

**INSTRUCTIONS FOR COMPLETION OF THE  
MEDI-CAL RENDERING PROVIDER/GROUP AFFILIATION/DISAFFILIATION FORM**

**DO NOT USE staples on this form or on any attachments.**

**DO NOT USE** correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date and initial in ink.

**DO NOT LEAVE** any question, boxes, lines, etc. blank. Enter N/A if not applicable to you.

This form is for the purpose of affiliating or disaffiliating rendering providers to billing group enrollments.

**Omission of any information on this form, including not signing the form, may result in your records with Medi-Cal not being updated as requested.**

Action requested. Enter the date you are completing the form.

**A. Affiliate Identification Information**

1. "Legal name of rendering provider"—enter the name as listed with the Internal Revenue Service (IRS).
2. "Rendering National Provider Identifier" – enter the rendering affiliate's NPI.
3. "Legal name of group provider" – enter the name of the billing group as reported to the IRS.
4. "Group National Provider Identifier" – enter the billing group's NPI.
5. - 8. Enter the actual enrolled service location(s) at which the rendering provider provides services for the group provider listed in item 3. Include the street name and number, room/suite number or letter, city, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.

**B. Rendering Provider Signature**

9. Legal name of rendering affiliate. An original signature is required.

Stamped, faxed, and/or photocopied signatures are **not** acceptable. **Rendering provider must also attach a legible copy of their driver's license or state-issued identification card.**

**C. Group Provider Signature**

10. Legal name of individual who is the sole proprietor, partner, corporate officer, or an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the group provider listed, including a delegated official, as defined in the Regulatory Provider Bulletin, *Requirements and Procedures for Medi-Cal Provider Groups Designating Delegated Officials for the Sole Purpose of Signing Affiliation Forms*. An original signature is required. Stamped, faxed, and/or photocopied signatures are **not** acceptable.
11. Location of signature and notarization.
12. This form must be notarized by a Notary Public except for those applicants and providers licensed pursuant to Business and Professions Code, Division 2, beginning with Section 500, the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

**D. Contact Person's Information**

13. "Contact person"—enter the name, title/position, contact telephone number, and contact e-mail address of the person who can be contacted regarding this form.



**MEDI-CAL RENDERING PROVIDER/GROUP  
AFFILIATION/DISAFFILIATION FORM**

**For State Use Only**

**Important:**

- Read all instructions before completing the form.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date and initial in ink.
- For Medi-Cal return completed forms to:  
 Department of Health Care Services  
 Provider Enrollment Division  
 MS 4704  
 P.O. Box 997412  
 Sacramento, CA 95899-7412  
 (916) 323-1945
- **Do not use staples on this form or on any attachments.**
- **Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.**

Action requested: <input checked="" type="checkbox"/> New rendering affiliation <input type="checkbox"/> Rendering disaffiliation	Date: 10/25/2018
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**A. Affiliate Identification Information**

1. Legal name of rendering provider as listed with IRS Kenneth William Cutler	2. Rendering national provider identifier (NPI) 1285786889
3. Legal name of group provider as listed with IRS County of Nevada Public Health	4. Group national provider identifier (NPI) 1700959863

Enter the enrolled service location(s) at which the rendering provider provides services for the group provider listed in item 3. Attach additional pages if needed.

5. Service location (number, street, suite/room)	City	State	ZIP code (9-digit)	Group NPI
500 Crown Point Circle, Ste 110	Grass Valley	CA	95945-9561	1700959863
6. Service location (number, street, suite/room)	City	State	ZIP code (9-digit)	Group NPI
10075 Levon Ave, Ste 202	Truckee	CA	96161-4804	1700959863
7. Service location (number, street, suite/room)	City	State	ZIP code (9-digit)	Group NPI
8. Service location (number, street, suite/room)	City	State	ZIP code (9-digit)	Group NPI

**B. Rendering Provider Signature**

9. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Care Services, Provider Enrollment Division. I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual. I understand that it is my responsibility to read the manual and its updates.

Printed legal name of rendering provider (last, first, middle)

Original signature of rendering provider

**ATTACH A LEGIBLE COPY OF RENDERING PROVIDER'S DRIVER'S LICENSE OR STATE-ISSUED ID**

**C. Group Provider Signature**

10. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief. I understand that incorrect or inaccurate information may affect my eligibility to receive Medi-Cal reimbursement and that I must report changes in the above information within 35 days to the Department of Health Care Services, Provider Enrollment Division. I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual. I understand that it is my responsibility to read the manual and its updates. I am authorized to sign this application pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).

Printed legal name of person signing this affiliation with authority to legally bind the group listed. Please see instructions under number 10 for who can sign. (last, first, middle)

Jill Blake

Original signature of person signing this affiliation with authority to legally bind the group listed

11. Executed at: \_\_\_\_\_, \_\_\_\_\_, on \_\_\_\_\_  
(City) (State) (Date)

**12. Notary Public:**

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

D. Contact Person's Information

13. Contact Person's Name (last, first, middle)

Cross, Cathy R

Title/Position	E-mail address	Telephone number
Administrative Analyst	cathy.cross@co.nevada.ca.us	(530) 265-1455

**Privacy Statement  
(Civil Code Section 1798 et seq.)**

All information requested on this form is mandatory. This information is required by the California Department of Health Care Services and any other California State Departments that are delegated responsibility to administer the Medi-Cal program, by the authority of the Welfare and Institutions Code, Sections 14043 - 14043.75, the California Code of Regulations, Title 22, Sections 51000 – 51451 and the Code of Federal Regulations, Title 42, Part 455. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Some or all of this information may also be provided to the California State Controller's Office, the California Department of Justice, the California Department of Consumer Affairs, the California Department of Corporations, the California Franchise Tax Board or other California state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or as required or permitted by law. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945.



JENNIFER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

**DATE:** November 14, 2017

ALL PLAN LETTER 17-019  
SUPERSEDES ALL PLAN LETTER 16-012

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** PROVIDER CREDENTIALING / RECREDENTIALING 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 the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F,<sup>1</sup> dated May 6, 2016. Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 Code of Federal Regulations (CFR), Section 438.214.<sup>2</sup> This APL supersedes APL 16-012.<sup>3</sup> 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 MCP network providers must enroll in the Medi-Cal Program. MCPs 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 (DHCS). MCPs electing 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-FC<sup>4</sup> 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 E<sup>5</sup> was to reduce the

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

<sup>2</sup> Title 42 CFR Section 438 is available at: [https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438\\_1214](https://www.ecfr.gov/cgi-bin/text-idx?SID=755076fcbadfbe6a02197ec96e0f7e16&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1214)

<sup>3</sup> APL 16-012 is available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-012.pdf>

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

<sup>5</sup> Title 42 CFR, Part 455, Subparts B and E are available at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5>

incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.

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 MCP 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 MCPs' provider networks.

MCPs 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 MCPs' network providers were not required to enroll in the Medi-Cal 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, prepaid inpatient health plans, and prepaid ambulatory health plans, in accordance with the requirements of Title 42 CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers<sup>6</sup> as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards that the Medi-Cal managed care program and MCPs must now implement.<sup>7</sup> Although the implementation date for Title 42 CFR Section 438.602(b) is not scheduled until July 1, 2018, Section 5005(b)(2) of the 21st Century Cures Act (Cures Act),<sup>8</sup> requires managed care network provider enrollment to be implemented by January 1, 2018.

The MCPs' 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 MCP contracts.<sup>9</sup> 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.

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<sup>6</sup> Exhibit E, Attachment 1 Definitions. The MCP Boilerplate contracts can be found at: <http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>

<sup>7</sup> State-specific Medi-Cal FFS provider enrollment requirements are contained in Title 22, CCR, Section 51000 through 51051, and Welfare & Institutions Code, Division 9, Part 3, Chapter 7 (commencing with Section 14043).

<sup>8</sup> 42 USC § 1396u-2 (d)(6)(A)

<sup>9</sup> Exhibit A, Attachment 4, Credentialing and Recredentialing.

## **POLICY:**

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

#### **Available Enrollment Options**

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<sup>10</sup> to obtain a list of currently enrolled Medi-Cal FFS providers. 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 the DHCS 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 may not also 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 DHCS.

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.

#### **MCP Enrollment Processes**

If the MCP elects to enroll a provider, the MCP must 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.<sup>11</sup> In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and

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<sup>10</sup> The CHHS Open Data Portal can be found at: <https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017>

<sup>11</sup> Applications packages by provider type can be found at the following: <http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx>. For associated definitions and provider types see Title 22 CCR 51000 – 51000.26 and 51051.

completeness. MCPs must ensure that all information specified in Title 22, 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 to the application package have been received. The MCP must obtain the provider's consent in order for DHCS and the MCP to share information relating to the 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 screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.<sup>12</sup> The application fee for calendar year 2017 is \$560. Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

#### **B. DHCS Provider Enrollment Agreement and Plan Provider Agreement**

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state (DHCS Provider Enrollment Agreement) as a condition of participating in the Medi-Cal Program pursuant to Section 1902(a)(27) of the Social Security Act and Section 14043.1 of the Welfare & Institutions Code. As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the DHCS Provider Enrollment Agreement. This provider agreement is separate and distinct from the Plan Provider Agreement (see below). MCPs must maintain the original signed DHCS Provider Enrollment Agreement for each provider and must submit a copy to DHCS, CMS, and other appropriate agencies upon request. MCPs 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 DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Plan Provider Agreement) is separate and distinct from the DHCS Provider Enrollment Agreement. Both the DHCS Provider Enrollment Agreement and the Plan Provider Agreement are required for MCP network providers. The DHCS Provider Enrollment Agreement does not expand or alter the MCP's existing rights or obligations relating to its 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, and Title 22, CCR, Section 51000.35. Providers who are unincorporated sole-proprietors are not required to

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<sup>12</sup> Application Fee information is available at: <http://www.dhcs.ca.gov/provgovpart/Pages/AppFeeChange2017.aspx>



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 Program. These disclosures must be provided when:

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

Upon MCP 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.<sup>13</sup>

Additionally, MCPs must comply with the requirements contained in Title 22, CCR, Section 51000.35, Disclosure Requirements. MCPs are not required to utilize the DHCS disclosure forms (DHCS 6207 and 6216<sup>14</sup>); however, MCPs must collect all information and documentation required by Title 22, CCR, Section 51000.35.

#### **D. "Limited," "Moderate," "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 requirements and for MCPs to stratify their network providers by risk level are set forth in Attachment 1 to 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 are

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<sup>13</sup> 42 CFR 455.105(b)

<sup>14</sup> DHCS Forms 6207 and 6216 are available at: [http://files.medi-cal.ca.gov/pubsdoco/prov\\_enroll.asp](http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp)

not able to enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

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.
- Have no suspensions or terminations on state and federal databases.

**Medium-Risk Providers:**

- Screening requirements of limited-risk providers.
- 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.
- 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.

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 DHCS Managed Care Operations Division (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 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.<sup>15</sup> 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. DHCS will make a pre-filled Live Scan form available to all MCPs to distribute to providers. 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 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 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, CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. In addition, all providers enrolled in the Medi-Cal Program, including providers enrolled through MCPs,<sup>16</sup> 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 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.

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<sup>15</sup> Welfare and Institutions Code 14043.38(c)(2)

<sup>16</sup> 42 CFR 455.432

### **G. Federal and State Database Checks**

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

- Social Security Administration's Death Master File.<sup>17</sup>
- National Plan and Provider Enumeration System (NPPES).<sup>18</sup>
- List of Excluded Individuals/Entities (LEIE).<sup>19</sup>
- System for Award Management (SAM).<sup>20</sup>
- CMS' Medicare Exclusion Database (MED).<sup>21</sup>
- DHCS' Suspended and Ineligible Provider List.<sup>22</sup>

### **H. Denial or Termination of Enrollment/Appeal Process**

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,<sup>23</sup> 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.

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 he/she may seek enrollment through DHCS.<sup>24</sup>

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.<sup>25</sup>

### **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

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<sup>17</sup> Social Security Administration's Death Master File is available at: <https://www.ssdmf.com/>

<sup>18</sup> NPPES is available at: <https://nppes.cms.hhs.gov>

<sup>19</sup> LEIE is available at: [https://oig.hhs.gov/exclusions/exclusions\\_list.asp](https://oig.hhs.gov/exclusions/exclusions_list.asp)

<sup>20</sup> SAM is available at: <https://www.sam.gov>

<sup>21</sup> MED is available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html>

<sup>22</sup> Suspended and Ineligible Provider List is available at: <http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp>

<sup>23</sup> 42 CFR 455.416

<sup>24</sup> Provider Enrollment information can be found at: <http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx>.

<sup>25</sup> 42 CFR 455.422

DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement (Attachment 2), 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 2. 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.
- 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 the 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 recertification efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their limited-risk and medium-risk network providers at least every five years,<sup>26</sup> and their high-risk network providers every three years. MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

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<sup>26</sup> 42 CFR 455.414

### **Data Base Checks**

MCPs must review the 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 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.

### **Retention of Documents**

MCPs are required to retain all provider screening and enrollment materials and documents for ten years.<sup>27</sup> 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**

### **Timeframes**

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

### **Delegation of Screening and Enrollment**

MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. 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.

## **Part 2: Medi-Cal Managed Care Credentialing and Recredentialing 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 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 MCP must ensure that its governing

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<sup>27</sup> 42 CFR 438.3(u)

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 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 recredentialing requirements described in this APL.

### **Provider Credentialing**

MCPs are required to verify the credentials of their contracted medical providers, and to verify the following items, as required for the particular provider type, through a primary source,<sup>28</sup> as applicable:<sup>29</sup>

- 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.<sup>30</sup>

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<sup>28</sup> “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.

<sup>29</sup> The listed requirements are not applicable to all provider types. When applicable to the provider’s designation, the information must be obtained.

<sup>30</sup> National Practitioner Data Bank is available at: <https://www.ncsbn.org/418.htm>.

- 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.<sup>31</sup>
- 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 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 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.<sup>32</sup>

### **Provider Recredentialing**

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. Recredentialing 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 recredentialing 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 serious quality deficiencies that result in suspension or termination of a network provider. MCPs 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.

MCPs must also conduct onsite reviews of their network provider sites. For detailed guidance, see Policy Letter (PL) 14-004, Site Reviews, Facility Site Review and Medical

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<sup>31</sup> The Suspended and Ineligible Provider List is available at: <http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp>.

<sup>32</sup> These limited statements comply with requirements of the Americans with Disabilities Act (ADA), as discussed in the attached PL 02-03. The ADA Attachment is available at (pg. 7): <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2002/MMCDPL02003.pdf>.



Record Review,<sup>33</sup> and any subsequent revisions to this PL. 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 Recredentialing**

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP 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 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. MCPs; however, 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.

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<sup>33</sup> Policy Letter 14-004 is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf>

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including applicable APLs, PLs and Dual Plan Letters. For questions regarding this APL, please contact your MCO contract manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief  
Managed Care Quality and Monitoring Division

Attachments

## **Attachment 1: Provider Types and Categories of Risk<sup>34</sup>/Screening Requirements**

**(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 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 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

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<sup>34</sup> CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations

- 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.** Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

## **Attachment 2: 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 Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) DHCS; or (2) an 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 beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (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 - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment 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.
  - 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' FFS 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 provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See <http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.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.