KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Medi-Cal Enrollment Policy				POLICY #: 4.43-P	
DEPARTMENT: Provider Relations					
Effective Date: 06/07/2018	Review/Revised Date:	DMHC		PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

Douglas A. Hayward
Chief Executive Officer — Date 6/7/18

Chief Medical Officer — Date 6/5/18

Chief Operating Officer — Date 6/4/18

Director of Provider Relations — Date 5/31/18

POLICY:

Kern Health Systems (KHS) requires that all plan contracted providers enroll in the Medi-Cal Program. Plan contracted providers have the option to enroll with the Medi-Cal program through the Department of Health Care Services (DHCS) Fee-For-Service (FFS), another Medi-Cal Managed Care Plan (MCP), or through KHS' Medi-Cal enrollment process. The Medi-Cal Enrollment process will be the responsibility of the Provider Relations Department.

PROCEDURES:

1.0 ENROLLMENT OPTIONS AND VERIFICATION

KHS will accept the enrollment and screening results conducted by the DHCS or other MCPs. KHS will verify DHCS Medi-Cal FFS Enrollment through California Health and Human Services (CHHS) Open Data Portal. For providers who are enrolled with Medi-Cal through another MCP, KHS will collect the "verification of enrollment" issued by the MCP.

Additionally, for providers not enrolled through the two methods outlined above, KHS will screen and enroll providers in a manner that is substantively equivalent to the DHCS enrollment process.

Medi-Cal enrollment will not be required for providers who are providing services pursuant to Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis.

2.0 Kern Health Systems Enrollment Process

A. Provider Application

Application for enrollment is made by submitting a completed application to the Provider Relations Department. Application shall include all appropriate information, data elements and supporting documentation required for each provider type. Upon receipt, the Provider Relations Department will review the application and applicable documentation for accuracy and completeness.

KHS will obtain provider's consent in order for the DHCS and KHS to share information relating to the provider's application and eligibility, including but not limited to issues related to program integrity.

B. DHCS Provider Enrollment Agreement

As a part of the submission of the Provider Application, providers will also submit to KHS the signed DHCS Provider Enrollment Agreement.

KHS will maintain the original signed DHCS Provider Enrollment Agreement for each provider and will submit a copy to the DHCS, CMS, and other appropriate agencies upon request.

C. Review of Ownership and Control Disclosure Information

As a part of the application and enrollment process, providers shall disclose the information required by 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 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:

- Provider submits the provider enrollment application
- Provider executes the DHCS Provider Enrollment Agreement
- Provider responds to KHS request during the enrollment re-validation process
- Within 35 days of any change in ownership of the network provider

Upon request from KHS, a 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;
- 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

KHS will comply with requirements contained in Title 22, CCR, Section 51000.35, and Disclosure Requirements

D. Federal and State Database Checks

During the provider enrollment process KHS will check the following databases to verify the identity and determine the exclusion status of all 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

E. Risk Assignment and Screening Requirements

Upon receipt of a provider application for enrollment, application for an additional location, and/or any application received in response to a networks provider's reenrollment or revalidation, the Provider Relations Department will

review and screen submitted documents to determine the provider's categorical risk as "limited," "moderate," or "high". If a provider fits more than one risk level, KHS will screen the provider at the highest risk level.

The federal requirements for screening requirements and for provider stratification by risk level shall be based on applicable DHCS regulations. 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. KHS shall not enroll any 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

KHS 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

F. Site Visits

KHS will conduct pre- and post-enrollment site visits of medium-risk and high-

risk providers to verify that the information submitted 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, 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:

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

G. Fingerprinting and Criminal Background Check

As a part of the enrollment process, all high-risk providers are subject to background checks, including fingerprinting; any person with a 5% or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check. Additionally, information discovered in the process of onsite reviews or data analysis may lead to request for fingerprinting and criminal background checks for other applicants.

DHCS will coordinate all criminal background checks. DHCS will make a pre-filled Live Scan form available to KHS to distribute to providers. When fingerprinting is required, KHS will furnish the provider with the Live Scan form and instructions on where to deliver the completed form. KHS will notify the DHCS upon the initiation of each criminal background check for a high risk provider and DHCS will notify KHS directly of Live Scan results.

H. Denial or Termination of Enrollment

If KHS acquires information, either before or after enrollment, that may impact a provider's eligibility to participate in the Medi-Cal program, or a provider refuses to submit to the required screening activities, KHS may decline to accept that provider's application. If KHS declines to enroll a provider, it will refer the provider to the DHCS for further enrollment options.

If at any time KHS determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, KHS will immediately suspend the enrollment process. KHS will

inform the prospective provider that they may seek enrollment through DHCS.

KHS reserves the right to refuse enrollment to any provider. KHS does not maintain an appeal process for enrollment refusal, denial, or termination. If KHS refuses, denies or terminates enrollment, it will refer the provider to the DHCS for further enrollment options.

I. Provider Enrollment Disclosure

At time of application, KHS will inform providers of the differences between DHCS enrollment process and KHS enrollment, including their right to enroll through DHCS. KHS' Provider Enrollment Disclosure, is attached to this document as *Attachment A.*

J. Timeframes

Within 120 days of a provider application, KHS will complete the enrollment process and provide applicant with written determination. KHS will allow providers to participate in their network for up to 120 days pending the outcome of the screening process.

KHS will retain all provider screening and enrollment materials and applicable documents for ten years.

3.0 Post Enrollment Activities

A. 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 KHS will revalidate the enrollment of each of their limited-risk and medium-risk providers at least every five years and high-risk providers every three years. KHS will not revalidate providers that are enrolled through DHCS or revalidated by another MCP.

B. Data Base Checks

KHS will review the SAM and LEIE database on a monthly basis. All other databases must be reviewed upon a provider's reenrollment to ensure that the provider continue to meets enrollment criteria. KHS network providers must maintain good standing in the Medicare or Medi-Cal Program; any provider terminated from the Medicare/Medi-Cal program may not participate in KHS' network.

4.0 Delegated Entities

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

ATTACHMENTS:

- ❖ Attachment A - Provider Enrollment Disclosure

REFERENCE:

Revision 2018-05: Policy created to comply with APL 17-019 Provider Credentialing/Recredentialing and Screening/Enrollment.

Attachment A

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.