KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Medi-Cal Provider Enrollment Policy	**Policy #**	23.13-P
Policy Owner	Quality Performance	**Original Effective Date**	05/2018
Revision Effective Date	06/2025	**Approval Date**	03/02/2026
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

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 under extenuating circumstances, through KHS' Medi-Cal enrollment process. The Medi-Cal Enrollment process will be the responsibility of the Quality Performance/Credentialing Department.

II. POLICY

All Providers, where a DHCS state-level enrollment pathway exists, must enroll in Medi-Cal through the DHCS Provider Enrollment Portal and must meet all established place-of-business requirements appropriate and adequate for the services billed or claimed to the Medi-Cal Program as relevant to scope of practice or type of business.

III. DEFINITIONS

TERMS	DEFINITIONS
DHCS	Department of Health Care Services
PED	DHCS Provider Enrollment Division
CHHS	California Health and Human Services Dataset Portal
PAVE	Medi-Cal Provider Enrollment Portal
MCP	Managed Care Plans

IV. PROCEDURES

A. ENROLLMENT OPTIONS AND VERIFICATION

KHS will accept the enrollment and screening results conducted by the DHCS Provider Enrollment Division (PED) or other Managed Care Plans (MCPs). KHS will verify DHCS Medi-Cal FFS Enrollment through California Health and Human Services (CHHS) Open Data Portal; a DHCS PED approval letter is also an acceptable form of initial enrollment verification. For providers who were screened and enrolled through another MCP, KHS will collect the "verification of enrollment letter" issued by the MCP.

KHS, at its discretion, may allow providers to participate in the network for up to 120 calendar days if the provider has a pending enrollment application with the DHCS PED. KHS will terminate its contract with the provider no later than 15 days of the provider receiving notification from the DHCS that the provider has been denied enrollment in the Medi-Cal program, or upon expiration of the first 120-day period.

KHS will not continue to contract with providers during the period in which the provider resubmits its enrollment application to the DHCS and will reinitiate a contract upon the provider's successful enrollment as a Medi-Cal provider.

If the provider termination impacts member access, KHS will notify the DHCS prior to the termination and submit a plan of action for continuity of services for DHCS review and approval.

Additionally, for providers not enrolled through the two methods outlined above, KHS may, at its discretion, choose to screen and enroll providers in a manner that is substantively equivalent to the DHCS enrollment process, as outlined in §2.0 Kern Health Systems Enrollment Process. KHS prefers providers enroll via the DHCS PED outlined above. KHS will notify the DHCS and submit policies and procedures regarding its screening and enrollment policy processes prior to implementation.

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.

Medi-Cal enrollment will not be required for provider types in which there is no FFS state-level provider enrollment pathway.

B. Kern Health Systems Enrollment Process

1. Provider Application

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

KHS will obtain provider's consent (release of information) 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.

2. 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, Centers for Medicare & Medicaid Services (CMS), and other appropriate agencies upon request.

3. Review of Ownership and Control Disclosure Information

As a part of the application and enrollment process, providers shall 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 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. Provider submits the provider enrollment application
b. Provider executes the DHCS Provider Enrollment Agreement
c. Provider responds to KHS request during the enrollment re-validation process
d. Within 35 calendar days of any change in ownership of the network provider

Upon request from KHS, a provider must submit within 35 days:

a. 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;
b. 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

4. 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:

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)
o (LEIE may be conducted in lieu of MED)
f. DHCS' Suspended and Ineligible Provider List
g. The Restricted Provider Database (RPD)
o (LEIE may be conducted in lieu of RPD)
h. CHHS Open Data Portal

5. 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 Network Management 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:

a. Meet state and federal requirements
b. Hold a license certified for practice in the state and has no limitations from other states
c. Have no suspensions or terminations on state and federal databases

Medium-Risk Providers:

a. Screening requirements of limited-risk providers
b. 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:

a. Screening requirements of medium-risk providers
b. 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:

a. The state imposes a payment suspension on a provider based on a credible

allegation(s) of fraud, waste, or abuse

b. The provider has an existing Medicaid overpayment based on fraud, waste, or abuse
c. 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

6. 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, 51000.40, 51000.45, and 51000.60. KHS must conduct post-enrollment site visits for medium-risk Network Providers at least every five years, and their high-risk Network Providers every three years or as necessary. Post-enrollment onsite visits verify that the information submitted to KHS is accurate and determines if providers are in compliance with state and federal enrollment requirements. 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:

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

7. 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 requests for fingerprinting and criminal background checks for other applicants.

DHCS will coordinate all criminal background checks. KHS will direct providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website, available at: https://oag.ca.gov/fingerprints/forms . KHS will ensure providers include the correct agency information on the Live Scan Form so that the application is processed correctly. 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.

8. 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.

9. Provider Enrollment Disclosure

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

10. 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.

If KHS denies enrollment, KHS will not continue to contract with providers during the period in which the provider resubmits its enrollment application and will on reinitiate a contract upon the provider's successful enrollment as a Medi-Cal provider.

If the provider termination impacts member access, KHS will notify the DHCS prior to the termination and submit a plan of action for continuity of services for DHCS review and approval.

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

11. Post Enrollment Activities

a. Revalidation of Enrollment - To ensure that all enrollment information is accurate and up to date, those providers, screened and enrolled through another managed care plan or through KHS's enrollment process 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.

b. Data Base Checks - KHS will review the SAM, LEIE, and RPD database on a monthly basis to ensure that contracted providers continue to meet enrollment criteria and will take appropriate action in connection with any identified exclusions. 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.

12. Reporting

KHS will submit a list of its newly enrolled providers to DHCS every six months via the DHCS contract manager.

C. Delegation

1. Delegated Activities

If KHS delegates Plan screening and enrollment activities of network providers to a subcontractor, the Plan will notify DHCS 60 day prior; notification will include policies and procedures that outline delegation authority and Plan monitoring and oversight activities.

2. 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.

D. ATTACHMENTS

Attachment A: Provider Enrollment Disclosure
Attachment B:

E. REFERENCES

Reference Type	Specific Reference
All Plan Letter(s) (APL)	APL Provider Credentialing Recredentialing and Screening Enrollment
Regulatory	Title 42, CFR, Sections 455.104, 455.105, and 455.106
Regulatory	Title 22, CCR, Sections 51000.30, 51000.31,51000.32, 51000.35, 51000.40, 51000.45, and 51000.60.

F. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	2025-06	Revisions made by Quality Performance updating Policy Name adding "Provider" and Department name from PNM to Quality Performance and few minor grammatical changes	QP Credentialing
Revised	2024-12	Revisions made by Quality Performance to Section 2.6 Site Visits adding additional language for site visits every 5-years as required by DHCS APL 22-013	QP Credentialing
Revised	2022-11	Revisions made by Provider Network Management to bring in like with DHCS APL 22-013, Provider Credentialing/Re-Credentialing and Screening/Enrollment. The policy was approved by the DHCS on 11/21/2022	PNM
Revised	2019-12	Minor revision made by Provider Relations to meet DHCS requirement	PNM
Effective	2018-05	Policy created to comply with APL 17-019 Provider Credentialing/Recredentialing and Screening/Enrollment.	PNM

G. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Department of Health Care Services (DHCS)	12-09-2024	12-12-2024
Department of Health Care Services (DHCS)	11-2022	11-21-2022
Choose an item.		

Attachment A

Background

Beginning January 1, 2018, federal law requires that all managed care network providers that have a state-level fee-for-service (FFS) enrollment pathway must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care Members. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (1) Department of Health Care Services DHCS; or (2) a Medi-Cal managed care health plan (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 Members and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to FFS providers will also apply to the enrollment process for managed care providers.
Regardless of the enrollment option a provider chooses, 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 or DHCS.
- 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' 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.

- DHCS' Provider Enrollment page and the Provider Enrollment information on DHCS' website has been updated to reflect that PED is no longer accepting paper applications for provider types supported in Provider Application and Validation for Enrollment (PAVE) portal. There are links per provider type that guide applicants to PAVE. For those provider not yet fully migrated into PAVE, the provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program until such time that the application is migrated into PAVE processing
- 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.