



<b>Policy and Procedure No: CR 6.6</b>		<b>Revision No: 6</b>
<b>Division: Care Management</b>		
<b>Department: Credentialing</b>		
<b>Title: PHC-CA Provider Screening Enrollment</b>		
<b>Effective Date: 3/8/2018</b>		
<b>Supersedes Policy No: CR 6.0, CR 6.1, CR 6.2, CR 6.3, CR 6.4, CR 6.5</b>		
<b>Reviewed/Revised by: Sandra Holzner</b>		<b>Review/Revision Date: 12/16/2025</b>
<b>Approving Committee: Credentialing Committee</b>		<b>Date: 12/16/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>		

**Purpose:**

To describe the policies and procedures of PHC California (the Health Plan) for the screening and enrollment of network providers.

**Policy:**

1. The Health Plan maintains a provider screening and enrollment process designed to meet the requirements of Department of Health Care Services (DHCS) and to ensure all network providers are enrolled in the Medi-Cal Program. The Health Plan screens prospective providers according to an assigned risk level.
2. In addition to conducting its own screening process, the Health Plan contracts with Medi-Cal providers screened and enrolled for Medi-Cal by DHCS. The Health Plan uses the California Health and Human Services' (CHHS) Open Data Portal to verify whether applicants are currently enrolled Medi-Cal providers.
3. The Health Plan accepts DHCS' Provider Enrollment Division (PED) approval letter as an acceptable form of initial enrollment verification.
4. The Health Plan does not enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.
5. If the Health Plan elects to screen and enroll a provider, the Health Plan must complete this process and furnish a written determination on Health Plan letterhead to the applicant within one-hundred and twenty (120) calendar days of receipt of the application.
6. The Health Plan submits a list of its newly enrolled providers every six (6) months to the DCHS Managed Care Operations Division (MCO) contract manager.
7. The Health Plan may allow providers to participate in its network for up to one-hundred and twenty (120) calendar days if the provider has a pending enrollment application currently in review with either the DHCS' Provider Enrollment Division (PED) or with the Health Plan.
  - a. The Health Plan must terminate its contract with that provider no later than fifteen (15) calendar days of the provider's receipt of notification from DHCS that the provider was denied enrollment in the Medi-Cal Program, or upon the expiration of the first one-hundred and twenty (120) day period.

- b. The Health Plan cannot continue to contract with a provider who has been denied enrollment or after the expiration of the first one-hundred and twenty (120) day period, if the provider resubmits an enrollment application to DHCS or the Health Plan, and the Health Plan can only re-initiate a contract upon the provider's successful enrollment into the Medi-Cal program.
    - c. If the Health Plan's termination of a provider will impact Member access, the Health Plan must notify DHCS prior to the termination and submit a plan of action for continuity of services for DHCS' review and approval before the termination is to take place.
8. The Health Plan conducts pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the Health Plan and DHCS is accurate, and to determine compliance with state and federal enrollment requirements, including but not limited to Title 22 of the CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. Additionally, all providers enrolled in the Medi-Cal program, including providers enrolled through the Health Plan, 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 Health Plan receives information that raises a suspicion of fraud.
9. If the Health Plan changes its screening and enrollment processes, the Health Plan must notify DHCS and submit policies and procedures for approval prior to the implementation of those processes. The policies and procedures must define the scope of the Health Plan's enrollment process if it does not enroll all provider types.
10. The Health Plan does not delegate provider screening and enrollment activities to a vendor.
  - a. In the event the Health Plan opts to delegate provider screening and enrollment activities to a vendor, it will notify DHCS at least sixty (60) calendar days prior to delegating such activities in writing and submit the policies and procedures that detail delegation authority and monitoring and oversight activities.
  - b. In the event the Health Plan delegates its authority to perform screening and enrollment activities to a vendor, the delegation must be written in a contract or agreement and comply with the requirements set forth in APL 17-004 and any subsequent APL requirements.
11. The Health Plan does not delegate its authority to perform credentialing reviews to a credentialing verification organization.

- i. In the event the Health Plan opts to delegate credentialing reviews to a credentialing verification organization, it will compose and execute a written contract or agreement that complies with the requirements set forth in DHCS All Plan Letter (APL) 17-004 or any successor APL.

**Procedure:**

1. Prospective network Providers must complete the Health Plan's practitioner application and any applicable attachments to the application.
  - a. The practitioner application collects all the appropriate information, data elements, and supporting documentation required for each provider type.
  - b. The Health Plan reviews each application for accuracy and completeness to ensure that all information, submittals and attachments specified in CCR Title 22 have been received.
  - c. The Health Plan obtains the provider's consent to share information relating to the application with DHCS.
2. At the time of application, the Health Plan uses the DHCS-supplied Provider Enrollment Disclosure Form to inform prospective providers of the differences between the Health Plan's and DHCS' enrollment processes. This disclosure describes the provider's right to enroll as a Medi-Cal Provider through DHCS in order to participate in the Medi-Cal FFS program and/or enroll as a network provider with the Health Plan.
3. The Health Plan employs the following databases to verify the identity and determine the exclusion status of all prospective providers:
  - Social Security Administration's Death Master File
  - National Plan and Provider Enumeration System (NPPES)
  - List of Excluded Individuals/Entities (LEIE)
  - System for Award Management (SAM)
  - CMS' Medicare Exclusion Database (MED)
  - DHCS' Suspended and Ineligible Provider List
  - Restricted Provider Database (RPD)
  - Procedure/Drug Code Limitation List

Medi-Cal managed care health plans (MCPs) are required to review the exclusionary databases listed above on a regular basis, and at least monthly. MCPs must take the appropriate action upon discovery of a Network Provider or Subcontractor on an exclusionary database or list. Each network provider must maintain good standing in the Medicare and Medi-Cal programs. Any provider suspended or excluded from the Medicare or Medi-Cal program may not participate in the



Health Plan's provider network.

4. The Health Plan screens prospective providers according to their risk level, assigned per information provided by DHCS.

a) Limited-Risk Providers:

- The Health Plan verifies that provider meets state and federal requirements
- The Health Plan verifies that provider holds a license certified for practice in the state and has no limitations from other states
- The Health Plan verifies that provider has no suspensions or terminations on state and federal databases

b) Medium-Risk Providers:

- The Health Plan conducts screening requirements for limited-risk providers
- The Health Plan conducts a pre-enrollment site visit and post-enrollment site visits at least every five (5) years.
- Information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks.

c) High-Risk Providers:

- The Health Plan conducts screening requirements for medium-risk providers
- The Health Plan conducts a pre-enrollment site visit and post-enrollment site visits every three (3) years or as necessary.
- The Health Plan requests criminal background checks based in part on sets of fingerprints. This requirement remains the same regardless of whether a high-risk provider has undergone fingerprinting in the past. Any person with a 5% or more direct or indirect ownership in a high-risk prospective provider must submit to fingerprinting and a criminal background check.

(1) The Health Plan notifies DHCS upon initiation of each criminal background check.

(2) The Health Plan distributes a prefilled Live Scan form provided by DHCS to the prospective provider with instructions on how to deliver the completed form to DHCS.

5. The Health Plan and DHCS adjust a provider's categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on 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 (10) years, or when a state or federal moratorium on a provider type has been lifted.
6. The Health Plan requires all successfully enrolled providers to execute and sign:
- a) The DHCS Provider Enrollment Agreement
- The Health Plan maintains the original signed DHCS Provider Enrollment Agreement
  - The Health Plan submits a copy to DHCS, CMS, and other appropriate agencies upon request
- b) The Health Plan's Provider Agreement
- The Health Plan maintains the original signed Plan Provider Agreement
7. Providers that apply as partnerships, corporations, governmental entities, or nonprofit organizations must complete DHCS Forms 6207 and 6216 to disclose ownership or control information.
- a) Disclosures must be provided when:
- A prospective provider submits the Health Plan's Practitioner Application
  - A provider executes the DHCS Provider Enrollment Agreement
  - A provider responds to the Health Plan's request during the enrollment re-validation process
  - Within thirty-five (35) days of any change in ownership of the network provider
- b) Upon the Health Plan's request, a network provider must submit within thirty-five (35) days:
- Full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the request; and,
  - Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five (5) year period ending on the date of the request.
8. The Health Plan maintains all provider enrollment documentation in a manner that ensures the confidentiality of each provider's personal information. This includes information the Health Plan receives from DHCS relating to a provider's high-risk designation and the results of criminal background checks. Enrollment records are to be made available upon request to DHCS, CMS, or other authorized governmental agencies. The Health Plan retains screening and enrollment materials and documents for a minimum of ten years.

9. The Health Plan may decline to enroll providers in its Medi-Cal Managed Care Plan under the following circumstances:
- Applicants meet exclusion criteria or are otherwise ineligible for participation in Medi-Cal
  - The Health Plan determines that applicant is not qualified in accordance with current applicable legal, professional, and technical standards and/or is not appropriately licensed, certified or registered
  - Information gathered from on-site visits, background checks or other sources indicate that the provider does not meet the Health Plan's standards for quality of care
  - Provider does not meet the Health Plan's requirements as delineated in the Practitioner Criteria and Primary Source Verification Table (please refer to Policy and Procedure PHC-CA Credentialing and Recredentialing Program).

The Health Plan does not have an appeal process for screening and enrollment decisions. Providers who are denied enrollment in the Health Plan are referred to DHCS for further enrollment options.

10. The Health Plan requires all low and medium-risk network providers to resubmit and recertify the accuracy of their enrollment information every five years, and high-risk providers every three (3) years. (The Health Plan does not revalidate providers that were enrolled through DHCS).

#### References:

1. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-019, [Provider Credentialing / Recredentialing and Screening / Enrollment](#), dated November 14, 2017.
2. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004, [Provider Credentialing / Recredentialing and Screening / Enrollment \(Supersedes APL 17-019\)](#), dated June 12, 2019.
3. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013, [Provider Credentialing/Recredentialing and Screening/Enrollment](#), dated July 19, 2022.
4. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-023, [Street Medicine Provider: Definitions and Participation in Managed Care](#), dated November 8, 2022.
5. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Attachment A, Medi-Cal Network Provider and Subcontractor Terminations, dated March 3, 2021.
6. California Code of Regulations (CCR), Title 22, Sections 51000.30-32, 51000.35, 51000.45, 51000.60
7. CCR, Title 42, CFR, Sections 438.602(b), 438.214, and 455.104
8. CCR, Title 22, CFR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60

9. Credentialing Policy and Procedure PHC-CA Credentialing and Recredentialing Program
10. Provider Relations Policy and Procedure PHC-CA Street Medicine
11. DHCS Contract 23-30211, Section 1.3.3, Provider Screening, Enrolling, and Credentialing/Recredentialing

