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DATE: January 16, 2018

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: APL 18-004: PROVIDER SCREENING / ENROLLMENT AND CREDENTIALING / RECREDENTIALING

PURPOSE:

The purpose of this All Plan Letter (APL) is to inform Medi-Cal Dental Managed Care (DMC) plans of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services (CMS) Medicaid Managed Care Final Rule (Final Rule), CMS-2390-F,¹ dated May 6, 2016. Additionally, this APL clarifies the DMC plans' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR) Sections 438.214 and 438.602.² The screening and enrollment responsibilities are located in Part 1 and the credentialing and recredentialing responsibilities are located in Part 2 of this APL.

All DMC plan network providers must enroll in the Medi-Cal Dental program. DMC plans have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or they may direct their network providers to enroll through the Department of Health Care Services (Department). DMC plans that elect to establish their own enrollment process are expected to have their infrastructure in place by January 1, 2018.

BACKGROUND:

On February 2, 2011, CMS issued rulemaking CMS-6028-FC³ to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act. The intent of Title 42 CFR Part 455, Subparts B and E⁴ was to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

¹ CMS-2390-F is available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf> .

² Title 42 CFR Section 438 is available at: https://www.ecfr.gov/cgi-bin/textidx?SID=755076fcbadf6e6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rqn=div5#se42.4.438_1214

³ CMS-6028-FC is available at: <https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf>

⁴ Title 42 CFR, Part 455, Subparts B and E are available at: <https://www.ecfr.gov/cgi-bin/textidx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rqn=div5>

In May 2016, CMS issued rulemaking CMS-2390-F, which extended the provider screening and enrollment requirements of 42 CFR, Part 455, Subparts B and E to DMC contracted providers (Title 42 CFR, Section 438.602(b)). These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the DMC's provider networks.

DMC plans are required to maintain contracts with their network providers (Plan-Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the DMC plans' network providers were not required to enroll in the Medi-Cal Dental Fee-for-Service (FFS) program. Title 42 CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations in accordance with the requirements of Title 42 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 Dental FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and DMC plans must now implement. Although the implementation date for 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, the 21st Century Cures Act (Cures Act),⁵ section 5005(b) (2), requires managed care network provider enrollment to be implemented by January 1, 2018.

The DMC plans' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all DMC contracts. Credentialing is defined as the recognition of professional or technical competence. 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:

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

Available Enrollment Options

DMC plans may screen and enroll network providers in a manner that is substantively equivalent to the Department's provider enrollment process. However, DMC plans may also rely on the enrollment and screening results conducted by the Department or other DMC plans. The Department is currently in the process of adding a list of currently enrolled Medi-Cal Dental FFS providers to the CHHS Open Data Portal, and will be

⁵ 42 USC § 1396u-2 (d)(6)(A)

working with DMC plans and the Dental Administrative Services Organization (ASO) to facilitate a provider data file transfer process. Provider status information that the plans receive from the Department or the Dental ASO is sufficient to confirm Dental FFS enrollment. DMC plans are required to issue network providers a “verification of enrollment” that DMC plans can rely on to prevent duplicate efforts by a provider when they choose to enroll with more than one plan. DMC plans may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through the Department enrollment process may participate in both the Medi-Cal Dental FFS program and contract with a DMC plan (provided the DMC plan chooses to contract with the provider). However, providers who only enroll through a DMC plan may not also participate in the Medi-Cal Dental FFS program. Although the Department does not require that DMC providers enroll as Medi-Cal Dental FFS providers, if a dental provider wishes to participate in, or receive reimbursement from the Medi-Cal Dental FFS program, the provider must enroll as a Medi-Cal Dental FFS provider through the Department’s Dental ASO contractor.

DMC plans are not required to enroll providers that render services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

DMC Enrollment Processes

If the DMC plan elects to enroll a provider, the DMC plan must comply with the following processes, in addition to existing requirements in the DMC contract, Exhibit A, Attachment 5 (Quality Improvement System):

General Requirements:

A. DMC Provider Application

DMC plans are not required to use the Department’s provider enrollment forms. However, DMC plans must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type. In addition, DMC plans must ensure that every network provider application they process is reviewed for both accuracy and completeness. DMC plans must ensure that all of the information as specified in Title 22 of the California Code of Regulations (CCR), including but not limited to, sections 51000.30, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments to the application package are received. The DMC plans must obtain the provider’s consent in order for the Department, its ASO contractor and the DMC plan to share information relating to the provider’s application and eligibility, including but not limited to issues related to program integrity.

B. FFS Dental Provider Enrollment Agreement and DMC Plan Provider Agreement

All Medi-Cal dental providers are required to enter into a provider enrollment agreement with the state (DHCS 5300, Denti-Cal Provider Application) as a condition of participating in the Medi-Cal Dental program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the California Welfare & Institutions Code.

As part of the DMC provider enrollment process, DMC plans are responsible for ensuring that all successfully enrolled DMC providers who are not already enrolled in FFS execute and sign the DHCS 5300, Denti-Cal Provider Application, including current DMC providers not currently enrolled in FFS. This Denti-Cal Provider Application is separate and distinct from DMC Plan Provider Agreements. DMC plans must maintain the original signed DHCS 5300, with an original wet signature, for each provider not already enrolled in FFS, and must submit a copy to the Department, CMS, and other appropriate agencies upon request. DMC plans are responsible for maintaining all provider enrollment documentation in a secure manner and place that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to the Department, CMS or other authorized governmental agencies.

Both the DHCS 5300 and the DMC Plan Provider Agreement are required for DMC network providers. The DHCS 5300 does not expand or alter the DMC plan's existing rights or obligations relating to its DMC Plan Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42 CFR Sections 455.104, 455.105, and 455.106, (related to disclosure by providers) and Title 22 CCR Section 51000.35. Providers who are unincorporated sole-proprietors are not required to disclose the ownership or control information described in Title 42 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 CFR Section 455.104.

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

- A prospective provider submits the DHCS 5300.
- A provider executes the DHCS 5300.
- A Provider responds to a DMC plan's request during the enrollment revalidation process.
- Within 35 days of any change in ownership of the network provider.

Upon DMC plan request, a network provider must submit within 35 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.⁶

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

D. Site Visits

In accordance with the DMC contract Exhibit A, Attachment 5, and federal regulations, DMC plans must conduct site visits of all providers at least once every five years⁷ to verify that the information submitted to the DMC plan and the Department is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to Title 42 CFR Section 455.414, Title 22 CCR Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Dental program, including providers enrolled through DMC plans, are subject to unannounced onsite inspections at all provider locations.

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

- The provider was temporarily suspended from the Medi-Cal Dental 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 DMC plan receives information that raises a suspicion of fraud.

E. Federal and State Database Checks

During the provider enrollment process, DMC plans are required to check the following databases to verify the identity and determine the exclusion status of all

⁶ 42 CFR 455.105(b)

⁷ 42 CFR 455.414

providers:

- a. Social Security Administration Death Master File.⁸
- b. National Plan and Provider Enumeration System (NPPES).⁹
- c. List of Excluded Individuals/Entities (LEIE).¹⁰
- d. System for Award Management (SAM).¹¹
- e. CMS' Medicare Exclusion Database (MED).¹²
- f. Department's Suspended and Ineligible Provider List.¹³

F. Denial or Termination of Enrollment/Appeal Process

DMC plans may enroll providers to participate in the Medi-Cal Dental Managed Care program. However, if the DMC plan declines to enroll a provider, it must refer the provider to the Department for further Dental FFS enrollment options. If the DMC plan acquires information, either before or after enrollment, that may impact the provider's eligibility to participate in the Medi-Cal Dental program, or a provider refuses to submit to the required screening activities, the DMC plan may decline to accept that provider's application. However, only the Department can deny or terminate a provider's enrollment in the Medi-Cal Dental FFS program.

If at any time the DMC plan determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the DMC plan must immediately suspend the enrollment process. The DMC plan must inform the prospective provider that he/she may seek enrollment through the Department's FFS.¹⁴

DMC plans are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to the Department when the suspension or termination occurs as part of the Department's denial of the Medi-Cal Dental FFS enrollment application¹⁵.

G. Provider Enrollment Disclosure

At the time of application, DMC plans must inform their network providers, as well as any providers seeking to enroll with a DMC plan, of the differences between the

⁸ Social Security Administration's Death Master File is available at: <https://www.ssdmf.com/>

⁹ NPPES is available at: <https://nppes.cms.hhs.gov>

¹⁰ LEIE is available at: https://oig.hhs.gov/exclusions/exclusions_list.asp

¹¹ SAM is available at: <https://www.sam.gov/portal/SAM/#1>

¹² MED is available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html>

¹³ Suspended and Ineligible Provider List is available at: <http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp>

¹⁴ Dental FFS Provider Enrollment information can be found at https://www.denti-cal.ca.gov/Dental_Providers/Denti-Cal/Enrollment_Toolkit/

¹⁵ 42 CFR 455.422

DMC plan and Dental FFS provider enrollment processes, including the provider's right to enroll through the Department.

The Department has enclosed a disclosure statement (Attachment 1), which DMC plans may use to advise providers. DMC plans are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment 1. The Department may periodically require DMC plans 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 DMC plan, but will continue to be performed by the Department, including fingerprinting and criminal background checks for high risk providers, and decisions to deny or terminate enrollment. Pursuant to 42 CFR Section 455.450, providers are designated high risk under the following conditions: 1. Payment suspension that is based on a credible allegation of fraud, waste or abuse; 2. Existing Medicaid overpayment; 3. Excluded by OIG or another State's Medicaid program within the previous 10 years; 4. A Moratorium was lifted within the previous 6 months prior to applying and the provider would have been prevented from enrolling due to the Moratorium.
- 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 a DMC plan, including provisional provider status with Medi-Cal Dental FFS, processing timelines of the enrollment application, and the ability to appeal a DMC plan's decision to suspend the enrollment process.
- A provision informing the provider that if the DMC plan receives any information that impacts the provider's eligibility for enrollment, the DMC plan will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through the Department's Medi-Cal Dental FFS provider enrollment process.
- A statement clarifying that in order for the provider to participate in the Medi-Cal Dental FFS program, the provider must enroll through the Dental ASO contractor, and that enrolling through the Department will also make the provider eligible to contract with the DMC plan.

H. 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. DMC plans may align revalidation efforts with their recertification efforts to reduce duplication of activities. DMC plans must revalidate the enrollment of each of their network providers at least every five years. DMC plans are not required to revalidate providers that were enrolled through the Department FFS or revalidated by another DMC plan.

Database Checks

DMC plans must review the Dental Board, SAM and LEIE databases on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continues to meet enrollment criteria. Each DMC plan network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal Dental programs; any provider terminated from Medicare or the Medicaid/Medi-Cal Dental program may not participate in the DMC provider network.

Retention of Documents

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

I. Miscellaneous Requirements

Timeframes

Within 120 days of receipt of a provider application, the DMC plan must complete the enrollment process and provide the applicant with a written determination. DMC plans may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process, in accordance with 42 CFR Section 438.602(b)(2).

Delegation of Screening and Enrollment

DMC plans may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the DMC plan remains contractually responsible for the completeness and accuracy of the screening and enrollment

activities. The DMC plan's subcontractor must meet both DMC plan and the Department standards, and the delegating DMC plan 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 DMC plan must continuously monitor, evaluate, and approve the delegated functions.

Part 2: Medi-Cal Dental Managed Care Credentialing and Recredentialing Requirements

DMC plans must ensure that each of their network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. DMC plans must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each DMC plan must ensure that its governing body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure 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 recredentialing requirements. Any such overlap does not require a DMC plan to duplicate any of the activities described in this APL. However, if a DMC plan relies on the screening and enrollment activities conducted by another DMC plan, or by the Department, the DMC plan must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing

DMC plans are required to verify the credentials of their contracted dental providers, and to verify the following items, as required for the particular provider type, through a primary source,¹⁶ as applicable.¹⁷

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

¹⁶ "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.

¹⁷ The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.

DMC plans must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- History of any suspension or curtailment of 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.¹⁸
- 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 DMC plan's provider network.¹⁹
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

Attestations

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

- Any limitations or inabilities 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.

¹⁸ National Practitioner Data Bank is available at: <https://www.ncsbn.org/418.htm> .

¹⁹ The Suspended and Ineligible Provider List is available at: <http://files.medical.ca.gov/pubsdoco/SandILanding.asp>

Provider Recredentialing

The Department requires each DMC plan to verify every three years that each network provider delivering dental services continues to possess valid credentials. DMC plans 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. Recredentialing must include documentation that the DMC plan has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and dental record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

DMC plans must maintain a system for reporting to the appropriate oversight entities serious quality deficiencies that result in suspension or termination of a network provider. DMC plans must maintain policies and procedures for disciplinary actions, including reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

DMC plans must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the DMC plan'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 Recredentialing

DMC plans may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the DMC plan remains contractually responsible for the completeness and accuracy of these activities. If a DMC plan delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the DMC plan 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 DMC and Department standards.
- Continuously monitors, evaluates, and approves the delegated functions.

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Entities such as dental groups or independent dental 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 a DMC plan. The DMC plan may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated dental organizations. If a DMC plan 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

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

DMC plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as the Department guidance, including applicable APLs. If you have any questions regarding the information in this letter, please send an email to dmcdeliverables@dhcs.ca.gov.

Sincerely,

Original signed by:

Alani Jackson, Division Chief
Medi-Cal Dental Services Division
Department of Health Care Services

Enclosure

Attachment 1: Managed Care Provider Enrollment Disclosure Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Dental Program if they wish to provide services to Medi-Cal Dental managed care beneficiaries. Dental managed care (DMC) providers have two options for enrolling with the Medi-Cal Dental program.

Providers may enroll through (1) the Department, through DHCS Form 5300, found on the Denti-Cal website or (2) a DMC plan. If a provider enrolls through the Department, the provider is eligible to provide services to Medi-Cal dental fee-for-service (FFS) beneficiaries and contract with DMC plans. If the provider enrolls through a DMC plan, the provider may only provide services to Medi-Cal Dental managed care beneficiaries and may not provide services to Medi-Cal dental 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, a dental managed care provider is required to enter into two separate agreements – a DMC Plan Provider Agreement and the DHCS 5300, Denti-Cal Provider Application. The DMC Plan Provider Agreement is the contract between a DMC plan and a provider defining their contractual relationship. The DHCS 5300, Denti-Cal Provider Application is the agreement between the Department and the provider and is required for all providers enrolled in the Medi-Cal Dental program, regardless of whether the provider is contracted with a DMC plan or participating in the Medi-Cal Dental FFS program.

Enrollment Options

A. Enrollment through a DMC plan. The following provides an overview of the DMC enrollment process:

- The provider will submit a provider enrollment application to the DMC plan using a process developed by the DMC plan.
- As part of the application process, the provider will be required to agree that the Department and the DMC plan may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The DMC plan will be responsible for gathering all necessary documents and information associated with the DMC plan application.
- The provider should direct any questions it has regarding its DMC plan application to the DMC plan.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by the Department and the results shared with the DMC plan.
- While the DMC plan enrollment process will be substantially similar to the Department enrollment process, timelines relating to the processing of the enrollment application may differ. In addition, DMC plans will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.
- Providers will not have the right to appeal a DMC plans decision to cease the enrollment process.
- The DMC plan 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 DMC plan's network for up to 120 days, pending approval from the DMC plan.
- Once the enrolling DMC plan places a provider on the Enrolled Provider List, the provider is eligible to contract with all DMC plans. However, a DMC plan is not required to contract with an enrolled provider.

- Only the Department is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the DMC plan receives any information that impacts the provider's enrollment, the DMC plan will suspend processing the provider's enrollment application and refer the provider to the Department's Administrative Service Organization (ASO) contractor for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal Dental FFS program, the provider must first enroll through the Department's ASO contractor, on the Denti-Cal website.

B. Enrollment through the Department.

- The provider will use the Department's standardized application form(s) when applying for participation in the Medi-Cal Dental program. See https://www.denti-cal.ca.gov/Dental_Providers/Denti-Cal/Provider_Forms/#prov_enroll
- Federal and state laws and regulations that apply to Dental FFS providers will apply to the enrollment process for DMC providers.
- Upon successful enrollment through Department/Denti-Cal, the provider will be eligible to contract with DMC plans 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 Department's Denti-Cal website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit their needs and objectives.