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## SECTION 3: PROVIDER CREDENTIALING

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# TABLE OF CONTENTS

<b>Section 3:</b>	<b>Provider Credentialing .....</b>	<b>3-1</b>
	Credentialing .....	3-1
	Requirements for Credentialing/Recredentialing .....	3-3
	The Credentialing Process.....	3-7
	Recredentialing.....	3-7
	Provider’s Rights During the Credentialing Process.....	3-8
	Credentialing a New Group Provider.....	3-10
	Facility and Ancillary Assessment and Verification .....	3-11
	Facility Site Review .....	3-12

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## SECTION 3: PROVIDER CREDENTIALING

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### CREDENTIALING

Credentialing is an important function of the Quality Improvement and Health Equity (QIHE) Department. Health Plan's credentialing program has been developed in accordance with applicable regulations from the Centers for Medicare and Medicaid Services (CMS), the California Department of Health Care Services (DHCS), California Department of Managed Health Care (DMHC) and the National Committee for Quality Assurance (NCQA). In selecting practitioners, Health Plan will not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. Health Plan may, however:

- Refuse to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's Enrollees
- Use different reimbursement amounts for different specialties or for different practitioners in the same specialty.
- Implement measures designed to maintain quality and control costs consistent with its responsibilities.

Health Plan regularly obtains, and reviews reports and other documentation to enable ongoing monitoring health care professionals, including but not limited to:

- Providers who have been sanctioned, excluded, or precluded from participation from state and federally funded programs
- Providers who have opted out of accepting federal reimbursement from Medicare
- Resolution of beneficiary grievances
- Sanctions and limitations on licensure

Health Plan initially credentials all physicians who provide services to D-SNP Enrollees (including members of physician groups), and all other types of health care professionals who provide services to Enrollees and who are permitted to practice independently under state law. Health Plan recredentials them at least every three years. Credentialing information submitted to Health Plan is reviewed and primary source verified, as applicable using CMS and DHCS approved sources. To verify information, Health Plan uses the same sources and processes for initial credentialing and recredentialing.

To ensure the highest quality health care delivery system and to maintain compliance with regulatory and accreditation agencies, Health Plan credentials, or oversees the credentialing, of the following types of Providers:

- Physicians (MD)
- Osteopathic Practitioners (DO)
- Podiatrists (DPM)

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## SECTION 3: PROVIDER CREDENTIALING

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- Nurse Practitioners (NP)
- Chiropractors (DC)
- Dentists (DMD)/Oral Surgeons
- Physician Assistants (PA)
- Nurse Midwives (NMW)
- Other practitioner types who serve Enrollees outside the inpatient hospital setting or outside ambulatory freestanding facilities and have an independent relationship with Health Plan
- Locum Tenens practitioners including physicians, dentists, chiropractors, optometrists, social workers, and psychologists after 90 calendar days of continuous service.
- Practitioners who are hospital-based but who see Enrollees as a result of their independent relationship with Health Plan including, but not limited to:
  - Anesthesiologists with pain management practices
  - Cardiologists
  - University faculty who are hospital-based and who also have private practices

In addition, Health Plan credentials the following allied health professional Providers:

- Psychologists
- Optometrists
- Physical Therapists
- Chiropractors
- Speech/Hearing Therapists
- Telemedicine Providers
- Audiologists
- Mental Health and Substance Use Disorder Provider
- Addiction Specialists
- Occupational Therapists
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage Family Therapists (LMFT)
- Clinical Nurse Specialists
- Other allied providers as deemed necessary
- Street Medicine Providers
- Clinical Nurse Specialists
- Board Certified Behavioral Analysts (BCBA)

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## SECTION 3: PROVIDER CREDENTIALING

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In accordance with Health Plan policies and procedures, the credentialing process typically takes between 60 and 90 days. Within 120 days of receipt of a provider application, Health Plan shall complete the enrollment process and provide the applicant with written determination. For Mental Health and Substance Use Disorder Providers, Health Plan will notify them within seven business days of receipt of a credentialing application to: 1) verify receipt; and 2) inform the Provider whether the application is complete. The information gathered during this process is confidential and disclosure is limited to parties who are legally permitted under state and federal law to have access to this information.

**In order to maintain health care quality standards, no Enrollees will be assigned or referred to Providers who have not completed the credentialing process and signed an Agreement with Health Plan to participate in the network.**

### REQUIREMENTS FOR CREDENTIALING/RE-CREDENTIALING

#### Requirements for Physicians

Health Plan will ensure that, at a minimum, physicians considered for network participation and continued participation are in good standing (through primary source verification, as applicable), and meet the following criteria before being accepted in the network:

- 1) A written credentialing application and attestation of correctness and completeness signed and dated by the applicant no more than six months in advance of new contract or recredentialing, that includes the following:
  - a) Work history of the preceding five years acceptable to Health Plan
  - b) Any limitations in ability to perform the essential functions of the position, with or without accommodation
  - c) Lack of present illegal drug use
  - d) History of loss of license and/or felony convictions
  - e) History of loss or limitation of privileges or disciplinary activity
  - f) Request for practitioner race, ethnicity, and languages in which the practitioner is fluent when discussing medical care. The application includes a statement that providing this information is optional and that Health Plan does not discriminate or base credentialing decisions on an applicant's race, ethnicity and language
- 2) Valid, unrestricted, and current California state license
- 3) Medicare and Medi-Cal Fee for Service or Ordering, Prescribing, and Referring (ORP) Enrollment
- 4) Clinical privileges in good standing at a hospital or coverage arrangements with another physician for Enrollees who require hospitalization (if applicable)
- 5) Current and valid federal Drug Enforcement Agency (DEA) registration or Controlled Dangerous Substance (CDS) certificate for the state

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## SECTION 3: PROVIDER CREDENTIALING

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- 6) Graduation from an approved medical school and completion of an appropriate residency or specialty program
- 7) Board certification (if required)
- 8) Current professional liability (malpractice) insurance in amounts acceptable to Health Plan
- 9) Professional liability claims history acceptable to Health Plan
- 10) Absence of Medicare and Medicaid sanctions and exclusions
- 11) Eligibility for participation in Medicare (i.e. not an opt-out provider)
- 12) Absence of state sanctions against licensure
- 13) National Practitioner Data Bank (NPDB) query results acceptable to Health Plan
- 14) Absence of Quality of Care and service issues
- 15) Facility Site Review (FSR) findings acceptable to Health Plan, if an office site visit is conducted

Health Plan has established a temporary, streamlined credentialing guideline for newly trained individuals. In the case of a newly trained health care professional who has completed all appropriate training and education within the last 12 months, Health Plan permits initial credentialing for a period of up to 60 days when the following conditions are met:

- 1) Health Plan verifies that the practitioner has a current, valid license from primary sources;
- 2) Health Plan verifies malpractice settlements from the last five years. (This may be performed by verifying with the malpractice carrier or the NPDB; attestation is not accepted);
- 3) Practitioner meets all standard credentialing requirements after 60 days; and
- 4) Health Plan Credentialing Committee has reviewed the case and makes the final determination about granting such an initial 60-day credentialing period.

For recredentialing, acceptable findings from quality reporting are required. This may include, but is not limited to, a review of:

- 1) Enrollee and Provider complaints
- 2) Results of access and satisfaction surveys
- 3) Grievance reports
- 4) Quality of care reporting

### Requirements for Institutional Provider and Supplier Certification

Health Plan will ensure, at a minimum, that each institutional provider or supplier has a signed contract or participation agreement and has met the following three requirements:

- 1) Medicare Approval for the following types of providers and suppliers:
  - a) Hospitals

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## SECTION 3: PROVIDER CREDENTIALING

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- b) Transplant Center
  - c) Critical Access Hospital
  - d) Skilled Nursing Facilities (SNFs)
  - e) Comprehensive Outpatient Rehabilitation Facilities (CORFs)
  - f) Home Health Agencies (HHA)
  - g) Hospices
  - h) Religious non-medical health care institution
  - i) Any clinic, rehabilitation agency or public health agency that has a Medicare participation agreement to furnish outpatient physical therapy or outpatient speech pathology services
  - j) An entity that has a Medicare participation agreement to furnish or opioid use disorder treatment services
  - k) Independent laboratory
  - l) Supplier of durable medical equipment prosthetics, orthotics, or supplies (DMEPOS)
  - m) Ambulance service provider
  - n) Independent diagnostic testing facility
  - o) Physician or other practitioner such as physician assistant
  - p) Physical therapist in private practice, an occupational therapist in private practice, or a speech-language pathologist
  - q) Supplier of portable X-ray services.
  - r) Rural health clinic (RHC).
  - s) Federally qualified health center (FQHC).
  - t) Ambulatory surgical center (ASC).
  - u) An entity approved by CMS to furnish outpatient diabetes self-management training
  - v) End-stage renal disease (ESRD) treatment facility that is approved by CMS as meeting the conditions for coverage of its services
  - w) A site approved by CMS to furnish intensive cardiac rehabilitation services
- 2) Current licensure to operate in California, and compliance with any applicable state or federal requirements
- 3) Review and approval by an accrediting body or meets standards established by Health Plan. Accrediting bodies include:
- a) The Joint Commission (formerly JCAHO)
  - b) Accreditation Association for Ambulatory Health Care (AAAHC)
  - c) Commission on Accreditation of Rehabilitation Facilities (CARF)
  - d) Council on Accreditation (COA)

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## SECTION 3: PROVIDER CREDENTIALING

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### e) Community Health Accreditation Program (CHAP)

Health Plan also complies with CMS requirements related to the use of Medicare-Approved facilities for performing certain procedures, including but not limited to:

- 1) Carotid artery stenting
- 2) Ventricular Assist Device (VAD) destination therapy
- 3) Bariatric surgery
- 4) Certain oncologic Positron Emission Tomography (PET) scans in Medicare-specified studies
- 5) Lung volume reduction surgery
- 6) Organ transplants

### **Requirements for Non-Physician Providers & Non-Physician Medical Practitioners**

Health Plan shall ensure, at a minimum, that non-physician Providers and non-physician medical practitioners considered for network participation and continued participation are in good standing (through primary source verification, as applicable) and meet the following criteria before being accepted in or continue participation in the network:

- 1) A written application and attestation of correctness signed and dated by the applicant no more than six months before the date of appointment, including
  - a) Work history of the preceding five years acceptable to Health Plan
  - b) History of loss of license and/or felony convictions
  - c) History of loss or limitation of privileges or disciplinary activity
- 2) Valid, unrestricted, and current California state license
- 3) For prescribing practitioners, current, valid federal DEA registration or CDS certificate for the state
- 4) Current professional liability (malpractice) insurance in amounts acceptable to Health Plan
- 5) Graduation from an approved professional school
- 6) Board certification, if applicable
- 7) Hospital clinical privileges, in good standing or coverage arrangements with other providers, if applicable
- 8) Professional liability claims history acceptable to Health Plan
- 9) Absence of OIG exclusions
- 10) Eligibility for participation in Medicare (i.e. not an opt-out provider) or Medi-Cal Fee for Service or Ordering, Prescribing, and Referring ORP Enrollment if a pathway exists.
- 11) Absence of state sanctions against licensure

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## SECTION 3: PROVIDER CREDENTIALING

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- 12) NPDB query results acceptable to Health Plan
- 13) Absence of Quality of Care and service issues

### THE CREDENTIALING PROCESS

During the credentialing process, the information on the Provider's electronic credentialing application is reviewed and verified for correctness, and then reviewed through government verification sources which will include, but not be limited to:

- 1) NPDB
- 2) OIG
- 3) State licensing boards for California and other states if applicable

In addition to providing documentation, a FSR may be required for Primary Care Physicians (PCP). Providers will be contacted by Health Plan's FSR team to schedule and coordinate the FSR.

Completed electronic credentialing applications will then be presented to the Peer Review and Credentialing Committee (PR&CC) which currently meets every other month. The PR&CC reviews each credentialing application to determine if the Provider meets the initial credentialing or recredentialing criteria and then makes the decision to either accept or reject a Provider's application.

All credentialing applications approved by the PR&CC are submitted to the San Joaquin County Health Commission for review and final approval. The Commission meets monthly and once the Commission grants approval, Health Plan can offer or complete an agreement with the Provider.

### RE-CREDENTIALING

Health Plan re-credentials all Providers at least every three years but may re-credential Providers more often if deemed necessary. The same information reviewed during the initial credentialing process is reviewed and updated during the recredentialing process with the exception of the Provider's educational credentials and work history. Board certification will be reverified only if the provider was due to be recertified or states they have become board certified since the last time they were credentialed or recredentialed.

In addition, Health Plan will review Provider contact logs to consider any information collected through Health Plan activities, including but not limited to its quality and utilization management programs.

The recredentialing process requires a timely response from all Providers. Providers will receive an electronic recredentialing link five months in advance of the three-year anniversary of the last credentialing date. Providers are required to complete identified areas of the application and attest that the information provided on the current application is correct and complete.

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## SECTION 3: PROVIDER CREDENTIALING

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The practitioner has 15 business days to send the recredentialing materials to Health Plan. If materials are not received within that timeframe, the Credentialing Specialist sends a second request on the 16th day. If the recredentialing materials are not received 15 business days after the second notice; on the 16th day, a THIRD AND FINAL notice is sent to the practitioner via email by the Contracting Department.

If the recredentialing materials are not received within 15 business days of the final notice; on the 16th day, the Credentialing Specialist notifies the Contracting Department. The Contracting Department attempts to obtain the materials. If unable to do so, the Contracting Department notifies the practitioner that he/she will receive an Administrative Termination via Certified Mail as the recredentialing appointment date has expired.

A practitioner may reapply for participation however the full initial credentialing process will be required.

### PROVIDER'S RIGHTS DURING THE CREDENTIALING PROCESS

#### Review of Credentialing Files

Providers have the right to review the information in their credentialing files that have been obtained in order to evaluate their credentialing application. This includes the application, attestation, and Curriculum Vitae (CV), and information from outside sources. Credentialing information that is not available for review includes references, recommendations, or other peer review protected information as this information is used by the Chief Medical Officer and/or PR&CC to determine initial network participation and/or contract continuance.

Requests to review this file must be made in writing to the Chief Medical Officer, and the Chief Medical Officer will be present at the time of review.

#### Notification of Errors in Credentialing Submissions

Providers have the right to be notified in the event that credentialing information obtained by Health Plan varies substantially from that provided by the Provider on the application materials, Health Plan Credentialing Specialists will notify the Provider by letter, telephone, or fax. If the notification is conducted by telephone, the date, time, and the person initiating the call and obtaining the information along with the response will be documented and the documentation retained in the credentialing file.

The notification to the Provider will include the following:

- 1) A description of the discrepancy
- 2) A request for a written explanation and/or correction of the discrepancy
- 3) The name and contact information of the Credentialing Specialist to whom the response should be submitted
- 4) Notification that a written response is due no later than 60 calendar days from the date of the letter

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## SECTION 3: PROVIDER CREDENTIALING

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- 5) Notification that failure to respond within the 60 calendar days will result in, for initial application, closure of the file for lack of response
- 6) For recredentialing Providers, notification that the file will be presented to the PR&CC without benefit of explanation or correction of the discrepancy

The Credentialing Specialist will review the response, sign and date the response, and then notify the Provider that the response has been received. The Credentialing Specialist will also document the receipt and notification to the Provider of the receipt of the information in the credentialing file. Health Plan is not required to reveal to a Provider the source of the information if the information is not obtained to meet Health Plan's credentialing verification requirements, or if law prohibits disclosure.

### **Correction of Erroneous Information**

Providers have the right to correct erroneous information they may have provided within 14 business days or which has been submitted by another party in the course of the credentialing process. If information provided on the application is inconsistent with information obtained via primary source verification in the credentialing or recredentialing process, the Credentialing Specialist will send the Provider a written notification of the discrepancy and request formal written clarification.

This letter will include a summary of the information in question and a request to have the Provider's written response to the information returned within 14 business days. This letter will be sent electronically or via certified mail marked as "Confidential" with return receipt requested.

Providers do not have the right to correct an application already submitted and attested to be correct and complete. Providers have the right to correct erroneous information prior to the notification of decision and for applications that have not yet been attested to be correct and complete. However, they may submit an addendum to correct erroneous information they may have provided, or which is submitted by another party. This can be sent to the Credentialing Specialist via electronic or certified mail. If preferred, the Provider may add an explanation for the erroneous information on their application, include a signed and dated statement attesting to the accuracy of the information provided, and then return the information to the Credentialing Specialist who initiated the query.

### **Application Status and Notification on Decision**

Providers have the right to receive information about the status of their application or reapplication and may contact the Credentialing Department at any time to request this information. Upon request, the Credentialing Specialist will provide information regarding the current stage of the application process, such as in progress/pending or awaiting additional information or clarification. The Credentialing Department will respond to these requests in writing no later than 60 days after receipt of request.

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## SECTION 3: PROVIDER CREDENTIALING

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Health Plan will notify Providers in writing of their approval no later than 30 calendar days from the PR&CC's approval date. Any Provider who is denied participation, approved with conditions, pending or terminated, will be notified in writing within 30 days of the PR&CC's action, given the reasons for the decision, and provided information about the process for appealing adverse participation decisions.

### Notification of Provider Rights

Health Plan notifies Providers of these rights through a number of methods, which includes notifications in the credentialing application or reapplication cover letter, written and web-based Provider Manual, and other publications distributed to Providers.

### CREDENTIALING A NEW GROUP PROVIDER

To ensure that there is no disruption in obtaining services requiring prior authorization and to avoid claims being denied, it is imperative that any new Provider who joins a group in Health Plan's Provider network is approved by the PR&CC prior to providing covered services to Enrollees.

Before a Provider can be added to a group contract, the new Provider must receive notification from the Credentialing Department that all credentialing requirements have been met. In addition, Providers must receive official notice from the Contracting Department as to the effective date upon which they can provide covered services to Enrollees. The Provider Services Department should be contacted as soon as possible when new Providers are joining a Group.

### Credentialing Provider Organization Certification

Health Plan may obtain Credentialing Provider Organization Certification (POC) from NCQA. HPSJ may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider's facilities.

### SITE REVIEWS

When appropriate and at its sole discretion, Health Plan may elect:

1. **Facility Site Review (FSR):** a formal review of primary care sites that occurs prior to the practice accepting D-SNP Enrollees, and then every three years thereafter
2. **Medical Record Review (MRR):** A review of selected medical records to determine compliance in the documentation of clinical care
3. **Physical Accessibility Review Survey (PARS):** A review to determine physical accessibility for seniors and people with disabilities
4. **Focused Review:** A focused review is a targeted review of one or more specific areas of the FSR or MRR. The Plan must not substitute a focused review for a site review. The Plan may use focused reviews to monitor Providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions. Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused

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## SECTION 3: PROVIDER CREDENTIALING

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review, or other methods to investigate identified deficiencies or situations. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to the Corrective Action Plan (CAP) timelines.

### FACILITY AND ANCILLARY ASSESSMENT AND VERIFICATION

Facilities and Ancillary Providers seeking to contract with Health Plan must complete an application to verify it meets regulatory and Health Plan network criteria. Application submission is not a guarantee of acceptance. The criteria for participation and continued participation may vary depending upon the types of D-SNP covered services provided and network need/adequacy. The minimum criteria are as follows:

#### Facility Providers

1. Valid California state license
2. Current general and professional liability (malpractice) insurance in amounts acceptable to Health Plan
3. Medicare/Medi-Cal Certification
4. Accreditation by Joint Commission or another accreditation body acceptable to Health Plan, if applicable
5. Absence of OIG exclusions

#### Ancillary Providers

1. Valid business license
2. Current general and professional liability (malpractice) insurance in amounts acceptable to Health Plan
3. Medicare/Medi-Cal certified and/or participating, as appropriate
4. Clinical Laboratory Improvement Amendment (CLIA) certificate if applicable
5. Accreditation for Radiology/Imaging, if applicable
6. Absence of OIG exclusions

For more information regarding specific requirements for participation, please contact the Provider Contracting Department at 1-888-361-7526

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## SECTION 3: PROVIDER CREDENTIALING

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### FACILITY SITE REVIEW

All new primary care sites must undergo an initial full scope site review and attain a minimum passing score of 80% on both the FSR and on MRR surveys. Initial full scope site reviews will be performed at sites that have not previously had an FSR, PCP sites that have not had a FSR within the past three years, and PCP sites that are returning to D-SNP and have a passing score but were previously terminated for cause and non-compliance with their CAP.

There are additional scenarios that require Health Plan to conduct an FSR. Examples include, but are not limited to, instances when:

1. A new PCP site is added to the Plan's network.
2. A newly contracted Provider assumes a PCP site with a previous failing FSR and/or MRR score within the last three years.
3. A PCP site is returning to the D-SNP program and has not had a passing FSR in the last three years.
4. There is a change of ownership of an existing Provider site.
5. A PCP site relocates.

When a PCP site relocates, Health Plan must:

1. Complete an initial FSR within 60 days of notification or discovery of the completed move.
2. Allow assigned Enrollees to continue to see the Provider.
3. Not assign new Enrollees to Providers at the site until the PCP site receives passing FSR and MRR scores.

The reviewer will also complete a PARS during the FSR.

The FSR can be waived by Health Plan for a pre-contracted Provider site if the Provider has documented proof that a current FSR with a passing score was completed by another health plan within the past three years. Health Plan may review sites more frequently if it is determined necessary.

### Non-Compliance or Failure on FSR

#### Pre-contractual Providers

A pre-contractual Provider who scores below 80% on the full scope site review survey shall not be counted as a network Provider. Prior to being contracted with Health Plan, a non-passing Provider must be re-surveyed and pass the Full Scope Site Review Survey at 80% or higher. After achieving a score of 80% or higher, a CAP shall be completed as specified under CAP steps. If the Provider fails the site review after the second attempt, the Provider will need to reapply to the MCP after six months from the date of the second attempt. Health Plan reserves the right not to contract with any Provider who does not pass the pre-contractual Site Review Survey.

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## SECTION 3: PROVIDER CREDENTIALING

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### Contracted Providers

Contracted Providers must also pass the FSR every 3-years at a score of eighty (80%) or higher. Non-passing Providers shall be notified of the survey score, all cited deficiencies, and CAP requirements at the time of the non-passed survey. Health Plan shall have the right to remove any Provider with a non-passing score from the Provider network.

### Failed Audit Scores

When a PCP site receives a failing score on an FSR or MRR, the Health Plan will notify the PCP site of the score, all cited deficiencies, and all CAP requirements. The Health Plan may choose to remove any PCP site with a failing FSR or MRR score from its Network. If the Health Plan allows a PCP site with a failing FSR or MRR score to remain in its Network, the Health Plan will require and verify that the PCP site has corrected the identified deficiencies within the CAP timelines established in this policy. The Health Plan will not assign new Members to Network PCP sites that receive a failing score on an FSR or MRR until the Health Plan has verified that the PCP site has corrected the deficiencies, and the CAP is closed.

If the PCP site fails the FSR or MRR on its third consecutive attempt, despite the Health Plan's ongoing monitoring and assistance, the PCP site will not have an opportunity to complete a CAP and must be removed from the Health Plan's Provider Network. Impacted Members must be reassigned to other Network Providers, as appropriate and as contractually required. If a PCP site is removed from one Health Plan's Network due to three consecutive failing scores, all other Health Plans must also remove the PCP site from their Networks.

### FSR/MRR CAP Noncompliance

Any network Provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and Members shall be appropriately re-assigned to other network Providers. Health Plan shall provide affected Members with a 30-day notice that the non-compliant Provider is being removed from the network. In addition, Provider sites that score below 80 percent in either the FSR or MRR for two consecutive reviews must score a minimum of 80 percent in the next site review in both the FSR and MRR (including sites with open CAPs in place). Sites that do not score a minimum of 80 percent in both the FSR and MRR despite Health Plan's ongoing monitoring, must be removed from the network and Members must be appropriately reassigned to other network Providers. Health Plan must provide affected Members with 30-day notice that it will remove the noncompliant Provider from the network.

### Site Review and Medical Record Review Requirements for Street Medicine:

Street medicine Providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review.

For street medicine Providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, Health Plan must conduct the full review process of the street medicine Provider and affiliated facility in accordance with APL 22-017: Primary

## SECTION 3: PROVIDER CREDENTIALING

Care Provider Site Reviews: Facility Site Review and Medical Record Review, as stated in APL-24-001

For street medicine Providers serving as an assigned PCP, and that are not affiliated with a brick-and mortar facility or mobile unit/RV, Health Plan must conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine Provider to ensure Member safety as per the limited/condensed (as shared by DHCS) FSR and MRR requirements that would apply only to a street medicine Provider under this scenario. (APL-24-001)

### Scoring

	Exempted Pass	Conditional Pass	Fail
FSR	<ul style="list-style-type: none"> <li>Score of 90% and above with no deficiencies in critical elements, infection control, or pharmacy</li> <li>CAP not required</li> </ul>	<ul style="list-style-type: none"> <li>Score of 90% and above with deficiencies in critical elements, infection control, or pharmacy</li> <li>Score of 80% and above</li> <li>CAP required</li> </ul>	<ul style="list-style-type: none"> <li>Score below 80%</li> <li>CAP required</li> </ul>
MRR	<ul style="list-style-type: none"> <li>Score of 90% and above, with all section scores at 80% and above</li> <li>CAP not required</li> </ul>	<ul style="list-style-type: none"> <li>Score of 90% and above with one or more section scores below 80%</li> <li>Score of 80% and above</li> <li>CAP required</li> </ul>	<ul style="list-style-type: none"> <li>Score of 79% or below</li> <li>CAP required</li> </ul>
Health Plan may require a CAP regardless of score for other findings identified during the survey that require correction.			

### Corrective Action Plans for Deficiencies

All sites that receive a conditional pass will require a CAP to address each of the noted deficiencies. Conditional pass is defined as a site score of 80% to 89%, or 90% and above with deficiencies in critical elements, pharmaceutical services, or infection control, will be required to establish a CAP that addresses each of the noted deficiencies.

CAP documentation must identify:

1. Specific deficiency
2. Corrective action(s) needed
3. Re-evaluation timelines/dates
4. Responsible person(s)

## SECTION 3: PROVIDER CREDENTIALING

5. Problems in completing corrective actions
6. Education and/or technical assistance provided by Health Plan
7. Evidence of the correction(s)
8. Completion/closure dates
9. Name/title of reviewer

### Timelines for CAP

Providers will be informed of non-passing survey scores, critical element deficiencies, other deficiencies that require immediate corrective action, and the CAP requirements for these deficiencies.

Below is the timeline for correction and reporting:

CAP Timeline	CAP Action(s)
FSR and/or MRR Completion Day	<p>Health Plan must provide the PCP site a report containing:</p> <ul style="list-style-type: none"> <li>• The FSR and/or MRR scores.</li> <li>• Any critical element findings, if applicable; and discussion of the CE CAP and this initiates the CAP timeline for CE</li> <li>• A formal written request for CAPs for all critical elements, if applicable.</li> </ul>
Within 10 business days of the FSR and/or MRR	<ul style="list-style-type: none"> <li>• The PCP site must submit a CAP and evidence of corrections to the MCP for all deficient critical elements, if applicable.</li> <li>• Health Plan must provide a report to the PCP site containing Non-FSR and/or MRR findings, along with a formal written request for CAPs for all non-critical element deficiencies. This starts the non- CE CAP timeline</li> <li>• Health Plan must provide educational support and technical assistance to PCP sites as needed.</li> </ul>
Within 30 calendar days from the date of the completed FSR and/or MRR (Audit date)	<ul style="list-style-type: none"> <li>• Health Plan must conduct a focused review to verify that CAPs for critical elements are completed.</li> <li>• Providers can request a definitive, time-specific extension period to correct CE deficiencies, and to be granted at the discretion of the MCP, not to exceed 60 calendar days from the date of the FSR.</li> </ul>

## SECTION 3: PROVIDER CREDENTIALING

Within 30 calendar days from the date of the FSR and/or MRR Report (10 days after the issuance of the CAP)	<ul style="list-style-type: none"> <li>• The PCP site must submit a CAP for all non-CE (FSR/MRR) deficiencies to the MCP</li> <li>• Health Plan must provide educational support and technical assistance to PCP sites as needed.</li> </ul>
Within 60 calendar days from the date of the FSR	<ul style="list-style-type: none"> <li>• For those sites that were granted an extension for CE CAPs, the MCP must verify that all CE CAPs are closed.</li> </ul>
Within 60 calendar days from the date of the FSR and/or MRR report	<ul style="list-style-type: none"> <li>• Health Plan must review, approve, or request additional information on the submitted CAP(s) for non-critical findings.</li> <li>• Health Plan must continue to provide educational support and technical assistance to PCP sites as needed.</li> </ul>
Within 90 calendar days from the date of the FSR and/or MRR report	<p>All CAPs must be closed.</p> <ul style="list-style-type: none"> <li>• Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.</li> </ul>
Beyond 120 calendar days from the date of the FSR and/or MRR Report	<ul style="list-style-type: none"> <li>• Under extenuating circumstances, MCPs can request from DHCS/CMS a definitive, time-specific extension period to allow for 1) the PCP site to complete the CAP and/or 2) the MCP to verify CAPs have been completed.</li> <li>• The MCP must conduct a focused FSR and/or MRR as applicable, within 12 months of the original FSR and/or MRR date(s).</li> </ul>