SANTA CLARA COUNTY
Behavioral Health Services

NEW MEGA REGS POLICY & PROCEDURE (P&P) APPROVAL REQUEST FORM

I. P&P INFORMATION

Assigned Policy Name: Provider Network Enrollment and Screening

Assigned Policy Number: 8200

Mega Regs Policy Area(s): Mark All That Apply

☐	Plan Administration and Organization	☒	Provider Network
☐	Scope of Services	☐	Documentation Requirements
☐	Financial Reporting Requirements	☐	Coordination and Continuity of Care
☐	Management Information Systems	☐	Beneficiary Rights
☐	Quality Improvement System	☐	Beneficiary Problem Resolution
☐	Utilization Management Program	☐	Program Integrity
☐	Access and Availability of Services	☐	Reporting Requirements

Submitted by: Victor Ibabao Date: 3/29/2018

Policy developed by: Elania Reis

Attach P&P Document For Review In this Section

II. APPROVAL

Section A: HHS Compliance and County Counsel

HHS Compliance: DocuSigned by: victoria phan 3527B4B4F12742C... Date: 4/4/2018

County Counsel: DocuSigned by: Lorraine Van Kirk C2D9923D8017445... Date: 4/10/2018

Section B: BHSD Executive Director

BHSD Executive Director: DocuSigned by: Toni Tullys AB2AABE6ED30409... Date: 4/11/2018

Note - A copy of the Approved Mega Regs P&P Form will be emailed to: BHSD Compliance Unit

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X	**BHSD County Staff**
X	**Contract Providers**
X	**Specialty Mental Health**
X	**Specialty Substance Use Treatment Services**

Title: PROVIDER ENROLLMENT & SCREENING

Approved/Issue Date:	**Behavioral Health Services Director:**	
Last Review/Revision Date:	**Next Review Date:**	**Inactive Date:**

REFERENCE:

- 42 Code of Federal Regulation (C.F.R) § 438.602(b). State Responsibilities
- 42 Code of Federal Regulation (C.F.R) § 438.608(b). Program Integrity Requirements under the Contract
- 42 Code of Federal Regulation (C.F.R) § 455 Subpart B - Disclosure of Information by Providers and Fiscal Agents
- 42 Code of Federal Regulation (C.F.R) § 455 Subpart E- Provider Screening and Enrollment
- MHP Provider Agreement Exhibit A, Attachment 8 - Provider Network
- ODS Provider Agreement Exhibit A, Attachment I – Program Specifications

POLICY:

To ensure that providers are enrolled as Medi-Cal providers and are appropriately screened, Behavioral Health Services Department (BHSD) requires that all providers must be enrolled as Medi-Cal providers with the State and meet federal disclosure, screening, and enrollment requirements.

DEFINITIONS:

Beneficiary. A Medi-Cal recipient who is currently receiving services from BHSD or a BHSD contracted provider.

Provider. A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in California Code of Regulations, title 9, Division 1, Chapters 10 or 11 and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health

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facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the Mental Health Plan.

PROCEDURE

Responsible Party	Action Required
BHSD Business Office	1. Must submit a group or provider type Medi-Cal enrollment package with the State. The package includes submission of an application, fees, National Provider Identifier (NPI), and fingerprints. http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp a. If contracted with BHSD to provide services to beneficiaries that may have partial or full Medicare coverage, providers are required to enroll as a physician or clinical group Medicare provider with Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html 2. Ensure all network providers are consistent with all current state and federal enrollment requirements, as well as all applicable legal, professional, and technical standards. Ensure that the license has not expired and that there are no current limitations on the provider's license. 3. Ensure entity and clinical staff are appropriately licensed, certified, and/or registered. 4. Ensure Providers disclose the following information about provider business transactions and provider ownership and control: a. Name, date of birth, social security number, address and tax identification of any person with beneficial ownership b. A person with beneficial ownership of five percent or more of the Provider's equity. c. Whether a person with a beneficial ownership is related to another person with ownership and has five percent or more of the Provider's equity.

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	5. Ensure providers are screened according to their categorical risk level, upon initial enrollment and upon re-enrollment or revalidation of enrollment. 6. A Provider may show proof of screening by Medicare, Medicaid and Children's Health Insurance Programs of other States can serve as evidence of prior compliance, but must demonstrate proof of screening in the State of California within 120 days of contract execution. 7. Ensure that provider will not receive FFS funding if they are not compliant with screening and enrollment requirements. 8. Providers must revalidate state and federal enrollment and screening at least every 5 years.
Program Director	1. May execute network provider agreements, pending the outcome of screening, enrollment and revalidation up to 120 days. 2. Will terminate or deny the enrollment of any provider immediately if: a. Any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any required screening methods. b. Any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years and no written State exception has been granted; c. The provider is terminated or after January 1, 2011, under title XVIII of the Act or under the Medicaid program or CHIP of any other State; d. The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, and no written exception has been granted by the State; e. The provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or a State Medicaid agency request, and no written exception has been granted by the State; or f. The provider fails to permit access to its locations for a required site visit.

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	3. In the event that the provider cannot be enrolled or the expiration of 120 days without enrollment of the provider BHSD must notify affected beneficiaries. 4. May reactivate provider enrollment and screening if provider demonstrates compliance and the State rescreens the provider.
Attachments:	