Department of Public Health
Office of Compliance & Privacy Affairs (OCPA)

Behavioral Health Compliance Office

Compliance Corner

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COMPLIANCE SPECIAL EDITION

Credentialing Policy

City and County of San Francisco

London Breed, Mayor

Grant Colfax, MD, Director of Health

Maggie Rykowski, Director & Chief Integrity Officer, Office of Compliance & Privacy Affairs

San Francisco Department of Public Health
Office of Compliance & Privacy Affairs
Behavioral Health Compliance Office

San Francisco Department of Public Health

Policy & Procedure Detail*

Policy & Procedure Title: Behavioral Health Services Compliance Office – Credentialing	
Category: Compliance	
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DPH Unit of Origin: Office of Compliance and Privacy Affairs (OCPA), Behavioral Health Compliance Office	
Policy Contact - Employee Name and Title; approver, and DPH Division/Unit: *Chona Peralta, LCSW, Compliance Officer, OCPA Behavioral Health Compliance Office*	
Contact Phone Number(s): *415-255-3706*	
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All sections in table required.

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.
We shall ~ Assess and research the health of the Community ~ Develop and enforce health policy ~ Prevent disease and injury ~
~Educate the public and train health care providers ~ Provide quality, comprehensive, culturally-proficient health services ~ Ensure equal access to all ~

PURPOSE

The purpose of this policy is to establish provider credentialing and re-credentialing requirements and standards for the San Francisco Behavioral Health Services Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) programs, established pursuant to the Department of Health Care Services (DHCS) MHSUDS Information Notice (MHSUDS IN) # 18-019, Title 42 of the Code of Federal Regulations, Part 438.214.

DESCRIPTION AND BACKGROUND

The Office of Compliance and Privacy Affairs (OCPA) Behavioral Health Compliance Office (BHCO) is mandated to protect the integrity of the Department of Public Health (DPH), Behavioral Health Services (BHS) program, as well as the health and welfare of the beneficiaries of those programs. These duties are carried out through Verifications, Credentialing, audits, investigations, and monitoring.

On May 6, 2016, The Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Final Rule), which aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. The SF BHS MHP and DMC-ODS are considered Prepaid Inpatient Health Plans, and must therefore comply with federal managed care requirements, with some exceptions.[1]

On March 30, 2016, CMS issued the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule) in the Federal Register (81 Federal Regulations 18390) to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. The Parity Rule aligned certain protections required of health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program.

The Managed Care Final Rule[2] requires DHCS to mandate County MHPs to establish a uniform credentialing and re-credentialing policy that addresses County Behavioral Health Services for Mental Health and Substance Use Disorder services providers.

The credentialing process is one component of the comprehensive compliance and quality improvement system included in all DHCS Mental Health Plan contracts. The credentialing process may include registration, certification, licensure, and/or professional association membership. Credentialing ensures that providers are licensed, registered, waivered, and/or certified as required by state and federal law.

REQUIREMENTS

OCPA BHCO Credentialing Unit must ensure that each of the DPH BHS providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, registered, waivered, and/or certified.[3] These providers must be in good standing with the Medicare, Medicaid/Medi-Cal programs and appropriate licensing boards.

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[1] DHCS MHSUDS IN # 18-019

[2] 42 CFR §438.214

[3] State Plan, Section 3, Supplement 3 to Attachment 3.1-A

Any provider excluded from participation in Federal Health Care programs, including Medicare and/or Medicaid/Medi-Cal and/or appropriate licensing board, may not participate in the Behavioral Health Services MHP and DMC-ODS programs. These includes all county-owned and operated providers (civil service providers) and contracted organizational providers, provider groups (Community Based Organizations (CBOs) contracted by BHS) and individual practitioners (Private Provider Network also known as the PPN).

Credentialing and re-credentialing requirements apply to all licensed, waivered, or registered mental health providers and licensed, registered, or certified substance use disorder services providers[4] employed by or contracting with the City & County of San Francisco, DPH, Behavioral Health Services, to deliver Medicare and/or Medi-Cal covered services. For Substance Use Disorder, per DMC ODS WAIVER, credentialing and re-credentialing requirements includes Pharmacists.

For Specialty Mental Health definition of Licensed Provider of the Healing Arts include MD/DO, NP, Licensed/Waivered Psychologist, ASW, LCSW, AMFT, LMFT, APCC, and LPCC.

As for the DMC ODS Waiver, definition of Licensed Provider of the Healing Arts include MD/DO, NP. PA, RN, Registered Pharmacists, Licensed/Waivered Psychologist, ASW, LCSW, AMFT, LMFT, APCC, and LPCC. In addition, per DHCS MH SUD IN # 18-019, all Registered and Certified Substance Use Counselor will be credentialed and re-credentialed.

CREDENTIALING

For all licensed, waivered, registered and/or certified providers[5], the OCPA BHCO Credentialing Unit must verify and document the following items through a primary source[6], as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the OCPA BHCO Credentialing Unit, unless OCPA BHCO 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, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of Completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type. Each provider must sign and date a statement attesting to the fact that they have completed the applicable continuing education requirements.

[4] Applicable provider types include licensed, registered, or waivered mental health providers, licensed practitioners of the healing arts, and registered or certified Alcohol or other Drug counselors.

[5] For SUD providers delivering covered services are defined in Title 22 of the California Code of Regulations, §51051.

[6] "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.

In addition, as part of the DHCS Credentialing mandate (DHCS MHSUDS IN # 18-019, dated 4/24/2018), OCPA BHCO Credentialing Unit must verify and document the following information from each licensed, registered, waivered and/or certified provider, as applicable, but need not verify this information through a primary source:

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National Provider Identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
9. 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 Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

ATTESTATIONS

For all licensed, registered, waivered, and/or certified providers who deliver covered services, each provider's application to work for the SF MHP or contract with the SF MHP must include three (3) ATTESTATIONS. These ATTESTATIONS must be signed and dated.

A. **Provider Agreement and Disclosure** attestation in that all information provided is true, accurate and complete, and that failure to disclose required information or disclosure of false information or misrepresentation shall result in denial of the application for credentialing, and/or may be grounds for cessation of privileges, clinical participation and billing and/or possible termination.

B. ATTESTATION to the satisfaction of any applicable **continuing education** requirements, as required for the particular provider type.

C. **ATTESTATION** 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[7];

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

2. A history of loss of license or felony conviction[8];
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The applications' accuracy and completeness.

PROVIDER RE-CREDENTIALING

DHCS requires that SF MHP through the OCPA BHCO Credentialing Unit verify and document at a minimum every three (3) years that each licensed, registered, waivered, and/or certified provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. It must be required that each licensed, registered, waivered, and/or certified provider to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation for CEUs, and a new signed attestation for:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation[9];
2. A history of loss of license or felony conviction[10];
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The applications' accuracy and completeness.

In addition, to the initial credentialing requirements, re-credentialing should include documentation of information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

CREDENTIALING COMMITTEE

The Credentialing Committee shall be a confidential multidisciplinary body of professional peers. All members shall be licensed in their respective discipline and be in good standing with their respective licensing boards.

All Credentialing Committee members are charged to act in good faith, ethically, respectfully responsibly, and confidentially in the performance of their committee duties.
The Credentialing Committee shall consist of a psychiatrist, a psychologist, LCSW, LMFT or LPCC, and a Certified Substance Use Provider. Effort shall be made to obtain a mix of expertise in both child and adult populations.
In line with the City & County of San Francisco's commitment to cultural competence in all areas, due consideration shall be given to diversity of membership within the above membership criteria.

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[8] A felony conviction does not automatically exclude a provider from participation in the SF MHP. However, in accordance with 42 C.F.R. §§ 438.214(d), 438610(a) and (b), and 438.808(b), SF MHP 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.

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

[10] A felony conviction does not automatically exclude a provider from participation in the SF MHP. However, in accordance with 42 C.F.R. §§ 438.214(d), 438610(a) and (b), and 438.808(b), SF MHP 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.

The Credentialing Committee is the review and formal decision-making authority for approving/disapproving Credentialing and Re-Credentialing. This committee shall review all recommendations for action in credentialing/re-credentialing matters, appeals and make decisions for final proposed actions.

Credentialing Committee meetings shall occur as often as needed, but at least every three (3) months.
OCPA BHCO Credentialing Unit may convene a meeting any time if there is at least one (1) application awaiting action. In no case however, shall an application wait longer than 30 days from date of completion of all necessary verifications for the Credentialing Committee review. Meetings shall also occur whenever there is need for timely action in any matter of appeal.

Three (3) members of the Credentialing Committee shall constitute a quorum. An applicant or provider's application will not be reviewed unless there is at least one (1) Credentialing member with the identical license/certification present.

Credentialing Committee actions shall be by majority vote. All Committee members will be provided opportunity to review the actual application in its entirety prior to voting. Voting may be by a show of hands or orally by individual.

When the Committee has made a decision on their recommendation to approve credentialing/re-credentialing, OCPA BHCO Credentialing Unit will send a letter to the provider notifying them of this decision.

When the Committee has made a decision on their recommendation to disapprove credentialing/re-credentialing, OCPA BHCO Credentialing Unit will send a letter to the provider notifying and explaining them of the decision. Information on how the applicant may appeal the decision will be included.

Minutes of all Credentialing Committee meetings shall be kept and reviewed at successive meetings. Minutes are confidential and shall have a limited distribution.

APPEAL PROCESS

When Credentialing/re-credentialing has been denied by the Committee, the applicant/provider will be given written notice of the proposed action, and the applicant/provider's right to request an appeal. The notice to the applicant/provider will state:

1. What action has been proposed against the applicant/provider
2. A brief description of the reason(s) for the proposed action
3. The applicant/provider has the right to request an appeal in writing within thirty (30) calendar days of the date on the notice
4. A brief summary of the applicant/provider's right for an appeal.

The applicant/provider shall have thirty (30) calendar days of the date of the notice of the denial of the credentialing/re-credentialing to request an appeal in writing. The appeal must be submitted to the OCPA BHCO Compliance Officer, currently at 1380 Howard St., 4th floor, San Francisco, CA 94103.
If the applicant/provider does not request an appeal within the time and manner prescribed, the provider will be deemed to have accepted the recommendation, decision, or action involved, and the decision may be adopted as the

final action for Credentialing/Re-Credentialing.
Upon receiving a request for an appeal, both the BHO Compliance Officer and the Director of Behavioral Health Services will proceed with mechanisms to ensure a fair review of the appeal process.

ACTIONS/CONSEQUENCES

Payments for any item or services furnished by a provider who is excluded, terminated, or suspended from participating in the Medicare/Medicaid program is prohibited.[11] Since the City & County of San Francisco (CCSF), Department of Public Health (DPH), Behavioral Health Services (BHS), receives Federal and State Funding, an excluded individual that submits a claim for reimbursement or causes a claim to be submitted may be subject to $10,000 for each item or service furnished during the period that the individual was excluded. The excluded individual may also be subject to treble damages for the amount claimed for each item or service. In addition, since reinstatement into the programs is not automatic, the excluded individual may jeopardize future[i] reinstatement into Federal Health Care Programs.[12] This action may be a Federal and/or State reportable and/or the appropriate Licensing Boards.

A. DPH BHS Employees (civil service employees):

If a DPH, BHS employee's name is identified as an excluded individual, the Office of Compliance & Privacy Affairs (OCPA), Behavioral Health Compliance Office (BHCO) Credentialing Unit, shall first validate the identity of the individual and do further investigation confirming the exclusion status of the employee. OCPA/BHCO shall follow up on any appropriate actions related to the employee, including notification to his/her supervisor(s), OCPA BHCO Compliance Officer, BH Director, and BH System of Care (SOC) Director, OCPA Chief Integrity Officer, and DPH Human Resources (HR). The excluded employee will be deactivated from the Electronic Health Record to prevent further billing. OCPA BHCO will recommend to DPH HR that they will need to inform the excluded employee to leave the premises, and/or to terminate employment. This action may be a Federal and/or State reportable.

If a DPH BHS employee's name is identified as a provider that is not in good standing with their licensure/certification (i.e. expired, suspended, revoked), OCPA BHS Credentialing Unit shall first validate the identity of the individual and do further investigation confirming the licensing/certification status of the employee. OCPA/BHCO shall follow up on any appropriate actions related to the employee, including notification to his/her supervisor(s), OCPA BHCO Compliance Officer, BH Director, and BH System of Care (SOC) Director, OCPA Chief Integrity Officer, and DPH Human Resources (HR). The employee, who is not in good standing with their licensure/certification, will not be allowed to provide services under the licensing/certification scope of practice and will be deactivated from the Electronic Health Record to prevent further billing. This action may be a Licensing Board reportable.

Furthermore, OCPA BHCO will conduct further investigation to determine whether DPH may have received any inappropriate payments for healthcare services from the federal or state government associated with the excluded individual's employment or from the employee who has their license expired, suspended or revoked. Any inappropriate payments shall be returned promptly to the appropriate government agency.

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[11] Title 42, Code of Federal Regulations, §1002.211; Title 42, US Code, §13396a(a)

[12] 42 CFR 1001.3002

B. DPH BHS Contractors and Agents:

If the DPH BHS contractor or agent finds that one of their employees is on the exclusion list, the contractor or agency shall notify the DPH OCPA BHCO Credentialing Unit within 2 business days. Notification to DPH OCPA BHCA Credentialing Unit shall include the individual's name, any information needed to positively identify the individual against the exclusion list, the date of the individual's employment and steps taken to ensure the individual is no longer providing services to DPH. This action may be a Federal and/or State reportable.

If a DPH BHS contractor or agent finds that one of their employees is not in good standing with their licensure/certification (i.e. expired, suspended, revoked), the contractor or agency shall notify the DPH OCPA BHCO Credentialing Unit within 2 business days. Notification to DPH OCPA BHCA Credentialing Unit shall include the individual's name, any information needed to positively identify the individual against the State of California Licensing Board(s), the date of the individual's employment and steps taken to ensure the individual is no longer providing services to DPH. This action may be a Licensing Board reportable.

OCPA BHCO will conduct further investigation to determine whether DPH may have received any inappropriate payments for healthcare services from the federal or state government associated with the excluded individual's employment or from the employee who has their license expired, suspended or revoked. Any inappropriate payments shall be returned promptly to the appropriate government agency, i.e. DPH returns funds to State Department of Health Care Services (DHCS) and/or Centers for Medicare/Medicaid Services (CMS). Contractor/Agency will pay back DPH for funds returned to DHCS and/or CMS, including any other fees that DHCS and/or CMS enforces to DPH.

CONFIDENTIALITY

All credentialing information, records, proceedings, deliberations, and related activities and information shall be confidential. Disclosure of such proceedings and records shall be made only as required by law, or as needed to fulfill the credentialing activities within the scope of this policy. Reports to the relevant licensing boards shall be made as required by Business and Professions Code, Section 805, without waiver of confidentiality.[13]

The following Release of Information will also be required:

- Release of Malpractice Insurance and/or Claims Information.
  This applies to **all** Contractors of Behavioral Health Services.
  NOTE: The City & County of San Francisco self-insures all its employees on malpractice insurance.
  To find more information on this, please contact:
  City & County of San Francisco,
  Office of the City Administrator
  Risk Management
  (415) 554-2300
  Email: risk.management@sfgov.org
- Residency Release Form (for **all** MDs and D

[13] CA Business & Professions Code. §800-8090.9
W&I Code, §4070 Evidence Code, §1157
Social Security Act, §1128 & 1156
CCR, Title 9. §1810.435

DHCS INFORMATION NOTICE

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: April 24, 2018

MHSUDS INFORMATION NOTICE NO.: 18-019

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: PROVIDER CREDENTIALING AND RE-CREDENTIALING FOR MENTAL HEALTH PLANS (MHPs) AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) PILOT COUNTIES

PURPOSE

The purpose of this Mental Health and Substance Use Disorders Services Information Notice (IN) is to inform county Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) pilot counties, herein referred to as Plans unless otherwise specified, of the Department of Health Care Services' (DHCS) statewide uniform provider credentialing and re-credentialing requirements, established pursuant to Title 42 of the Code of Federal Regulations, Part 438.214.

BACKGROUND

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Final Rule), which aimed to align Medicaid managed care

regulations with requirements of other major sources of coverage. County MHPs and DMC-ODS pilot counties are considered Prepaid Inpatient Health Plans, and must therefore comply with federal managed care requirements (with some exceptions).

This IN also includes policy changes DHCS has made for compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule).

On March 30, 2016, CMS issued the Parity Rule in the Federal Register (81.Fed.Reg. 18390) to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program.

The Managed Care Final Rule[1] requires the State to establish a uniform credentialing and re-credentialing policy that addresses behavioral health and substance use disorder services providers.

The credentialing process is one component of the comprehensive quality improvement system included in all Plan contracts. The credentialing process may include registration, certification, licensure, and/or professional association membership. Credentialing ensures that providers are licensed, registered, waivered, and/or certified as required by state and federal law.

REQUIREMENTS

Plans must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, registered, waivered, and/or certified.[2] 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 any Plan's provider network. For the purposes of this IN, network providers include county-owned and operated providers (i.e., MHP employees) and contracted organizational providers, provider groups, and individual practitioners.

The uniform credentialing and re-credentialing requirements in this IN apply to all licensed, waivered, or registered mental health providers and licensed substance use disorder services providers[3] employed by or contracting with the Plan to deliver Medi-Cal covered services. Effective immediately, Plans must implement and maintain written policies and procedures for the initial credentialing and re-credentialing of their providers in accordance with the policy outlined in this IN.

CREDENTIALING POLICY

For all licensed, waivered, registered and/or certified providers[4], the Plan must verify and document the following items through a primary source,[5] as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the Plan unless the Plan 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, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition, Plans must verify and document the following information from each network provider, as applicable, but need not verify this information through a primary source:

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National Provider Identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
9. 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 Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

ATTESTATION

For all network providers who deliver covered services, each provider's application to contract with the Plan must include a signed and dated 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[6];
2. A history of loss of license or felony conviction;[7]
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and

5. The application's accuracy and completeness.

PROVIDER RE-CREDENTIALING

DHCS requires each Plan to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. The Plan must require each provider to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition to the initial credentialing requirements, re-credentialing should include documentation that the Plan has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

PROVIDER CREDENTIALING AND RE-CREDENTIALING PROCEDURES

A Plan may delegate its authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the Plan remains contractually responsible for the completeness and accuracy of these activities. If the Plan delegates credential verification activities to a subcontractor, it shall establish a formal and detailed agreement with the entity performing those activities. To ensure accountability for these activities, the Plan must establish a system that:

- Evaluates the subcontractor's ability to perform these activities and includes an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;
- Ensures that the subcontractor meets the Plan's and DHCS's standards; and
- Continuously monitors, evaluates, and approves the delegated functions.

Plans are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations and other contract requirements as well as DHCS guidance, including applicable INs.

Each Plan must maintain a system for reporting serious quality deficiencies that result in suspension or termination of a provider to DHCS, and other authorities as appropriate. Each Plan must maintain policies and procedures for disciplinary actions, including reducing, suspending, or terminating a provider's privileges. Plans must implement and maintain a process by which providers may appeal credentialing decisions, including decisions to deny a provider's credentialing application, or suspend or terminate a provider's previously approved credentialing approval.

If you have any questions regarding this IN, please contact the Mental Health Services Division at (916) 322-7445 or MHSDFinalRule@dhcs.ca.gov or the Substance Use Disorder Program, Policy and Fiscal Division at (916) 327-8608 or DMCODSWaiver@dhcs.ca.gov.

Sincerely,

Original signed by

Brenda Grealish,

Acting Deputy Director

Mental Health & Substance Use Disorder Services

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[1] DHCS MHSUDS IN # 18-019

[2] 42 CFR §438.214

[3] State Plan, Section 3, Supplement 3 to Attachment 3.1-A

[4] Applicable provider types include licensed, registered, or waivered mental health providers, licensed practitioners of the healing arts, and registered or certified Alcohol or other Drug counselors.

[5] For SUD providers delivering covered services are defined in Title 22 of the California Code of Regulations, §51051.

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

[8] A felony conviction does not automatically exclude a provider from participation in the SF MHP. However, in accordance with 42 C.F.R. §§ 438.214(d), 438610(a) and (b), and 438.808(b), SF MHP 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.

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[11] 1 Title 42, Code of Federal Regulations, §1002.211; Title 42, US Code, §13396a(a)

[12] 42 CFR 1001.3002

[13] CA Business & Professions Code. §800-8090.9

[14] W&I Code, §4070 Evidence Code, §115

Link to Prior Newsletters: https://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/