicant can review all documentation in their file, except for the checklist used to document the dates verifications were completed and the Credentialing Specialist who completed the verifications.

ii. Correct erroneous information: After completion of the verification of the required elements as listed, Plan Credentialing staff will notify the applicant in writing within ten business days of finding any discrepancy between the submitted material and the information obtained through the verification process. The applicant has 15 business days to reply to the Plan regarding discrepancies. Applicants may submit corrections to the Credentialing Specialist through certified mail. A letter of acknowledgement is sent to the applicant within three business days upon receipt of corrections. Once the corrected discrepancy document is received by a Credentialing Specialist, the document is date stamped and the staff will re-run the primary source verification where the discrepancy was noted.

iii. Receive the status of their credentialing or re-credentialing application, upon request.

iv. Applicants may call the Credentialing Department at (408) 885-2221 or send a request to Credentialing@vhp.sccgov.org to receive information on the status of their application.

v. Applicants are informed of their rights on in the Information Release page of the application describes the right to have a fair hearing, have access to their application and to update information should there be changes during the credentialing or recredentialing process.

vi. When signing the release and acknowledgements page of the credentialing application, the provider consents to sharing information related to credentialing and qualifications.

5. **Notification of Credentialing Decision and Appeal Rights**

a. All applicants who have submitted a completed application to VHP for participation (initial or re-credentialing) and have been presented to the CC, the BHSD Medical Director or designee, will be notified of the decision in writing within 5 business days of the clean file review or committee decision. A notification of the decision is sent via e-mail and followed with a signed letter. If a provider is approved to participate with BHSD an acceptance letter is mailed, access is given to the online Provider Manual, and the Plan and BHSD directories are updated accordingly.

i. If a provider is denied participating in the Plan or BHSD, a denial letter, that includes the reason for denial or participation as well as the provider's right to appeal, is sent to the provider via certified mail within 30 calendar days of the Credentialing Committee's decision.

ii. If a provider submits a request to appeal, and the Credentialing Committee votes to uphold the decision, the provider will be offered a fair hearing within 30 calendar days.

6. **Medical Record Confidentiality and Facility Site Review**

a. Medical records of all Plan members and BHSD clients, including all other lines of business, are kept confidential and only disclosed to and by other persons within the provider's organization only as necessary to provide medical care and quality,

peer review, or complaint and appeal review of medical care under the terms of the applicable program contract and as required in accordance with applicable laws and regulations. Information contained in the medical record may be used by the Plan or its providers only for a purpose directly connected with the performance of the Plan' obligations, including enforcement of the member or clients' rights, or as otherwise required by applicable laws and regulations.

7. **Site Visit Process**

BHSD may conduct site visits to review compliance with State and Federal requirements related to health and safety of the facility and required posting.

B. Recredentialing

1 Recredentialing is completed to determine continued participation with the Plan or BHSD no longer than every three years (36 months) after the previous credentialing determination.

a. Providers going through the re-credentialing process are required to complete and submit a signed, current attestation questionnaire and release of information page. Providers who terminate the Plan or with the BHSD and do not return until 30 calendar days after the termination date, are required to repeat the initial credentialing process.

b. The Plan's Credentialing staff complete the steps outlined in the credentialing process, including verification of all necessary information from primary sources. Except for verification of residency training, education, and work history. Attestation questions must be answered, and signature must be within 180 days of the credentialing committee decision.

c. In addition to the qualification verification, the CC is presented with a report detailing provider performance in the following quality improvement target areas to assist in evaluation of the provider's compliance with the Provider Agreement provisions and Quality Improvement Program standards:

i. Member complaint history including a summary of quantity, category, and outcome of complaints related to provider.

ii. Results of quality review studies, if any, related to the provider.

iii. Member and client satisfaction survey results specific to provider including a Plan assessment of accessibility, appointment availability, and wait times.

d. Ongoing Monitoring: On a monthly basis, the Plan conducts on-going monitoring of all providers including behavioral health providers, through review of appropriate California licensing boards, Office of Inspector General (OIG) exclusions in the LEIE databases, DEA Controlled Substance Act Registrant Database, Medicare/Medicaid Opt Out in the CMS.gov database and the Department of Health Care Services Medi-Cal Suspended and Ineligible Provider List.

i. Providers who have opted out of Medicare will be excluded from participation in a Medicare program.

ii. Ongoing monitoring of license sanctions or limitations and Medicare and Medi-Cal is also conducted monthly through provider participation in the NPDB continuous query process.

iii. Applicants are Medi-Cal and Medicare certified at the time of re-credentialing with enrollment maintained on an annual basis. If during ongoing monitoring it is found that a provider has been convicted of a criminal felony or of any criminal misdemeanor relating to the practice of a medical profession, other health care related matters, third-party reimbursement, controlled substances violations, child/adult abuse charges, or any other matter that, in the opinion of the Plan, would adversely affect the ability of the provider to participate in the Plan, the findings will be presented to the CC for termination.

iv. The Credentialing Manager and Credentialing Specialists, also subscribes to the Medical Board of California License Alerts and upon notification, providers whose license has been suspended or restricted will be reviewed during the CC meeting for termination, as the provider is no longer meeting the contractual requirement of an unrestricted license to.

e. Complaints and Adverse Events: BHSD investigates provider-specific complaints from members and BHSD clients upon receipt.

    i. The evaluation includes the specific complaint and the provider's history of issues, as appropriate. Based on the severity and the number of complaints, the provider is reviewed by the CC for appropriate action.

f. Adverse actions (an injury that occurs while a Plan member or BHSD client is receiving health care services from a provider) are reviewed upon receipt by the Plan Chief Medical Officer and may be brought to the CC if the complaint is determined to be a validated quality concern. Providers who contract with an additional group or has an additional affiliation, will not require recredentialing prior to signing a new contract.

    1. Providers who do not return their recredentialing application within the required timeframe to recredential them within 36 months will be sent to the CC for termination.

    2. Inability to score the required 90% or greater on an office site visit as a result of a complaint.

    1 Failure to meet or maintain minimum qualification criteria or additional criteria established by the Plan. Responses to verification of education, license, sanctions, malpractice coverage, or other qualifications that do not meet minimum standards. Should the provider be a PCP, the PCP's member assignment panel will be closed to new membership until the CC has an opportunity to review file.

2 If a provider does not maintain a valid, current, unrestricted license, the provider does not meet criteria based on the following:

a Providers who have been convicted of a criminal felony or of any criminal misdemeanor relating to the practice of a medical profession, other health care related matters, third-party reimbursement, controlled substances violations, child/adult abuse charges, or any other matter that, in the opinion of the Plan, would adversely affect the ability of the provider to participate in the Plan.

b Providers who have had medical staff appointment or clinical privileges denied, revoked, or terminated by any health care facility.

c At any time during the five-year period preceding the date of the provider's initial application, more than two legal actions have been commenced and the aggregate amount of the resulting judgments and/or settlement resulted in judgments and/or settlements were $100,000 or more.

d At any time during the three-year period preceding the date of the provider's application for re-credentialing, three or more legal actions resulted in judgements and/or settlements above the limits as stated above.

e Failure to provide professional services of acceptable quality as determined by the BHSD to meet criteria as specified in the policy.

f Repeated failure to follow Plan or the BHSD' utilization review policies.

g Repeated failure to follow or comply with the BHSD's quality of care standards.

h Failure to meet the standards and provisions of the relevant Provider Agreement.

i Provider suspension/termination from any government agency, including Medicare or Medicaid/Medi-Cal.

3. Notification is promptly made to the provider by Plan's Chief Medical Officer or designee, via certified mail, regarding all actions made by the Plan that constitute grounds for a hearing.

3. The notice of action includes the action being proposed, the effective date of the action, a statement of reasons for the proposed action, notice that the provider has a right to request a hearing with the CC within 30 calendar days, and a summary of the provider's rights in the hearing.

a. Plan's Chief Medical Officer will report notification of action to the appropriate Board of California, National Practitioner Data Bank, and contracted health plans, pursuant to Business and Professions Code Section 805, as well as filing an 805.01 form, Health Facility/Peer Review Reporting Form, to the Medical Board of California within 15 business days.

1. Providers may file an appeal for a hearing regarding the committee's action of denial, termination, sanction, or reduction of participation when the cause of the action is related to clinical competency or professional conduct. Providers appealing a decision by the CC must submit documentation regarding the appeal within 15 business days.

1. Grounds for hearing

   a. Except as otherwise specified in this Credentialing Policy, any one or more of the following actions or recommended actions shall constitute grounds for a hearing:

      i. Involuntary termination of the provider's ability to treat BHSD's members as a participating provider when the reason is due to a disciplinary action or due to reasons of clinical competency or professional conduct.

      ii. Involuntary termination of the provider's Services Agreement with BHSD when the reason is due to a disciplinary action or due to reasons of clinical competency or professional conduct.

      iii. Denial of a provider's application to become a participating provider with BHSD when the denial is based upon disciplinary reasons or based on reasons of clinical competency or professional conduct.

   b. The provider must exhaust the remedies afforded by the Credentialing Policy and CC Hearing Policy before resorting to arbitration action. Otherwise, the provider shall have waived the hearing and appeal rights of the Plan and shall have to accept the recommendation or action involved.

2. Request for hearing

   a. The provider has 30 days from the date of receipt of notification of action in which to request a hearing by the CC. The request must be received in writing, addressed to the Chief Medical Officer or designee, and include the rationale and supporting documentation for the hearing. The Chief Medical Officer and/or designee will coordinate all notifications, arrangements, and requests related to the hearing process. The date of the hearing will not be less than 30 days and not more than 60 days from the date of original notification of action to the provider.

   b. The provider will be notified by mail of the date and time of the hearing. The hearing notification will include the following: a list of any witnesses expected to testify on behalf of the Plan at the hearing and a statement of the provider's rights in the hearing process.

   c. The provider's rights in the hearing process are:

i. A practitioner shall have the option of being represented by an attorney at the licentiate's expense. No peer review body shall be represented by an attorney if the licentiate is not so represented.

ii. Generation of a record of the proceeding, copies of which may be obtained by the provider upon payment of any reasonable charges associated with their preparation.

iii. Submission of a written statement at the close of the hearing.

d. The provider will be notified that failure of the provider to appear at the hearing, without good cause, forfeits their rights to the hearing and the action shall become effective immediately. In the event the provider does not request a hearing as required within the 30-day time period, they will be deemed to have accepted the action involved and it will become effective immediately.

8. Reporting and fair procedure rights

a. If, because of the approval or re-approval action taken pursuant to this policy and procedure, a provider's status as a participating provider is denied, suspended, restricted, or terminated for a medical practice disciplinary cause or reason, a report will be filed within 15 days, and/or as required by applicable law, including California Business & Professions Code 805 and 805.01 and Health Care Quality Improvement Act.

b. If an approval or re-approval action pursuant to this policy and procedure results in a report to the relevant licensing agency pursuant to California Business and Professions Code Section 805 and 805.01, the provider shall be offered a notice of hearing rights in compliance with California Business and Professions Code Section 809 et.seq.

E. Maintenance of Files, Confidentiality and Secure Systems

1. An electronic record will be maintained for each provider including the application and any additional documentation related to the provider's participation. The checklist will include the identity of the individual verifying all credentialing information and the date of the verification.

   A credentialing and provider participation status will be maintained and used to store the specific provider demographic information utilized by BHSD to prepare directories and reporting.

   a. Access to Credentials files

      i. Credentials files and quality files are maintained and protected under state law protecting such records from discovery.

      ii. Persons within the organization, including specified officers, employees, and agents, may access credential and quality files in the course and scope of their duties for or on behalf of the organization to the extent necessary to

perform those duties. Such persons include by way of example the Chief Medical Officer, or designee, CC and the Plan's Credentialing Staff.

iii. A provider or their authorized representative may review his or her own credentials or quality file subject to applicable law and policies and procedures governing access to confidential and privileged information.

iv. Persons outside the organization, including accreditation bodies and authorized representatives of State and Federal agencies, may access credentials and quality files to the extent and in the manner expressly authorized by applicable law and/or contract.

v. The Plan's Credentialing Manager shall determine, in consultation with legal counsel, whether law and/or contract authorizes the access requested.

b. Confidentiality

i. Credentialing files and quality files are maintained as protected under state law protecting such records from discovery.

ii. Plan will maintain all provider files within a locked secure environment. All provider files, including the computer database, shall be considered confidential. Only the Credentialing staff will be allowed access to modify Credentialing files and/or records. For example, if the provider has an update to their license, like expiration dates, type of hospital privileges or is no longer board certified, the Credentialing Specialist will verify these changes and if necessary, delete the previous verification from the database since it no longer applies to the provider or add a new date if the expiration has changed.

iii. The Credentialing Manager, Credentialing Supervisor and Credentialing Specialists may access credentialing files and/or the credentialing database, in the course and scope of their duties for or on behalf of the organization to the extent necessary to perform those duties. When not in use, the computers are locked so confidential information is not accessible.

iv. All discussions and decisions made by the CC will be kept confidential.

v. To ensure this, the sign-in-sheet has a statement which includes all materials and discussions from the meeting are to be treated as confidential and peer review.

c. Secure Systems Control and Passwords:

1 An electronic checklist is used as a guide for documenting primary source verifications and other credentialing requirements and the Credentialing Specialist assigned to the file will electronically sign and date the checklist for tracking. Verifications, including NPDB, BreEZe for licensing verifications, OIG, and SAMS, are conducted on the appropriate site through VHP's secured network. The Credentialing Specialists will review and verify the required elements and electronically sign and date each document. Files are created in

Adobe Acrobat as pdf files and stored on a secure SharePoint site in alphabetical order and date for tracking. Only the Credentialing Specialists and the Credentialing Manager have access or are authorized to delete information or make modifications to files, which are stored in a secure folder on the SharePoint site.

2 When the Credentialing Specialists must modify information in the provider's file, because of a discrepancy, update to expired verifications or the applicant submits changes, the modifications are tracked on the checklist and notes, including e-mail messages, with date, time and who made the modification are kept in the correspondence section at the end of the credentialing file.

Regarding electronic systems, VHP follows all system requirements as required by the County of Santa Clara which includes the following: Password-protecting electronic systems including user requirements to use strong passwords, avoid writing down passwords, using unique passwords for different accounts, and changing passwords periodically.

It also includes policies on changing or withdrawing passwords, including alerting appropriate staff who oversee computer security to change passwords when appropriate, and disabling or remove passwords of employees who leave the organization.

An electronic checklist is used as a guide for verifying primary source verification and checking other sources while entering an electronic signature of the Credentialing Specialist assigned to the provider's file. The Credentialing Specialists verify the required elements and electronically sign and dates each document. Files are created in Adobe Acrobat as pdf files and stored on a secure SharePoint site in alphabetical order and date for tracking.

Electronic credentialing files are stored on a secure SharePoint site, with access only given to Credentialing staff. To prevent unauthorized access, changes and release of information, the Credentialing Manager will submit a service desk ticket request to Technology Services and Solutions (TSS) to grant or remove access.

C. Credentialing Process Audit

1. The Credentialing Manager and the Credentialing Supervisor will conduct a random audit of ten percent of all completed credentialing files prior to the monthly CC. This audit will include a review of PSV information received, dated, and stored; verification of modified and/or deleted information and the staff authorized to review, modify, and delete information which will verify current Systems Controls policies are being followed and will assure accuracy and compliance with VHP's credentialing policies prior to submission to the CC.

2. Compliance with these policies is spot-checked with a policy checklist and a sampling of at least five percent of relevant credentialing files for that year are reviewed by VHP's Compliance Department.

3. VHP utilizes the Health Industry Collaborative Effort (HICE) or similar industry best practice tool for the initial and recredentialing audit processes

VI. REFERENCES

N/A

VII. APPROVED/REVISION HISTORY

Original Effective Date:	11/2023	**Last Reviewed or Revised Date:**	
Approved By Manager:	Rhonda Bibbins	**Title: Credentialing Manager**	
Manager Signature:		**Date:**	
Approved By Department Executive:		**Title:**	
Department Executive Signature:		**Date:**	
Committee Reviewed By (if applicable):	☐ UM ☐ P&T ☐ QIC ☐Compliance ☒ __Credentialing__________ ☐ N/A	**Approved Date:**	
Committee Chair Name			