

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



MICHELLE BAASS
DIRECTOR



GAVIN NEWSOM
GOVERNOR

DATE: July 19, 2022

ALL PLAN LETTER 22-013
SUPERSEDES ALL PLAN LETTER 19-004

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RE-CREDENTIALING AND
SCREENING / ENROLLMENT

PURPOSE:

The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all Network Providers pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438 and Part 455 (Subparts B and E).^{1, 2} This APL also outlines MCPs' contractual obligations related to credentialing and re-credentialing as required in Title 42 of the CFR, Section 438.214. The screening and enrollment responsibilities are located in Part 1 of this APL and the credentialing and re-credentialing responsibilities are located in Part 2. Additionally, this APL clarifies an MCP's responsibility to monitor the enrollment status of Network Providers, as well as the notification and approval requirements when the MCP develops and implements its own managed care provider screening and enrollment process. This APL supersedes APL 19-004.³

BACKGROUND:

On February 2, 2011, the Centers for Medicare and Medicaid Services (CMS) issued rulemaking CMS-6028-FC to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act.⁴ The intent of Title 42 of the CFR, Part 455, Subparts B and E is to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification. The CMS Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F, dated May 6, 2016, extended the provider screening and enrollment requirements of Title 42 of the CFR, Part 455, Subparts B and

¹ The CFR is searchable at: <https://www.ecfr.gov/>.

² "Network Provider" is defined in 42 CFR, Section 438.2.

³ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

⁴ CMS-6028-FC is available at: <https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf>.

E to MCP Network Providers.⁵ These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

MCPs are required to maintain contracts with their Network Providers (Network Provider Agreement) and perform credentialing and re-credentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' Network Providers were not required to enroll in the Medi-Cal program. Title 42 of the CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all Network Providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, aligning with the FFS enrollment requirements described in Title 42 of the CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting Network Providers as well as prospective Network Providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards. The Medi-Cal managed care program and MCPs must comply with statewide Medi-Cal FFS enrollment standards and federal enrollment standards when verifying enrollment of providers through a state-level enrollment pathway or developing a provider enrollment pathway.⁶ The 21st Century Cures Act (Cures Act) required managed care Network Provider enrollment to be implemented by January 1, 2018.⁷

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and re-credentialing processes. The credentialing and re-credentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.⁸ Credentialing is defined as the recognition of professional or technical competence.⁹ The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

POLICY:

⁵ CMS-2390-F is available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.

⁶ Welfare and Institutions Code (WIC), Sections 14043 through 14045. State law is searchable at: <https://leginfo.legislature.ca.gov/faces/codes.xhtml>.

⁷ Title 42 of the United States Code (USC), Section 1396u-2(d)(6)(A). The USC is searchable at: <http://uscode.house.gov/>.

⁸ MCP Contract, Exhibit A, Attachment 4, Credentialing and Re-credentialing. MCP contracts are available at: <https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>

⁹ MCP Contract, Exhibit A, Attachment 1, Definitions.

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCP Network Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program.^{10, 11} State-level enrollment pathways are available either through the Department of Health Care Services' (DHCS) Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.¹² MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or MCPs may direct their Network Providers to enroll through a state-level enrollment pathway. DHCS' PED is the primary developer of state-level enrollment pathways for FFS providers. If an MCP chooses to enroll a provider type into their network that does not have an enrollment pathway through PED, DHCS will recognize all other state-level enrollment pathways.

MCPs may screen and enroll Network Providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers.¹³ A PED approval letter is also an acceptable form of initial enrollment verification. MCPs are required to issue Network Providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through a state-level enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP cannot participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through a state-level enrollment pathway. For providers who are

¹⁰ "Network provider" is defined in 42 CFR, Section 438.2.

¹¹ More information on Network Provider status is available in APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status.

¹² For a complete list of state-level enrollment pathways, refer to the Provider Enrollment Options webpage, available at: <https://www.dhcs.ca.gov/provgovpart/Pages/Provider-Enrollment-Options.aspx>.

¹³ The CHHS Open Data Portal can be found at: <https://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider>

typically required to enroll but are restricted due to a moratorium, MCPs must develop their own enrollment pathway if the MCP chooses to include them in their network.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis. Additionally, pursuant to the July 24, 2018, CMS Medicaid Provider Enrollment Compendium (MPEC), MCPs are no longer required to enroll providers that do not have a state-level enrollment pathway.¹⁴ Additionally, DHCS will only process provider applications that have a state-level enrollment pathway established by DHCS' PED; therefore, applications submitted to DHCS from providers who do not have a state-level enrollment pathway through PED will be denied.¹⁵ MCPs that choose to enroll these providers must do so through their own established enrollment process, through the recognized enrollment process developed by another MCP, or, if applicable, through a state-level enrollment pathway established by another state department.

Requirements for MCPs Electing to Screen and Enroll their Providers

Processing Timeframes for Screening and Enrollment

Pursuant to DHCS policy, if an MCP elects to screen and enroll its providers, the MCP must complete the process and provide the applicant with a written determination on MCP letterhead within 120 calendar days of its receipt of a provider application (while state law allows DHCS up to 180 calendar days to act on an enrollment application if the provider applies directly to DHCS).¹⁶ The MCP must submit a list of its newly enrolled providers to DHCS every six months to their DHCS Managed Care Operations Division (MCO) contract manager.

Network Provider Contracts with Pending Providers

MCPs may allow providers to participate in their networks for up to 120 calendar days if the provider has a pending enrollment application in review with either DHCS' PED or with the MCP, if the MCP conducts its own screening and enrollment.¹⁷ However, the MCP must terminate its contract with the provider no later than 15 calendar days of the provider receiving notification from DHCS that the provider has been denied enrollment

¹⁴ The MPEC is available at: <https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf>.

¹⁵ More information on PED's enrollment process and pathways is available at: <https://www.dhcs.ca.gov/provgovpart/pages/pave.aspx>.

¹⁶ WIC Section 14043.26.

¹⁷ 42 CFR Section 438.602(b)(2).

in the Medi-Cal program, or upon the expiration of the first 120-day period.^{18, 19, 20} MCPs cannot continue to contract with providers during the period in which the provider resubmits its enrollment application to DHCS or the MCP, and can only re-initiate a contract upon the provider's successful enrollment as a Medi-Cal provider. If the MCP termination will impact Member access, the MCP must notify DHCS prior to terminating the provider and submit a plan of action for continuity of services for review and approval before terminating.

DHCS Notification and Approval

If the MCP elects to develop its own screening and enrollment process, the MCP must notify DHCS and submit its policies and procedures (P&Ps) for approval prior to implementation. The P&Ps must define the scope of their enrollment process if the MCP does not enroll all provider types. The P&Ps must also outline how the MCP will comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.²¹ In addition, MCPs must ensure that every Network Provider application they process is reviewed for both accuracy and completeness. MCPs must ensure that all information specified in Title 22 of the California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments of the application package, are received.²² As part of the application process, the MCP must obtain the provider's consent to allow DHCS and the MCP to share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.

MCPs may collect an application fee, established by CMS from unenrolled prospective Network Providers, to cover the administrative costs of processing a provider's

¹⁸ Denials in enrollment resulting in changes as defined in in CCR 1300.52.4. are subject to DMHC filing requirements under the Knox-Keene Act.

¹⁹ 42 CFR, Section 438.602(b)(2).

²⁰ For more information, see APL 21-003, or any future iterations of this APL.

²¹ Application packages by provider type can be found at the following:

<https://www.dhcs.ca.gov/provgovpart/Pages/ApplicationbyProviderType.aspx>. For associated definitions and provider types, see 22 CCR, Sections 51000 – 51000.26 and 51051.

²² The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>.

screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.²³ Before collecting this fee, the MCP should be certain that the Network Provider is not already enrolled.

B. Medi-Cal Provider Agreement and Network Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state as a condition of participating in the Medi-Cal program.^{24, 25} As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the Medi-Cal Provider Agreement (DHCS Form 6208).²⁶ This provider agreement is separate and distinct from the Network Provider Agreement (see below). MCPs must maintain the original signed Medi-Cal Provider Agreement for each provider. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and location that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Network Provider Agreement) is separate and distinct from the Medi-Cal Provider Agreement. Both the Medi-Cal Provider Agreement and the Network Provider Agreement are required for MCP Network Providers. The Medi-Cal Provider Agreement does not expand or alter the MCP's existing rights or obligations relating to its Network Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42 of the CFR, Sections 455.104, 455.105, and 455.106, and Title 22 of the CCR, Section 51000.35. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information described in Title 42 of the CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42 of the CFR, Section 455.104.

²³ For more information on DHCS' current application fee, see the "Latest News" section of the PED homepage, available at: <https://www.dhcs.ca.gov/provgovpart/pages/ped.aspx>.

²⁴ Social Security Act (SSA), Section 1902(a)(27). SSA, Section 1902 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

²⁵ WIC, Section 14043.1(c).

²⁶ The Medi-Cal Provider Agreement (DHCS Form 6208) is available at: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/provappsenroll/02enrollment_DHCS6208.pdf.

Other relevant forms related to provider agreement requirements are available at: https://files.medi-cal.ca.gov/pubsdoco/prov_enroll.aspx#Forms.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal program. These disclosures must be provided when:

- A prospective provider submits the provider enrollment application.
- A provider executes the Medi-Cal Provider Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 calendar days of any change in ownership of the Network Provider.

Upon MCP request, a Network Provider must submit within 35 calendar days:

- Full and complete information about the ownership of any Subcontractor with whom the Network Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the Network Provider and any wholly owned supplier, or between the provider and any Subcontractor, during the five-year period ending on the date of the request.²⁷

Additionally, MCPs must comply with the requirements contained in Title 22 of the CCR, Section 51000.35. MCPs are not required to utilize the DHCS disclosure forms (DHCS Forms 6207 and 6216); however, MCPs must collect all information and documentation required by Title 22 of the CCR, Section 51000.35.

D. Limited, Moderate, and High Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a Network Provider's reenrollment or revalidation request to determine the provider's categorical risk level as limited, moderate, or high. If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening and for MCPs to stratify their Network Providers by risk level are set forth in Attachment A of this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs must not enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

²⁷ 42 CFR, Section 455.105(b).

Providers are subject to screening based on verification of the following requirements:

Limited-Risk Providers:

- Meet state and federal requirements;
- Hold a license certified for practice in the state and has no limitations from other states; and
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers

- Screening requirements of limited-risk providers; and
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers; and
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.
- The provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.^{28, 29}

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their MCO contract manager.

E. Additional Criteria for High Risk Providers – Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a

²⁸ 42 CFR, Section 455.450(e)(2).

²⁹ WIC, Section 14043.38(b)(4).

high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a 5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.³⁰ In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. MCPs must direct providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website.³¹ MCPs must ensure providers include the correct agency information on the Live Scan form when submitting their application to the California DOJ so their application is processed correctly. The agency-specific information must be included in the appropriate fields as detailed below:

Applicant Submission

Field	Entry
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit <u>OR</u> Working Title	MCMC

Contributing Agency Information

Field	Entry
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or P.O. Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811

³⁰ WIC, Section 14043.38(c).

³¹ The Live Scan form is available on Forms for Applicant Agencies webpage on the DOJ website, available at: <https://oag.ca.gov/fingerprints/forms>.

Contact Telephone Number	(916) 750-1509
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When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider must deliver the completed Live Scan form to the California DOJ. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of the criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22 of the CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.40, 51000.45, and 51000.60. MCPs must conduct post-enrollment site visits for medium-risk Network Providers at least every five years, and their high-risk Network Providers every three years or as necessary. Post-enrollment onsite visits verify that the information submitted to the MCP and DHCS is accurate, and determine if providers are in compliance with state and federal enrollment requirements. In addition, all providers enrolled in the Medi-Cal program, including providers enrolled through MCPs, are subject to unannounced onsite inspections at all provider locations.³²

Onsite visits may be conducted for many reasons including, but not limited to, the following:

- The provider was temporarily suspended from the Medi-Cal program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

³² 42 CFR, Section 455.432.

G. Federal and State Database Checks

During the provider enrollment/reenrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion and/or enrollment status of all providers:³³

- Social Security Administration's Death Master File.³⁴
- National Plan and Provider Enumeration System (NPPES).³⁵
- List of Excluded Individuals/Entities (LEIE).³⁶
- System for Award Management (SAM).³⁷
- CMS' Medicare Exclusion Database (MED).³⁸
- DHCS' Suspended and Ineligible Provider List.³⁹
- Restricted Provider Database (RPD).⁴⁰
- CHHS Open Data Portal.⁴¹

In addition to checking all the databases upon a provider's enrollment/reenrollment, MCPs must also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted providers continue to meet enrollment criteria, and take appropriate action in connection with the exclusion. Each MCP Network Provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the MCP's provider network.

H. Denial or Termination of Enrollment/Appeal Process

³³ 42 CFR, Section 455.436.

³⁴ Information on requesting access to the Social Security Administration's Death Master File is available at: https://www.ssa.gov/dataexchange/request_dmf.html.

³⁵ NPPES is available at: <https://npiregistry.cms.hhs.gov/>.

³⁶ LEIE is available at: https://oig.hhs.gov/exclusions/exclusions_list.asp.

³⁷ SAM is available at: <https://www.sam.gov/SAM/>.

³⁸ An overview of MED is available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html>. The MED database is the source that is used to populate the LEIE list. MCPs can use the LEIE if they are not able to access MED.

³⁹ The Suspended and Ineligible Provider List is available at: <https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx>.

⁴⁰ The Restricted Provider Database is available at: <https://eportal.dhcs.ca.gov/dhcs/ai-rp>. For information on gaining access to the database, refer to the FAQ included with this APL.

⁴¹ The CHHS Open Data Portal is available at: <https://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider>.

MCPs may enroll providers to participate in the Medi-Cal managed care program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment that may impact the provider's eligibility to participate in the Medi-Cal program, or a provider refuses to submit to the required screening activities, the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal program.⁴²

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that they may seek enrollment through DHCS.⁴³

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.⁴⁴

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their Network Providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement in Attachment B of this APL, which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment B. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

⁴² 42 CFR, Section 455.416.

⁴³ Provider enrollment information can be found at:

<https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx>.

⁴⁴ 42 CFR, Section 455.422.

- A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through DHCS' Medi-Cal FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal FFS program, the provider must enroll through DHCS, and that enrolling through DHCS will also make the provider eligible to contract with the MCP.

J. Post Enrollment Activities

Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their re-credentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their Network Providers at least every five years.⁴⁵ MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

Retention of Documents

MCPs are required to retain all provider screening and enrollment materials and documents for ten years.⁴⁶ Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Delegation of Screening and Enrollment

MCPs may delegate their authority to perform screening and enrollment activities to a Subcontractor. The delegation must be in a written subcontract or agreement, and

⁴⁵ 42 CFR, Section 455.414.

⁴⁶ 42 CFR, Section 438.3(u).

complies with the requirements set forth in APL 17-004 and any subsequent APL requirements. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the Subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the Subcontractor's ability to perform these activities, including an initial review to ensure that the Subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

MCPs must notify DHCS 60 calendar days prior to delegating the screening and enrollment to a Subcontractor. The MCP must submit its P&Ps that outline the delegation authority, as well as the MCP's monitoring and oversight activities.

Part 2: Medi-Cal Managed Care Credentialing and Re-credentialing Requirements

MCPs must ensure that each of its Network Providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and re-credentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, re-credentialing, recertification, and reappointment of their Network Providers. Each MCP must ensure that its governing body, or the designee of its governing body, reviews and approves these policies and procedures, and that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and re-credentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and re-credentialing requirements described in this APL.

Provider Credentialing

MCPs are required to verify the credentials of their Network Providers, and to verify the following items, as required for the particular provider type, through a primary source, as applicable:^{47, 48}

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every Network Provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.
- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.⁴⁹
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the MCP's provider network.
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

MCPs are required to credential all contracted providers that render services to assigned Members, whether the providers have a state-level FFS enrollment pathway or not, in accordance with state and federal law.

Attestations

⁴⁷ "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.

⁴⁸ The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.

⁴⁹ National Practitioner Data Bank is available at: <https://www.npdb.hrsa.gov/>.

For all Network Providers types who deliver Medi-Cal covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or incapacities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.⁵⁰

Provider Re-credentialing

DHCS requires each MCP to verify every three years that each Network Provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Re-credentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, Member grievances, and medical record reviews. The re-credentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities all serious quality deficiencies that result in the suspension or termination of a Network Provider. MCPs must maintain P&Ps for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their Network Provider sites.⁵¹ MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Re-credentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization. The delegation must be in a written subcontract or agreement, and comply with the requirements set forth in APL 17-004 and any

⁵⁰ For more information, see Policy Letter (PL) 02-003, or any future iterations of this PL. PLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx>.

⁵¹ For more information, see APL 20-006, and any future iterations of this APL.

subsequent APL. When doing so, the MCP remains contractually responsible for the completeness and accuracy of these activities. In addition to meeting the requirements of APL 17-004, to ensure accountability for these activities, the MCP must establish a system that:

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

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. However, MCPs retain overall responsibility for ensuring that credentialing requirements are met. Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

If the requirements contained in this APL necessitate a change in an MCP's P&Ps, the MCP must submit its updated P&Ps to its MCOD contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements,

and other DHCS guidance, including APLs and PLs.⁵² These requirements must be communicated by each MCP to all Subcontractors and Network Providers. If you have any questions regarding this APL, please contact your MCO Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

Attachments

⁵² For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

Attachment A

Provider Types and Categories of Risk⁵³

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or the NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
 - Exception: Any such provider that is publicly traded on the NYSE or the NASDAQ is considered “limited” risk
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
 - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered “limited” risk
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities

⁵³ The CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations is available at: <https://www.govinfo.gov/content/pkg/FR-2011-02-02/pdf/2011-1686.pdf>.

- Non-public, non-government owned or affiliated ambulance services suppliers
 - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered “limited” risk.

(3) High Risk Provider Types. Characteristics and provider types:

- Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS
- Providers prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months
- Diabetes Prevention Program (DPP) providers

Attachment B

Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that managed care providers that have a state-level fee-for-service (FFS) enrollment pathway must enroll in the Medi-Cal program if they wish to provide services to Medi-Cal managed care Members. Managed care providers have two options for enrolling with the Medi-Cal program. Providers may enroll through either (1) the Department of Health Care Services (DHCS); or (2) a Medi-Cal managed care health plan (MCP). If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care Members and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to FFS providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements: (1) the Network Provider Agreement and (2) the Medi-Cal Provider Agreement. The Network Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The Medi-Cal Provider Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.

- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.
- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP or DHCS.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS. The following provides information on DHCS' enrollment process:

- DHCS' Provider Enrollment page and the Provider Enrollment information on DHCS' website has been updated to reflect that PED is no longer accepting paper applications for provider types supported in the Provider Application and Validation for Enrollment (PAVE) portal. There are links per provider type that guide applicants to PAVE. For those provider not yet fully migrated into PAVE, the provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program until such time that the application is migrated into PAVE processing.⁵⁴

⁵⁴ For more information, see the "Application Information by Provider Type" webpage on the DHCS website, available at:

<https://www.dhcs.ca.gov/provgovpart/Pages/ApplicationbyProviderType.aspx>.

- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.