PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPCR20</td><td colspan="3">Lead Department: Provider Relations</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Medi-Cal Managed Care Plan Provider Screening and Enrollment</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 12/08/2017
Effective Date: 01/01/2018</td><td colspan="4">Next Review Date: 01/14/2026
Last Review Date: 01/08/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td>☐ QUAC</td><td></td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☐ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☒ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Marshall Kubota, MD</td><td colspan="3">Approval Date: 01/08/2025</td></tr>
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I. RELATED POLICIES:

A. MPPR208 Provider Notification of Provider Termination, Site Closure or Change in Location Information

II. IMPACTED DEPTS:

N/A

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. Provider Types and Categories of Risk/Screening Requirements
B. Managed Care Provider Enrollment Disclosure

V. PURPOSE:

To document Partnership HealthPlan of California's (Partnership) policy for screening and enrolling providers in Partnership's Medi-Cal managed health care plan as mandated and in accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013 dated July 19, 2022, which supersedes All Plan Letter (APL) 19-004.

VI. POLICY / PROCEDURE:

All Medi-Cal managed health care plan (MCP) network providers, including Non-Emergency Medical Transportation (NEMT), must enroll in the Medi-Cal Program.

MCPs have the option to develop and implement a managed care provider screening and enrollment process, or they may direct their providers to enroll through DHCS. Partnership has made a business decision to require all eligible, network providers to enroll in the Medi-Cal program via the state's Provider Application and Validation for Enrollment (PAVE) portal, as identified in APL 22-013. Partnership checks enrollment of all contracted and subcontracted providers through DHCS's Open Data Portal on a monthly basis.

A. Partnership accepts DHCS' Provider Enrollment Division (PED) letter as an acceptable form of initial enrollment verification. Partnership checks enrollment of all contracted and subcontracted providers thru DHCS's Open Data Portal on a monthly basis.
B. Partnership allows providers to participate in the Partnership network for up to 120 calendar days if the provider has a pending enrollment application in review with DHCS' PED.
C. In scenarios where there is little to no potential for member harm or significant/widespread impact to member access, Partnership will terminate the provider contract no later than 15 calendar days of

the provider receiving notification from DHCS that the provider has been denied enrollment into the Medi-Cal program, or upon the expiration of the first 120-day period.

1. If the termination of the provider will impact member access or cause member harm, Partnership will notify DHCS for advisement and approval regarding a plan of action for continuity of services before terminating the provider.

D. Partnership will only re-initiate a contract with a provider that has been denied enrollment or after the expiration of the 120-day period, after their successful enrollment as a Medi-Cal provider.

E. Should Partnership decide to develop its own screening and enrollment process, Partnership will notify DHCS and submit its policies and procedures (P&Ps) for approval prior to implementation.

The following documents the process that would be used by Partnership should the Plan decide to screen and enroll providers into the State Medi-Cal program.

In limited circumstances, based on the direction of the Partnership's Chief Executive Officer (CEO) or Chief Medical Officer (CMO), the Plan may screen and enroll eligible providers according to this policy. Circumstances for which enrollment may be processed involve providers required to improve access to care. Partnership 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 Partnership application fee must be comparable to, and must not exceed, the state's application fee. Before collecting this fee, Partnership would be certain that the network provider is not already enrolled.

Before contracting with a provider, Partnership will verify the provider is enrolled in Medi-Cal through DHCS' PAVE. Partnership will not rely on the enrollment and screening results conducted by other Medi-Cal managed care health plans. Partnership will direct all providers who are not enrolled in the Medi-Cal program to enroll through DHCS' PAVE.

All providers that fall under the category of Moderate or High Risk providers as defined by DHCS will be directed by Partnership to enroll through DHCS' PAVE. Partnership will not screen and enroll providers categorized by DHCS as Moderate or High Risk.

Partnership is not required to screen and enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements or on an urgent or emergent basis.

"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 A. 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 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:

A. Limited-Risk Providers:
   1. Meet state and federal requirements.
   2. Hold a license certified for practice in the state and has no limitations from other states.
   3. Have no suspensions or terminations on state and federal databases.

B. Medium-Risk Providers:
   1. Screening requirements of limited-risk providers.
   2. 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.

C. High-Risk Providers:
   1. Screening requirements of medium-risk providers.
   2. Criminal background checks based in part on a set of fingerprints.

D. Partnership and DHCS will adjust the categorical risk level when any of the following circumstances occur:
   1. The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
   2. The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
   3. 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 Partnership on a regular basis. Partnership may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers - Fingerprinting and Criminal Background Check
   1. 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. 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.
   2, 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.
   2. 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, are subject to unannounced onsite inspections at all provider locations.

1. Onsite visits may be conducted for many reasons including, but not limited to, the following:
   a. The provider was temporarily suspended from the Medi-Cal Program.
   b. The provider's license was previously suspended.
   c. There is conflicting information in the provider's enrollment application.
   d. There is conflicting information in the provider's supporting enrollment documentation.
   e. As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

G. Procedure

1. Provider Enrollment Application
   a. Partnership will only offer this enrollment process to practitioners, in very limited circumstances when approved by the Chief Executive Officer, (CEO) or the Chief Medical Officer (CMO), where Partnership is in need of specific services to support network access. Partnership will use DHCS' standardized provider enrollment application forms located at: https://www.dhcs.ca.gov/formsandpubs/forms/Pages/Applications.aspx
   b. Partnership will ensure the collection of all the appropriate information, data elements, and supporting documentation required for each provider type. In addition, Partnership will ensure that every network provider application processed is reviewed for both accuracy and completeness.
   c. Partnership will 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.
   d. Partnership will obtain the provider's written consent for DHCS and Partnership to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.
2. DHCS Provider Enrollment Agreement and Plan Provider Agreement
   a. As part of the Partnership enrollment process, Partnership will be 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 located at https://www.dhcs.ca.gov/formsandpubs/forms/Pages/Applications.aspx
   b. Partnership will maintain the original signed DHCS Provider Enrollment Agreement for each provider and will submit a copy to DHCS, CMS, and other appropriate agencies upon request.
   c. Partnership is 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 will be made available upon request to DHCS, CMS, or other authorized governmental agencies.

d. Partnership will submit a list of newly enrolled providers to DHCS every six (6) months to the DHCS Managed Care Operations Division (MCOD) contract manager if Partnership elects to screen and enroll providers.

3. Review of Ownership and Control Disclosure Information
   a. 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.
      1) Providers who are unincorporated sole-proprietors are not required to disclose the ownership or control information described in Title 42, CFR, Section 455.104.
      2) 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.
      3) Full disclosure throughout the Partnership enrollment process is required for participation in Partnership's managed Medi-Cal Program. These disclosures must be provided when:
         a) A prospective provider submits the provider enrollment application.
         b) A provider executes the DHCS Provider Enrollment Agreement.
         c) A provider responds to Partnership's request during the enrollment re-validation process.
         d) Within 35 days of any change in ownership of the contracted network provider.
      4) Upon Partnership request, a Partnership network provider must submit within 35 days:
         a) Full and complete information about the ownership of any subcontractor with whom the Partnership network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
         b) Any significant business transactions between the Partnership 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.

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

4. Federal and State Database Checks
   a. During the provider enrollment process, Partnership will:
      1) Verify the provider:
         a) Meets state and federal requirements.
         b) Holds a license certified for practice in the state and has no limitations from other states.
         c) Has no suspensions or terminations on state and federal databases.
      2) Check the following databases to verify the identity and determine the exclusion status of all providers:
         a) Social Security Administration's Death Master File.
         b) National Plan and Provider Enumeration System (NPPES).
         c) List of Excluded Individuals/Entities (LEIE).
         d) System for Award Management (SAM).
         e) CMS' Medicare Exclusion Database (MED).
         f) DHCS' Suspended and Ineligible Provider List.
         g) Restricted Provider Database (RPD)
   b. Once Partnership confirms a provider has met the DHCS Medi-Cal enrollment requirements

and the provider has been approved by the Partnership Credentials Committee, Partnership will issue the network provider a "verification of enrollment" to prevent enrollment duplication.

5. Denial or Termination of Enrollment
   a. If Partnership declines to enroll a provider, Partnership will refer the provider to DHCS for further enrollment options. Partnership will notify the provider within 30 calendar days of the decision to decline but no later than 120 calendar days from the provider's submission of its application.
   b. If Partnership 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, Partnership may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal Program.
   c. If at any time Partnership determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, Partnership must immediately suspend the enrollment process. Partnership must inform the prospective provider that he/she may seek enrollment through DHCS.
   d. There is no appeal process through Partnership for screening and enrollment decisions.
   e. 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.
6. Provider Enrollment Disclosure
   a. At the time a provider applies to become a Partnership provider, Partnership will inform the provider of the differences between the Partnership and DHCS provider enrollment process, using the DHCS Managed Care Provider Enrollment Disclosure statement (Attachment B). DHCS may periodically require Partnership to provide additional disclosures to providers relating to differences in the enrollment processes.
7. Post Enrollment in Partnership's Managed Health Care Plan Screening/Enrollment Process
   a. Revalidation of Enrollment
      1) To ensure that all enrollment information is accurate and up-to-date, all contracted providers that were screened and enrolled by Partnership must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process.
      2) Partnership will align the revalidation process for those providers that were screened and enrolled by Partnership as part of its standard three year re-credentialing process.
   b. Data Base Checks
      1) In accordance with Partnership's credentialing policies, Partnership will review the System for Award Management, the Medi-Cal Sanctions Suspended and Ineligible List and the Office of Inspector General (OIG) List of Excluded Individuals/Entities databases monthly. All other databases must be reviewed upon a contracted provider's reenrollment under this process to ensure that the contracted provider continues to meet enrollment criteria.
      2) Partnership's network providers must maintain good standing in the Medicare and Medicaid/Medi-Cal Programs.
      3) Any provider terminated from the Medicare or Medicaid/Medi-Cal Program may not participate in the Partnership's provider network.
   c. Retention of Documents
      1) Partnership must retain all provider screening and enrollment materials and documents for ten (10) years. Additionally, Partnership must make all screening and enrollment

documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

d. Requirement Timeframes
   1) Within 120 days of receipt of a provider's screening application, Partnership must complete the enrollment process and provide the applicant with a written determination on Partnership letterhead.

e. Delegation of Screening and Enrollment
   1) Partnership will not delegate their authority to perform screening and enrollment activities to a subcontractor.

VII. REFERENCES:

A. Title 22, California Code of Regulations (CCR).
B. Title 42, CFR, Section 438.602 (b), Sections 455.104, 455.105, and 455.106
C. DHCS All Plan Letter (APL) 22-013Provider Credentialing / Recredentialing and Screening / Enrollment (July 19, 2022), which supersedes APL 19-004
D. CMS-6028-FC Tables 1–3. Federal Register /Vol. 76, No. 22/February 2, 2011/Rules and Regulations

VIII. DISTRIBUTION:

Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Manager of Provider Network Education and Credentialing

X. REVISION DATES: 06/13/18, 06/12/2019, 04/08/2020, 04/14/2021, 04/13/2022, 4/12/2023, 8/31/2022 Draft, 01/10/2024, 01/08/25

PREVIOUSLY APPLIED TO:
N/A