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BHS Policies and Procedures

City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

1380 Howard Street, 5th Floor San Francisco, CA 94103
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Policy or Procedure Title: Individual Provider Enrollment, Screening, and Credentialing Standards in Federal Insurance Programs

Issued By:

DocuSigned by:
imo momoh
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Imo Momoh
Director, Office of Managed Care

Date: October 2, 2023

Manual Number: 2.03-29

Federal-level References: §438.608, Program Integrity Requirements Under the State Medicaid Contract; CFR42, Part 455 (Medicaid Program Integrity); Individual Provider Screening and Enrollment; Part 455, Subpart E and Disclosures of Information by Individual Providers CFR42, Part 455, Subpart B) Part 455 (Medicaid Program Integrity); (42CFR42 §438 and §455), US Department of Justice, Federal Sentencing Guidelines (Chapter 8, Sentencing of Organizations)

CA State-level: WIC §14043.1: Definitions in the Context of Provider Enrollment, Application and Participation Chapter 7 (Basic Health Care-Medical Assistance)

CA DHCS-level: IN 18-019; IN 20-071; Annual SMHS Audit Protocol for FY22-23

New Policy

Equity Statement: The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum ofbecoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, clients, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, leads with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse clients. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our clients' needs and lived experiences.

Purpose: This document communicates and describes the standards for individual provider

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enrollment, screening, and credentialing activities conducted by BHS Compliance for individual providers. The document also communicates the required monitoring, reporting, and enforcement actions required for Medicaid participation.

Scope: This policy applies to all individuals associated with Behavioral Health Services' implementation of federal insurance programs, including but not limited to Medicaid, Medicare, and Children's Health Insurance Program (CHIP).

Background: Multiple bodies of federal law and regulations related to Medicare (42CFR Part 424) and Medicaid (42CFR 435 and 455) require that, as a condition of payment and/or participation, managed care organizations, including County Mental Health Plans and DMC-ODS Counties (Prepaid Inpatient Health Plans) must implement an effective compliance program to detect, prevent, and intervene around improper payments, including overpayments due to healthcare fraud, waste, and abuse. Improper payments include payments to an individual provider who is not eligible to participate in federal insurance programs as a function of their eligibility, enrollment and/or individual disclosures.

Policy: BHS is a Prepaid Inpatient Health Plan (PIHP, a type of Medicaid Managed Care Organization) and BHS Compliance implements activities for individuals to enroll into the Medicaid program and be credentialed as a provider to obtain reimbursement in the SMHS and/or DMC/ODS programs. Additionally, in circumstances where individuals are not able to maintain their eligibility for federal insurance programs, BHS Compliance implements procedures to pause and/or terminate the billing credentials and report the information as required to state and/or federal regulators.

1. Provider Enrollment into DHCS' Provider Enrollment System (PAVE): Every eligible individual must enroll into the Medicaid program as a "Ordering, Referring or Prescribing" (ORP) provider by using the California Department of Health Care Services (DHCS) web-based system called PAVE ("Provider Application and Validation for Enrollment"), unless the individual can provide evidence to BHS Compliance of an existing enrollment as a "Fee-for-Service" (FFS) provider (see IN 20-071, effective 12/15/2020). Furthermore, eligible individuals must update and maintain their enrollment information within PAVE and submit this updated information to BHS Compliance.
    a. The DHCS PAVE enrollment application requires eligible individuals to provide information about their identity (e.g., your NPI number), to disclose any eligibility restrictions (e.g., a conviction of crime related to federal insurance programs), and to sign a provider agreement (e.g., detailing the Conditions of Participation for Medicaid). By enrolling into the Medicaid program in PAVE, the DHCS Provider Enrollment Division is able to monitor provider eligibility statewide.
    b. To meet the standard of PAVE enrollment, every eligible individual must provide evidence of ORP enrollment (or pre-existing FFS enrollment) by emailing a pdf copy of the DHCS Approval Letter that includes the effective date (see Attachment 1 for an example DHCS Approval Letter and Attachment 2 for the list of required eligible individuals). ***If an eligible individual cannot meet this standard, then BHS Compliance will implement the required corrective action—including internal reporting to PIPH administrators, external reports to DHCS' Provider Enrollment Division, and reducing, suspending, or terminating a provider's privileges***.

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c. Individuals who need information, instructions or support should use the resources established by DHCS including: (1) PAVE Help Desk, (866) 252-1949; (2) the Provider Resources posted at DHCS' PAVE homepage: https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx.

2. Provider Enrollment into Behavioral Health Services' PIHP as Individual Provider (SMHS and/or DMC-ODS) Program: Every eligible individual must enroll into the BHS' PIHP as Individual Provider (SMHS and/or DMC-ODS) programs by completing the initial BHS Compliance credentialing process as well as periodic re-credentialing. Furthermore, every eligible individual must update and acutely maintain their credentialing information and submit this updated information to BHS Compliance.
    a. As with the DHCS enrollment system, our BHS Compliance credentialing process requires individuals to provide information about their identity (e.g., their NPI number), to disclose any eligibility restrictions (e.g., conviction of crime related to federal insurance programs), and to sign a provider agreement (e.g., detailing the Conditions of Participation for Medicaid). This enables BHS Compliance to monitor individual provider's eligibility as required.
    b. To meet the standard of enrollment into BHS' PIHP, every eligible individual must successfully complete the initial and updated enrollment process using BHS' software program (MD-App) and thereby maintain their credentialing file with the most accurate information related to provider eligibility (i.e., evidence that you meet federal and state rules to maintain your provider type; you maintain your required unrestricted license/certification; you are not excluded from participation in federal insurance programs) at all times. ***If an eligible individual cannot meet this standard, then BHS Compliance will implement the required corrective action—including internal reporting to PIPH administrators, external reports to DHCS' Provider Enrollment Provider Enrollment Division, and reducing, suspending, or terminating a provider's privileges***.
    c. Eligible individuals for BHS Compliance credentialing include individuals who:
        i. Provide SMHS and/or DMC-ODS direct treatment, intervention, and/or support services activities.
        ii. Submit claims for reimbursements for SMHS and/or DMC-ODS activities.
        iii. Access behavioral health records within an electronic health record system for administrative oversight of chart documentation (quality management, quality assurance, quality improvement, compliance, utilization management, information technology/electronic health record staff, credentialing staff).
        iv. Contracted external clinical supervisor for an individual who is working in a Medi-Cal certified provider organization and who is appropriately registered with California State Licensing Boards and submitting reimbursements for SMHS/ODS activities.
    d. The instructions and procedural steps for eligible individuals to obtain and maintain credentials appear on the BHS webpage. Generally, eligible individuals will:
        i. Submit a valid request form for initial credentialing.
        ii. Use the online credentialing system (MD-App) to provide all of the required information.
        iii. Receive an email communication from BHS Compliance that communicates the outcome of credentialing (successful vs. not).
        iv. In circumstances where information related to your provider eligibility

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changes—submit a valid request for updated information. Common scenarios requiring an update to your credentialing could include:

1. Transition from “Associate” to “Licensed” status with the Board of Behavioral Sciences (e.g., ASW to LCSW).
2. Transition from “Registered” to “Certified” status with the Addiction Counselor Certification Board of California.
3. Obtaining the DHCS Certified Peer certificate.
4. Any change in information to your license/registration/certification (e.g., change to your legal name).

3. Medicaid and Medicare Required Level of Screenings & Associated Activities for Individual Provider Enrollment: BHS Compliance conducts a “Limited Categorical Risk” screening for individual providers per 42CFR §424.518 (Medicare Provider Types Within the Screening Levels). Below, Table 1 summarizes the required activities within Risk Categories (Limited, Moderate, High) and Insurance Program (Medicaid/Medicare). As a reference to the reader, Table 2 provides more detailed guidance and identifies organizational provider screening requirements as well.

Table 1. Enrollment Requirements, by Type of Categorical Risk

Type of Federal Insurance and CFR Citation	**Limited Categorical Risk:** **Activities to Complete**	**Moderate Categorical Risk:** **Activities to Complete**	**High Categorical Risk:** **Activities to Complete**
42CFR §455.450 Screening levels for ***Medicaid*** providers	1. Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination. 2. Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with 42CFR §455.412. 3. Conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with § 455.436.	1. Perform the “limited categorical risk” screening requirements described. 2. Conduct on-site visits in accordance with § 42CFR §455.432.	1. Perform the “limited” and the “moderate categorical risk” screening requirements described. 2. Conduct a criminal background check. 3. Require the submission of a set of fingerprints in accordance with § 455.434. Note—if a provider (or any person with 5 percent or greater direct or indirect ownership in the provider) fails to provide fingerprinting, then their application should be denied and/or enrollment should be terminated.

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Type of Federal Insurance and CFR Citation	**Limited Categorical Risk:** **Activities to Complete**	**Moderate Categorical Risk:** **Activities to Complete**	**High Categorical Risk:** **Activities to Complete**
§ 424.518 Screening levels for ***Medicare*** providers and suppliers	1. Verifies that provider- supplier meets all applicable Federal regulations and State requirements prior to making an enrollment determination. 2. Conducts license verifications, including licensure verifications across State lines for physicians or non-physician practitioners and providers and suppliers that obtain or maintain Medicare billing privileges as a result of State licensure, including State licensure in States other than where the provider or supplier is enrolling. 3. Conducts database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.	1. Perform the "limited categorical risk" screening requirements described. 2. Conduct on-site visit.	1. Perform the "limited" and the "moderate categorical risk" screening requirements described. 2. Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier; and 3. Conducts a fingerprint-based national background/criminal history record check of the Federal Bureau of Investigation's Integrated Automated Fingerprint Identification System on all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier. Note—if an individual fails to provide fingerprinting, then the billing privileges must be denied and/or revoked.

Table 2. Provider Types (Organizational; Individual) and Their Categorical Risk

Type of Federal Insurance and CFR Citation	Limited Categorical Risk Activity	Moderate Categorical Risk Activity	High Categorical Risk Activity
42CFR §424.518 Medicare Provider Types Within the Screening Levels	• Physician or non-physician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics • Ambulatory surgical centers • Competitive Acquisition Program/Part B Vendors • End-stage renal disease facilities • Federally qualified health centers • Histocompatibility laboratories • Home infusion therapy suppliers • Hospitals, including critical access hospitals, rural emergency hospitals, Department of Veterans Affairs hospitals, and other federally owned hospital facilities • Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act • Mammography screening centers • Mass immunization roster billers • Opioid treatment programs (if § 424 67(b)(3)(ii) applies) • Organ procurement organizations • Pharmacies newly enrolling or revalidating via the CMS–855B application • Radiation therapy centers • Religious non-medical health care institutions • Rural health clinics	• Ambulance service suppliers • Community mental health centers • Comprehensive outpatient rehabilitation facilities • Hospice organizations • Independent clinical laboratories • Independent diagnostic testing facilities • Physical therapists enrolling as individuals or as group practices • Portable x-ray suppliers • Revalidating home health agencies • Revalidating DMEPOS suppliers • Revalidating MDPP suppliers • Prospective (newly enrolling) opioid treatment programs that have been fully and continuously certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) since October 23, 2018 • Revalidating opioid treatment programs • Revalidating skilled nursing facilities (SNFs)	• Prospective (newly enrolling) home health agencies • Prospective (newly enrolling) DMEPOS suppliers • Prospective (newly enrolling) MDPP suppliers • Prospective (newly enrolling) opioid treatment programs that have not been fully and continuously certified by SAMHSA since October 23, 2018 • Prospective (newly enrolling) (SNFs) • Enrolled OTPs that have not been fully and continuously certified by SAMHSA since October 23, 2018, DMEPOS suppliers, MDPP suppliers, HHAs, and SNFs that are submitting a change of ownership application pursuant to 42 CFR 489 18 or reporting any new owner (regardless of ownership percentage) pursuant to a change of information or other enrollment transaction under title 42

Notes:

Medicaid: State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "limited," "moderate," or "high " If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

Medicare: Medicare contractor is required to screen all initial applications, revalidation applications, change of ownership applications pursuant to 42 CFR 489 18, applications to add a new practice location, and applications to report any new owner (regardless of ownership percentage) pursuant to a change of information or other enrollment transaction under title 42, based on a CMS assessment of risk and assignment to a level of "limited," "moderate," or "high."

4. DHCS Standards for Individual Provider Enrollment into Medi-Cal (Medicaid): DHCS published standards for Credentialing and Re-Credentialing individuals for Prepaid Inpatient Health Plans (PIPHs; see Information Notice 18-109, "Provider Credentialing and Re-Credentialing for Mental Health Plans (MHPs) And Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot

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Counties") BHS Compliance relies on the primary source verification that is conducted by state and Federal licensing, certification and/or registration boards BHS Compliance implements the following:

a. Only for licensed, waivered, registered and/or certified providers (i e , licensed, registered, or waivered mental health providers, licensed practitioners of healing arts, and registered or certified Alcohol or Other Drug counselors), BHS Compliance verifies the following:
    i. License and/or board certification and/or registration, as required for the particular provider type.
        1. At the time of credentialing and monthly thereafter, BHS Compliance conducts a check that these are current and have no limitations.
    ii. Evidence of graduation or completion of any required education, as required for the particular provider type.
        1. At the time of credentialing, individuals provide a copy of the transcript from the educational institution.
    iii. BHS Compliance does not directly verify the following because the respective licensing, registration, or certification boards roles and functions:
        1. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
        2. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.
b. For all providers, BHS Compliance verifies to following (at the time of credentialing, re-credentialing and monthly):
    i. Work history:
        1. individuals provide a copy of the resume.
    ii. Current Drug Enforcement Administration identification number:
        1. BHS Compliance staff review website to ensure the number is current and valid.
    iii. National Provider Identifier number:
        1. BHS Compliance staff review website to ensure an NPI record exists.
    iv. Current malpractice insurance in an adequate amount, as required for the particular provider type:
        1. BHS Compliance staff obtain a copy of the malpractice insurance evidence.
    v. Provider information, if any, entered in the National Practitioner Data Bank, when applicable (reference: https://www.npdb.hrsa.gov):
        1. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: (A) providers terminated from either Medicare or Medi-Cal, or (B) providers on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network This list is available at the DHCS website.
    vi. History of sanctions or limitations on the provider's license issued by California state's agencies or licensing boards.
        1. BHS Compliance conducts a check that these are current and have no limitations.
    vii. *BHS Compliance intends to review, as soon as practically possible*:
        1. For states other than California where the provider is licensed/certified/registered, the history of sanctions or limitations on the provider's license issued by California state's agencies or licensing boards.
    viii. *BHS Compliance does not check the following directly—instead, we obtain these information by way of the National Practitioner Databank*:

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1. History of liability claims against the provider.
2. History of any suspension or curtailment of hospital and clinic privileges.

c. For all providers, BHS Compliance obtains signed and dated Attestations (at the time of credentialing and re-credentialing) to confirm:
   i. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation (BHS Compliance conducts a check that these are current and have no limitations).
   ii. A history of loss of license or felony conviction DHCS' IN 18-019 clarifies that a felony conviction does not automatically exclude a provider from participation in the Plan's network However, in accordance with 42 C F R §§ 438 214(d), 438 610(a) and (b), and 438 808(b), Plans may not employ or contract with individuals excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.
   iii. A history of loss or limitation of privileges or disciplinary activity.
   iv. A lack of present illegal drug use.
   v. The application's accuracy and completeness.

d. Specific Guidance—Only for the Substance Use Disorder (SUD) Medical Director position within Contracted Organizational Providers (per DMC/ODS Intergovernmental Agreement—Exhibit A, Attachment I A1, Program Specifications; Disclosures that shall be provided; Provider Selection and Certification): BHS Compliance uses the Medicare guidance that requires every SMHS and DMC/ODS eligible individual be subjected to the "Limited Categorical Risk" of screening by BHS Compliance.

   As a reminder, in Table 1 above—the Limited Categorical Risk level of screening requires three elements: (1) verification that the provider meets all applicable Federal regulations and State requirements prior to making an enrollment determination (2) verifying license verifications (BHS is not currently including licensure verifications across State lines for physicians or non-physician practitioners that obtain or maintain Medicare billing privileges as a result of State licensure, including State licensure in States other than where the provider or supplier is enrolling); (3) database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

   Therefore, because the current standard for all individuals (Limited Categorical Risk review) is the same requirement for the SUD Medical Director position (subjected to Limited Categorical Risk review), then there are no additional obligations related to the SUD Medical Director position for BHS Compliance.

   However—CDTA (for programs that are newly contracted) and/or BOCC (for re-certification) and/or SOC (for programs that need to hire a replacement SUD Medical Director) must initiate a specific request for SUD Medical Director screening This is easily accomplished by emailing the BHS Compliance Officer with the required information. The results of the Limited Categorical risk enrollment screening will be communicated to the requestor. If an SUD Medical Director individual cannot meet the relevant standards above, then BHS Compliance will implement the required corrective action—including internal reporting to PIHP administrators, external reports to DHCS' Provider Enrollment Division, and reducing, suspending, or terminating a provider's privileges.

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5. BHS Compliance Reporting for Federal Program Integrity Requirements (CFR42 §438.608): There are circumstances where BHS Compliance credentialing and provider enrollment information and/or outcomes must be communicated internally (within BHS and SFDPH) and externally (to DHCS, CMS, etc.) to comply with Program Integrity Requirements that apply to PIHPs. To complete this, we use the "BHS Compliance Program Integrity Communication, Reporting and Routing Form (CFR §438.608) ."
    a. ***If BHS Credentialing and Private Provider Network identify an individual provider who is no longer eligible to participate in the managed care program due to Disclosure and/or Exclusion Lists, the BHS Compliance Unit first communicates this information internally to SFDPH OCPA, BHS Billing/Fiscal, BHS CDTA/BOCC and subsequently, refers the case, including the provider's name and NPI number to the DHCS Provider Enrollment Division at 1501 Capitol Ave, Sacramento, CA 95814, (916) 323-1945. That communication from BHS to DHCS is stored in the provider's credentialing file***.
    b. ***In the course of implementing Individual Provider Screening and Enrollment processes (CFR42, Part 455, Subpart E) and Disclosures of Information by Individual Providers (CFR42, Part 455, Subpart B), in circumstances where BHS Credentialing observes an individual who is not eligible for participation in the federal insurance program, then the BHS Compliance Unit first communicates this information internally to SFDPH OCPA, BHS Billing/Fiscal, BHS CDTA/BOCC and subsequently, refers the issue to the DHCS Provider Enrollment Division at 1501 Capitol Ave, Sacramento, CA 95814, (916) 323-1945.***

6. Accuracy, Integrity, and Security of Enrollment and Credentialing Information and Management Information Systems: the BHS Compliance provider enrollment system is composed of (1) a software system used to collect information directly from individuals (e.g., MD-Staff software); (2) paper forms and paper files (e.g., application forms for the Private Provider Network) and (3) organizational structures and oversight Within each sphere, BHS Compliance staff must protect the accuracy, integrity, and security of the information used to establish credentials and privileges.
    a. When BHS Compliance staff use our own software systems (e.g., MD-Staff), we implement the following principles:
        i. Credentialing materials received are dated and stored securely.
        ii. Any modification to paper or electronic credentialing materials or data are dated and tracked in a manner that can be monitored or audited by regulatory agencies.
        iii. Only authorized staff are permitted to access and/or modify credentialing materials.
        iv. Security controls within software systems are utilized.
        v. Additional security measures are used (e.g., locked file cabinets).
    b. In circumstances where BHS Compliance staff are requested to enter provider enrollment and/or credentialing into any electronic system that is not maintained by BHS Compliance (i e , an MIS, electronic health record, spreadsheet, "homegrown" database, etc.), then the request may not be implemented unless the following occurs:
        i. The request for BHS Compliance staff to enter outcome information into a system that is not maintained by BHS Compliance must be submitted directly to and approved by the BHS Compliance Officer and the OCPA Deputy Director. The request must be accompanied by:
        ii. A pdf copy of the user manual for the electronic system.
        iii. A pdf of the SFDPH standard work procedures for the electronic system.

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iv. The names and contact information of the SFDPH staff who manage the vendor contract for the electronic system and staff who directly implement and service the electronic system.
v. The names and contact information of the SFDPH staff who hold Compliance for the electronic system (Data Security, Data Privacy, Regulatory Requirements).

c. The personally and professionally identifying information collected by BHS Compliance is kept secure and private within our software systems (e.g., MD-Staff), but it is important to note that the software system is used across all sections of SFDPH for provider enrollment and also, for screening new hires into the San Francisco Health Network (e.g., San Francisco General Hospital, Laguna Honda Hospital, the health clinics of the San Francisco Health Network, the DPH Human Resources Department) . These provider datasets are used to publish information for beneficiaries (like Provider Directories), to report managed care information to DHCS (like Network Adequacy), and for related provider enrollment activities (e.g., when an employee is being enrolled as a Medicare provider, the BHS or SFDPH Fiscal/Billing Department may use information from the Medicaid enrollment process to populate the individual's Medicare application).

Contact Person: BHS Compliance Officer

Attachment(s): Attachment 1-Example DHCS Approval Letter; Attachment 2 for DHCS' list of required eligible individuals (IN 20-071, Enclosure 1, Examples of Provider Types that Must Enroll)

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State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

November 10, 2021

Lady Gaga
Born This Way Road
Oakland, CA 94618-1416

APPLICATION IDENTIFICATION NUMBER: 123456
DATE APPLICATION RECEIVED: August 24, 2021

The Department of Health Care Services (DHCS), Provider Enrollment Division (PED) has approved your application for enrollment in the Medi-Cal program at the business address above, effective **August 24, 2021**. The Medi-Cal claims system will update your submitted information within 2-3 business days of this notification letter. You will also receive a Welcome Packet and a PIN from Xerox in the next few weeks.

PED appreciates your program participation and your willingness to provide services to Medi-Cal beneficiaries.

Should you have any questions or require further information, you may submit your inquiry easily and securely through the PAVE messaging portal via Messages button or visit the DHCS's website for program information available in the PAVE Portal.

Provider Enrollment Division

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ENCLOSURE 1:

Examples of Provider Types that Must Enroll

The following are examples of provider types that must enroll; however, this is not a complete list. Please see "Provider Types Eligible to Enroll Through PAVE"

- Certified Pediatric/Family Nurse Practitioner
- Certified Family Nurse Practitioner
- Licensed Clinical Specialist [LCSW, LMFT]
- Licensed Counselor [LCSW]
- Licensed Clinical Social Worker
- Licensed Educational Psychologist
- Licensed Marriage and Family Therapist
- Licensed Professional Clinical Counselor
- Licensed Professional Counselor [LPCC]
- Marriage & Family Counselor [LMFT]
- Nurse Practitioner
- Occupational Therapist
- Physician (MD)
- Osteopath (DO)
- Physician Assistant
- Psychologist
- Registered Pharmacist/Pharmacist
- Speech Therapist

Annotation from San Francisco BHS (October 2023):

This enclosure document is a component of DHCS BHIN 20-071 (December 15, 2020), Specialty Mental Health Provider Screening and Enrollment Requirements in Medi-Cal (21st Century Cures Act and the CMS Medicaid and CHIP Managed Care Final Rule requirements)

BHIN 20-071: *https://www.dhcs.ca.gov/Documents/BHIN-20-071-21st-Century-Cures-Act-Provider-Enrollment-Requirements.pdf*

BHIN 20-071 Enclosure 1*: https://www.dhcs.ca.gov/Documents/Enclosure-1-BHIN-20-071-Provider-Types.pdf*

As noted in BHIN 20-071, the DHCS website with the most comprehensive list of providers can be found here: https://www.dhcs.ca.gov/provgovpart/Pages/Provider-Enrollment-Options.aspx