Section (Primary Department) **Quality Management**		**SUBJECT (Document Title)** **Facility Site and Medical Record Review Process - CA**	
Effective Date 02/14/1997	**Date of Last Review** 10/11/2023	**Date of Last Revision** 10/11/2023	**Dept. Approval Date** 10/11/2023
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☒ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Blue Cross Medi-Cal (Plan) has a process to ensure the following:

- Primary Care Provider (PCP) facility site reviews are completed according to regulatory, contractual, policy and accreditation requirements
- PCP facility sites required to complete corrective action plans (CAPs) are reviewed and monitored
- Level of physical accessibility of provider offices servicing the Senior and Persons with Disabilities (SPD) population is assessed
- Ongoing oversight and monitoring of PCP sites between reviews is performed; and
- The quality of office sites is reviewed and monitored in response to issues raised by members' complaints/grievances

Pursuant to Title 22, California Code of Regulations, Section 56230 and California Department of Health Care Services (DHCS) Managed Care Quality & Monitoring Division (MCQMD) All Plan Letters 22-017 and 15-023 and Policy Letter 12-006, the Plan shall complete:

- An initial provider site inspection[1] [2] for each of its contracted PCPs prior to the PCP providing services to the Plan's members
- A medical record review

[1] The site inspections are conducted regardless of the status of other accreditation and/or certifications if there is no evidence of a current passing survey completed by another local health plan within the last three years, or when a contracted provider from an approved site moves to a new site that has not previously been reviewed.

[2] In accordance with the DHCS MCQMD All Plan Letter 22-017, facility site reviews are conducted to ensure all PCP sites used for delivery of services to Plan members have sufficient capacity to:

- Provide appropriate primary health care services
- Carry out processes that support continuity and coordination of care
- Maintain patient safety standards and practices
- Operate in compliance with all applicable federal, state and local laws and regulations

- A physical review survey to assess the level of physical accessibility of provider sites that serve SPDs
- A physical review survey to assess the physical accessibility of facilities used by providers of ancillary services and Community-Based Adult Services (CBAS) that serve a high volume of SPDs on Attachment D and Attachment E
- Subsequent periodic site inspections and medical record reviews

The Plan Medical Director is accountable for oversight of the full scope and interim provider facility site review and medical record review processes.

DEFINITIONS:

Certified Master Trainer (CMT): A Physician, Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) certified by the State of California DHCS MCQMD to conduct reviews (as referenced in this policy as a "Reviewer") and certify candidates as Reviewers.

Certified Site Reviewer (CSR): A Physician, Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) who has completed site review training and is certified by the Plan's CMT to conduct reviews (as referenced in this policy as a "Reviewer").

Collaborating Health Plan(s): Medi-Cal Managed Care health plan(s) in the county that is/are mutually contracted with providers in that county. The plans collaborate locally within each contracted county to establish systems and implement procedures for the coordination, consolidation, dissemination and completion of facility site audits and surveys.

Corrective Action Plan (CAP): The standard approved tool that is used to document deficiencies, notify providers of the actions needed to correct deficiencies and document subsequent actions taken by the provider to improve site and or medical records.

Critical Element (CE): A criterion in the site review tool that is identified as having potential for adverse effects on the patient's health and/or safety. There are fourteen (14) critical elements in the FSR.

Facility Site Review (FSR) Attachment A: The most current FSR tools and standards issued by the Department of Health Care Services (DHCS) to ensure primary care practitioners (PCP) and OB/GYNs acting as PCPs are in compliance with all applicable local, state, and federal laws and regulations and have the capacity to support the safe and effective provision of primary care services.

FSR Attachment B: The most current MRR tools and standards issued by the Department of Health Care Services (DHCS) to ensure primary care practitioners (PCP) and OB/GYNs acting as

PCPs are in compliance with the medical record documentation and confidentiality standards for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.

FSR Attachment C: The most current Facility Site Physical Accessibility Review Survey tool used to assess the physical adequacy of provider sites that provide services to a high volume of SPDs.

FSR Attachment D: The most current Facility Site Physical Accessibility Review Survey tool used to assess the physical adequacy of ancillary service provider sites are free-standing facilities that provide diagnostic and therapeutic services such as but not limited to Allergy, Cardiovascular Disease, Dermatology, Endocrinology, ENT, Gastroenterology, General Surgery, Hematology, Infectious Diseases, Nephrology, Neurological Surgery, Neurology, Obstetrics & Gynecology, Occupational Medicine, Oncology, Ophthalmology, Orthopedic Surgery, Pediatric Cardiology, Physical Medicine and Rehabilitation, Physical Therapist, Podiatry, Pulmonary Diseases, Radiation Oncology, Rheumatology, Speech Therapy, and Urology.

FSR Attachment E: The most current Facility Site Physical Accessibility Review Survey tool used to assess the physical adequacy of CBAS provider sites including all facilities that provide bundled CBAS services and do not include Licensed Only Adult Day Health Care centers and Programs of All-inclusive Care for the Elderly. CBAS centers offer a package of health, therapeutic, and social services in a community-based day health care program. The services are designed to prevent premature and unnecessary institutionalization and keep recipients as independent as possible in the community.

Interim FSR: Facility Site Review tool used to monitor the provider site between periodic full scope FSR and MRRs.

PCP: Primary Care Provider. Note: The State of California DHCS MCQMD All Plan Letter 22-017 defines a PCP as a "general practice physician, family practice physician, internal medicine physician, pediatrician, or obstetrician/gynecologist who provides primary care services".

PROCEDURE:

I. Health Plan Collaboration[3]

[3] As described in DHCS MCQMD All Plan Letter 22-017, this collaborative and standardized system-wide process for conducting reviews of provider sites minimizes site review duplication and supports consolidation of PCP site reviews for all Medi-Cal Managed Care health plans.

The Plan shall collaborate locally within each contracted Medi-Cal Managed Care county or region to establish systems and implement procedures for the coordination, consolidation and dissemination of facility site audits (inclusive of medical record review audits and surveys used to assess the physical adequacy of sites that provide services to the SPD population) for mutually shared PCPs per DHCS MCQMD All Plan Letter 22-017, Health and Safety Code Section 1342.8. The process to exchange site review and medical record review scores and information and monitor the effectiveness of the collaboration effort is described in policy *CA_QMXX_083 Monitoring the Facility Site Review (FSR) Collaborative Process.*

The decision to delegate or subcontract the facility site review is a determination made by each plan. However, each Collaborating Health Plan shall determine the acceptance of reviews completed by the entities delegated or subcontracted by another local plan.

All Collaborating Health Plans within a county or region have equal responsibility and accountability for the coordination and consolidation of provider full scope reviews and therefore, are expected to participate in these collaborative activities including collection and storage of site review results and security of Protected Health Information (PHI).

All Collaborating Health Plans within a county shall collaborate to determine processes for scheduling full scope reviews, notification of review status and results on shared providers. All health plans shall have equal responsibility and accountability for ensuring providers complete CAPs to correct cited deficiencies. The ultimate accountability for the CAP process remains with the health plan that performed the review. All Collaborating Health Plans within a county or region shall also collaborate to share results on sites and results of the physical accessibility review survey for the SPD population.

FSR responsibilities may be shared equally by all Collaborating Health Plans within a county or region, delegated to one or more plans or Participating Medical Groups (PMGs), and/or subcontracted to other agencies/entities. The process for selecting, monitoring, and overseeing delegated activities is described in Policy *DEL 101 Enterprise Performance Management Entity Oversight.* The Medical Director is ultimately responsible for facility site review activities. The Plan does not delegate the Medical Director's responsibility.

To avoid duplication of efforts and disruption to PCPs practicing at the same site, the Plan may include a non-contracted PCP(s) in the site review, at the agreement of the Collaborating Health Plans. At the discretion of the Plan, site review scores and

outcomes may be shared and accepted. In the event site review scores are not accepted by the Plan, a site review shall be performed.

In instances where contracted PCP sites are located in a bordering county, Collaborating Health Plans may share site activity information such as scores, CAP completion, and/or noncompliance, with bordering county Managed Care Plans (MCPs) to avoid duplicative site reviews. Formal agreements shall be in place in order to disclose PHI, such as the review of medical records of a Member belonging to another Collaborating Health Plans.

Reviewers shall only assess review criteria that are appropriate to their level of education, expertise, training, and professional licensing scope of practice as determined by California statute. The responsible Reviewer for each survey shall be, at a minimum, an RN who shall sign the facility site review and/or medical record review. FSR Attachment C, D and E reviews do not require a clinical staff person to complete the review. Training and oversight of non-clinical staff shall be the responsibility of a CMT and CSR. Please reference *CA_QMXX_071 Facility Site Reviewer Certification and Inter-rater Process*.

An FSR may be accepted for a pre-contracted provider site at the same address, if the provider or another local plan has documented proof that a current full scope review with a passing score was completed by another Collaborating Health Plan within the past 3 years in accordance with DHCS MCQMD All Plan Letter 22-017.

The most current facility site, medical record and physical accessibility reviews shall be shared and accepted by all Collaborating Health Plans contracting with the provider(s).

Each health plan contracted with the DHCS is accountable for the PCP sites where delivery of care is provided to their members.

Each health plan is responsible for tracking the review status of all contracted Managed Care provider sites. The Plan shall exchange the physical accessibility data with Collaborating Health Plans on at least a quarterly basis with the exception of the LA Care Health Plan. The physical accessibility review results shall be sent to LA Care as they are completed for Anthem Blue Cross' Medi-Cal Managed Care Providers.

The Plan shall maintain original electronic documentation of its FSR assessments and shall make this information available to DHCS or its representatives for contract monitoring/auditing purposes.

II. Initial and Periodic Full Scope Review

A. Overview

All PCP sites participating in the Medi-Cal Managed Care Program are required by California Code of Regulations (22 CCR § 56230) and California DHCS MCQMD All Plan Letter 22-017 to: 1) complete an Initial FSR, subsequent periodic Full Scope Reviews (FSR and MRR); and (2) complete CAPs and correct those deficiencies within DHCS-specified timelines when deficiencies are noted.

An Initial FSR consists of completion of the MCQMD Facility Site Review Tool (FSR Attachment A), including an assessment of medical-recordkeeping practices, minimum physical accessibility requirements and accompanying interpretive guidelines. The Medical Record Review (FSR Attachment B) shall be completed after assignment of members. At the time of the review, each PCP site shall also complete a Physical Accessibility Review Survey (FSR Attachment C), used to assess the physical adequacy of provider sites that provide services to a high volume of SPDs. The FSR Attachment C does not necessarily have to be completed on the same date as the FSR Attachment A.

Listed below are scenarios that require the Plan to conduct an Initial FSR. Examples of these scenarios include, but are not limited to, instances when:

- A new PCP site is added to the Plan's network.
- A newly contracted provider establishes an independent practice in an existing PCP site.
- A PCP site is returning to the Medi-Cal Managed Care Program and has not had a passing FSR in the last three years.
- At the discretion of the MCP, a separate site review may be conducted for solo practices/organizations.
- Upon identification of multiple independent practices that occupy the same site, a separate site review shall be completed for all PCP practices at that site and a unique alphanumeric DHCS Site ID must be assigned for each independent PCP practice at the site if ownership is different. All Collaborating Health Plans within a county developed processes through Memorandum of Understanding (MOU) agreements regarding conducting separate site reviews for shared sites.
- A newly contracted provider assumes a PCP site with a previous failing FSR and/or MRR score within the last three years.
- A change in ownership of an existing provider site is planned and/or identified (without joint ownership between the new and previous

owners for at least two months or a different timeframe established by the MCP collaborative in each county).

- A PCP site relocates. When a PCP site relocates, the Plan shall:
  - Complete an initial FSR within 60 days of notification or discovery of the completed move.
  - Allow assigned Plan members to continue to see the provider until a passing Initial FSR score is achieved at the new PCP site.
  - Not assign new members to providers at the site until a passing Initial FSR score is achieved at the new PCP site and all CAPs are complete and verified.
  - If the relocated PCP site does not pass the initial FSR within two attempts, or does not complete required CAPs per established timelines, the following will occur:
    - The relocated PCP site may not be added to the MCP's Provider Network.
    - The previous PCP site must be removed from the Network if the site has closed.
    - Current assigned membership must be reassigned to another Network PCP if the previous site has closed.
    - The relocated PCP site may reapply six months from the last FSR survey.
- A new MCP is established or an existing MCP expands to a new service area. New MCPs and those that expand to a new service area must complete an initial site review on a specified number of PCP sites as outlined in the bulleted list below. The FSR portion of the initial site review must be completed prior to the start of new or expanding MCP operations.
  - Five percent of the PCP sites in its proposed network, or on thirty PCP sites, whichever is greater in number.
  - All of the remaining proposed PCP sites within the first six months of operation or expansion.
  - All of the PCP sites in the network if there are thirty or fewer PCP sites in the network.
  - The Plan may use site reviews of existing county MCPs as evidence of completion of the required initial site reviews.
  - The Plan shall submit data and relevant information to DHCS, in a format and timeframe to be specified by DHCS, for the instances described above.
  - For preoperational and expansion site reviews, MCPs must submit site review data to DHCS at least six weeks prior to site operation.

An initial FSR is not required when a new provider joins a PCP site that has a current passing FSR score.

The Plan must not assign members to providers until the site receives a passing FSR score of at least 80% and completes all CAPs. A provider site that is returning to the Managed Care Program after a termination due to compliance issues must attain a minimum passing score of 80%, OR a higher passing percentage (i.e. 90%) threshold on the Initial FSR as set by the Medical Advisory Committee (MAC) or Medical Director on a case by case basis. These pre-contracted providers who do not pass the Initial FSR after two attempts may reapply to the Plan after six months of the second attempt.

A DHCS Site Identification Number ("DHCS Site ID") is a unique identifier and must be assigned by designated MCPs to each PCP site reviewed. DHCS releases sets of DHCS Site ID numbers for each county. In the event of an ownership change at an established PCP site, a new DHCS Site ID will be assigned. The new DHCS Site ID may be the existing Site ID but with a modifier to represent a change of ownership at the site. Local county MCPs collaborate to manage and assign the DHCS Site ID numbers specific to the county.

The Plan shall conduct subsequent site reviews, consisting of an FSR and MRR, at least every three years, beginning no later than three years after the initial FSR. The Plan may conduct site reviews more frequently per county collaborative decisions, or when determined necessary based on monitoring, evaluation, or CAP follow-up issues.

B. Scheduling and Notification Process

A facility site review request for a provider site requiring an audit is sent to the Quality Management Department.

The Clinical Quality Program Specialist notifies the Reviewers to schedule a review after verifying that a current full scope review with a passing score has not been completed by another health plan within the past 3 years.

The Reviewers contact the provider office to schedule an appointment date and time with each site. The Reviewers explain the facility site review process to the provider/office manager prior to the review and sends the provider office the following:

- Letter, email and/or fax with audit date and time
- Audit preparation worksheet/checklist
- Any additional information as requested.

When a new site refuses to schedule or does not respond to at least three (3) attempts in a two-week period to schedule an Initial FSR, the site shall not be allowed in the network. When a contracted provider refuses to schedule a periodic FSR or does not respond to at least three (3) attempts in a two-week period, the Reviewer shall make the necessary attempts to complete the review before escalating the provider for termination as described in *policy CA_QMXX_004 Termination of Providers for Non-Compliance with Facility Site or Medical Record Reviews.*

When a contracted provider has extenuating circumstances that prevents the completion of their periodic FSR, the Plan shall inform the collaborating Health Plans and request for an extension from DHCS prior to the due date. The Plan shall provide updates to the collaborating Health Plans and DHCS until completion of the FSR.

C. Critical Elements

There are fourteen (14) critical elements identified to have potential for adverse effects on patient health or safety. Critical elements have a scored weight of two points on the review tool (FSR Attachment A). All other elements are weighted at one point. The fourteen (14) critical elements are as follows:

- Exit doors and aisles are unobstructed and egress (escape) accessible
- Airway management equipment, appropriate to practice and populations served, are present on site
- Emergency medicine such as Asthma, Chest Pain, Hypoglycemia, and Anaphylactic reaction management are present on site.
- Only qualified/trained personnel retrieve, prepare or administer medications
- Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results
- Only lawfully authorized persons dispense drugs to patients
- Drugs and vaccines are prepared and drawn only prior to administration
- Personal protective equipment (PPE) is readily available for staff use
- Needle stick safety precautions are practiced on-site
- Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/bio-hazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport or shipping
- Cold Chemical Sterilization: Staff demonstrate/verbalize necessary steps/process to ensure sterility and/or high-level disinfection to ensure sterility/disinfection of reusable equipment

- Cold Chemical Sterilization: Appropriate PPE is available, exposure control plan, MSDS and cleanup instructions in the event of a cold chemical sterilant spill
- Autoclave / Steam Sterilization: Management of positive mechanical, chemical, and or biological indicators of the sterilization process
- Autoclave / Steam Sterilization: Spore testing of autoclave/steam sterilizer is completed (at least monthly), with documented results

Sites found deficient in any critical element during a Full Scope Site Review Survey shall be required to submit a CAP and correct deficiencies, regardless of survey score within 10 business days of the survey date and the Plan shall verify the corrective action within 30 calendar days of the survey date.

III. Medical Record Review

A. Overview

Once the provider is approved for participation in the network and members are assigned, an in-depth review of medical records shall take place. Medical records of new PCPs or contracted PCPs at new sites shall be reviewed within 90 calendar days of the date on which members are first assigned to the provider using the Medical Record Review Survey tool (FSR Attachment B). An additional extension of 90 calendar days may be allowed only if the new provider does not have a sufficient number of Medi-Cal Managed Care plan members to complete a review of 10 medical records.

If there are still fewer than 10 assigned member records at the end of six months, a medical record review shall be completed on the total number of records available. The scoring shall be adjusted according to the number of records reviewed.

If the new provider has panels open for membership assignment but still do not have members assigned at the end of six months, an initial medical record review shall be completed on the total number of records available during the site's next Interim FSR or periodic full scope review, whichever is the earliest opportunity to complete the review.

Medical record reviews shall be performed at the time of the scheduled site evaluation or another mutually agreed upon time.

The site and medical records may be reviewed more frequently in order to address identified deficiencies or to monitor the implementation of a CAP.

B. Medical Record Selection Criteria

Individual Medical Records

Prior to the medical record review process, the Reviewer shall determine which populations (adult, pediatric, obstetrics/perinatal) are served by the site in order to determine which medical records should be pulled for review. The office shall be asked to pull 20 medical records (for each 10 records to be reviewed) of all applicable health plan members who have had at least 3 visits within the past 12 months for each PCP at the site. If the provider does not have any Medi-Cal Managed Care members, the provider's medical record-keeping practices shall be evaluated.

The choice of medical records for review may be Medi-Cal Managed Care members belonging to any health plan and shall be in compliance with the individual health plan's Compliance and Legal Departments interpretation of the current HIPAA regulations. Collaborating Health Plans that are not able to review other health plan medical records shall notify the other contracted health plans in writing and when possible, in advance of conducting the review to facilitate joint reviews.

The medical record score is based on a standard review of 10 randomly selected records (from the files pulled by the provider) per provider, consisting of a reasonable combination of five pediatric and five adult records. For sites with only adult or only pediatric patients, all 10 records reviewed are scored in the appropriate preventive care area. For Obstetricians and Gynecologists acting as PCPs and PCPs providing obstetric care in accordance with American College of Obstetricians and Gynecologists and Comprehensive Perinatal Services Program standards, all medical records must be reviewed using preventive care criteria for adults or pediatrics (pregnant Members under age 21 years) and obstetrics.

The Plan reviewers reserve the right to request specific records to be pulled by the provider for the medical record review when compliance issues or other concerns arise. Reviewers may select members from quality reports (i.e. gap in care lists), member panel lists, or other reports.

Shared Medical Records

Shared medical records shall be considered those that are not identifiable as separate records belonging to any specific PCP.

In PCP sites where patient care is shared by multiple PCPs and documentation occurs in the same medical record, the medical records shall be reviewed as a shared medical record system.

A medical record review shall not be required for a new PCP joining a PCP office that shares medical records as long as the office has a current passing medical record review survey. A PCP joining a PCP site that does not share medical records shall be required to undergo a medical record review (FSR Attachment B).

The random selection criterion for shared medical records according to the number of PCPs and population served is shown below.

Number of PCPs	Minimum number of medical records (based on the general patient population distribution: pediatric, adult, obstetrics)
1 – 3	10
4 – 6	20
≥ 7	30

Records do not need to be pulled for specific providers but should be pulled randomly for all providers.

C. Medical Record Review Process

The Reviewer shall randomly select 10 medical records (depending upon the number of providers at the site as described in the table above) to review. If a minimum number of records are not available for review due to limited patient population, the reviewer will complete the MRR, document the rationale, and adjust the score as needed.

The Reviewer shall conduct the reviews with the Medical Record Review Tool (FSR Attachment B) with accompanying Standards.

Each medical chart should be reviewed for one area of preventive care: pediatric, adult health or obstetric/perinatal services as described in policy CA_QMXX_045 Medical Record Documentation and Confidentiality Standards. For sites with only adult, only obstetric or only pediatric patients, all records reviewed are scored in the appropriate preventive care area.

During the MRR, site reviewers have the option to request additional medical records for review to ensure adequate review of all Provider specialties, Member populations, etc.

MCPs may choose to conduct the MRR portion of the site review onsite or virtually. The virtual process must comply with all applicable HIPAA standards at all times, regardless of the chosen method. Both onsite and virtual MRRs may include the review of medical records for Members belonging to another MCP, and may include the viewing, collection, storage, and transmission of PHI.

When the medical record review has been completed, the Reviewer shall calculate the combined medical record score to determine the need for a CAP.

IV. Scoring Methodology for Facility Site Reviews and Medical Record Reviews

The scoring methodology of facility site reviews and medical record reviews is in accordance with standards described in the DHCS MCQMD All Plan Letter 22-017.

A minimum score of 80% for the FSR must be achieved to pass the survey. A minimum score of 80% of the MRR must be achieved to pass the survey. If either overall score in FSR or MRR is below 80%, that component of the review is considered non-passing.

No partial points are awarded (only full points) for any scored element. Zero (0) points shall be given if an element does not meet criteria. A score of 0 points requires a written comment of explanation. The Reviewer shall determine the “not applicable” (NA) status of each criterion based on site-specific assessment – a written comment of explanation is required.

After the site review, the Reviewer shall calculate the FSR and MRR score to determine the compliance rates.

The facility site review contains a total of 170 points possible with the following compliance level categories:

Compliance Categories	Compliance Rate
Exempted Pass	90% or above without deficiencies in critical elements, Infection Control and Pharmaceutical criteria.
Conditional Pass	80-89%; or 90% and above with deficiencies in any of the fourteen (14) identified critical elements or deficiencies in Infection Control or Pharmaceutical criteria.

Compliance Categories	Compliance Rate
Non-Passing	Below 80%

The total possible points in the MRR are dependent on the type of provider, the age of the member and the types of services provided.

Compliance Categories	Compliance Rate
Exempted Pass	90% or above
Conditional Pass	80-89%; or any MRR survey sub-section score below 80% regardless of the overall MRR score.
Non-Passing	Below 80%

If a provider site receives a non-passing score by one health plan, the site shall be considered to have a non-passing score by all other Collaborating Health Plans.

If a contracted PCP site receives a non-passing score during a Full Scope Review on FSR and/or MRR, a full scope review shall be conducted within 12 months from the site review date. A grace period of one to two months is acceptable.

Provider sites that score below 80% in either the FSR or MRR for two consecutive reviews must score a minimum of 80% in the next review in both the FSR and MRR. Sites that do not score a minimum of 80% in both the FSR and MRR must be removed from the network and the Plan's members shall be appropriately re-assigned to other participating providers. The Plan shall notify affected members with a 30-day notice that the affected Provider will be removed from the network.

If a provider site received a non-passing score for the FSR and/or MRR surveys two consecutive times but received a passing score the third time, an FSR and MRR survey is required within 10-14 calendar months from the date of the last survey. If a passing score of a minimum of 80% is obtained on the fourth FSR and/or MRR survey, then the next periodic review shall be in three (3) years. If a failing score is obtained on the fourth FSR and/or MRR, then the process is repeated.

Members shall not be assigned to providers applying for participation in the network that score below 80% on an Initial FSR until the site has achieved a score of 80% or greater and corrections, if any have been verified and the CAP is closed.

New members shall not be assigned to providers already contracted in the network at a location that scores below 80% on a periodic full scope FSR and MRR until the corrections are verified and the CAP is closed.

ALL full scope and Initial FSR/MRR scores shall be reported to DHCS on a semi-annual basis. All CAPs of all non-passing full scope FSR/MRRs shall be submitted to DHCS on a semi-annual basis.

V. Summary of Review Results and Exit Conference

The Reviewer shall calculate the FSR and MRR survey scores and at the exit conference discuss the findings with the PCP and/or site contact focusing on those areas that are critical elements, other areas requiring improvement and the need for a CAP, if applicable.

The Reviewer shall forward the results of the site survey, including Attachments A, B and C, as applicable to the Clinical Quality Program Specialist within 2 weeks of the review. If no CAP is required or if the requested CAP is complete and verified, the Clinical Quality Program Specialist shall issue an approval letter and copy of a Certified Quality Provider Site certificate to the site.

The Reviewer shall also ask the PCP or designee to complete a Post-Review Satisfaction Survey to evaluate the effectiveness of the site review process. Results of the satisfaction survey are reviewed and evaluated as described in policy *CA_QMXX_083 Monitoring the Facility Site Review Collaborative Process.*

VI. Sites with Non-Passing Reviews

New sites that receive a non-passing score on the Initial FSR (a score below 80%) shall not be accepted into the Plan's network. PCPs or PCP sites applying to return to the Medi-Cal Managed Care network with known compliance issues and score below the percentage threshold set by the Medical Advisory Committee (MAC) shall not be accepted into the Plans' network.

The Reviewer shall send the provider the *Non-Passing Score for New Providers Letter (ACAPEC-0712-16 Pre-Contractual Non-Passing Score*), notifying the provider that the site is not approved for member assignment. A copy of the letter is sent to the Quality Management Department and all appropriate key stakeholders.

For PCPs already participating in the network and relocated to a new site and receiving a non-passing score, the Clinical Quality Program Specialist shall submit a request to the Provider Data Management team to close the provider panel to new patients, effective on the date the transaction is processed. The provider may request a re-audit once the deficiencies have been corrected. Upon re-audit, if the site scores a conditional pass, the CAP process shall be implemented and completed before the site

is admitted to the network at, and new and existing members assigned to the new location. If the site receives a second non-passing score, the relocated PCP site may not be added to the network, the previous PCP site must be removed from the network if the site has closed, and existing membership at the previous site must be reassigned to another Network PCP if the previous site has closed. The relocated site may reapply after six (6) months from the last audit date.

New sites (either for PCPs already participating or providers applying for participation in the network) that receive a Conditional Pass shall be considered for participation in the network as long as they comply with the CAP timelines as described below.

VII. CAP Process for FSR and MRRs

A. Overview

There are established CAP processes, timelines, and follow-up procedures for FSR and/or MRRs that do not meet established benchmarks.

A CAP is required on all cited deficiencies for existing PCP sites with a conditional or non-passing score on either the FSR or MRR or for deficiencies identified by the Plan or State through oversight and monitoring activities.

A provider site with deficiencies identified through an FSR resulting in a total score of less than 90%, or that has deficiencies in CE, Infection Control or Pharmaceutical criteria, requires a CAP. A CAP is required for a total MRR score below 90% or if any sub-section score of the MRR is less than 80%.

A CAP is not required for a provider site that receives an Exempted Pass for the FSR/MRR. However, the Reviewer may issue a CAP per their discretion.

B. Documentation

The *CAP Tool* is a standardized document developed in collaboration with other health plans. The health plan conducting the site review is responsible for follow-up, verification, and closure of the CAP.

The *CAP Tool* contains 3 separate sections:

- Critical Elements
- Facility Site Review
- Medical Record Review

The *CAP Tool* and documents must identify:

- Name and title of Reviewer who conducted the survey
- The specific deficiency
- Corrective actions needed
- CAP due dates
- Instructions for CAP submission
- Correction dates
- Responsible persons
- Evidence of correction
- Health Plan verification and date of corrections

The CAP document includes disclosure and release statements regarding CAP submission timeline and authorization to furnish results of the reviews and corrective actions to health plans participating in the collaboration, government agencies that have authority over the health plans and authorized county entities in the State of California. The CAP informs the PCP that participating health plans have collaborated for FSR and MRRs, have agreed to accept the review findings and share with each other the review information (e.g. scores, CAP completion dates, etc.).

The signed and dated FSR and MRR CAP documents are placed in the PCP's file that is maintained by the health plan responsible for completing the audit. At a minimum, these documents include:

- All pages of the CAP Tool with documented deficiencies
- Signed and dated face sheet
- Signed and dated attestation
- Evidence of corrections

The closed/complete CAP document must include:

- Documentation of problems in completing corrective actions (if any)
- Resources and technical assistance provided by the Plan
- Evidence of the corrections
- Completion and closure dates
- Name and title of the Plan Reviewer

C. CAP Process for Contracted Network Provider with a Non-Passing or Conditional Passing Score

During the exit interview, the Reviewer discusses the findings, the required actions, and the process for successful completion of the CAP process with the PCP or designee. The Reviewer notifies the provider or designee in writing of their compliance

category (Exempted Pass, Conditional Pass or Non-Passing), the review findings, formal request for corrections, CAP Tool and process information. This information shall be shared with Collaborating Health Plans as necessary and appropriate. If the provider received a non-passing score, the Reviewer advises provider or designee that the site's panel will be immediately closed to assignment of new members until corrections are verified and the CAP is closed. A contracted provider with a non-passing score may be removed from the network at the discretion of the Plan's Medical Director.

The Reviewer obtains the signature of the provider or designee on the 1st CAP Notification document and explains that the provider or designee's signature on the document acknowledges receipt of the CAP and agreement to comply with the CAP timelines established by DHCS.

If the provider received a non-passing score, the Non-Passing Score for Existing Providers Letter is sent via certified mail to the provider by close of business day or the following business day advising that the panel is closed to new members and indicating the dates by which the CAP must be submitted. The provider may require more frequent periodic full scope reviews (at least annually) for closer monitoring.

The Clinical Quality Program Specialist shall submit a request to the Provider Data Management team to close the provider panel to new patients, effective on the date the transaction is processed.

All Collaborating Health Plans participating in the FSR and MRR collaboration shall be notified within three business days of PCP scores below 80% and/or after non-compliance with the CAP timelines per DHCS All Plan Letter 22-017 or most current version, for Initial and Periodic Reviews.

Providers who received a Non-Passing score and allowed to remain in the network or those who achieve a Conditional Passing score are expected to comply with APL 22-017 CAP timelines:

- Survey date: The reviewer shall provide to the PCP the following:
  - Verbal notification of any CE findings and a signed attestation by the PCP/site designee and the MCP staff confirming that a discussion regarding CE findings occurred. (This serves as the start of the CE-CAP timeline.)
  - A formal written request for CAPs to address all CEs, if applicable, the day of the site visit but no later than one business day after site visit completion
  - The FSR and/or MRR scores the day of the site visit but no later than one business day after the site visit completion

  - The Plan shall provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written request for CAPs for all non-CE deficiencies within 10 business days of the survey date. (This serves as the start of the non-CE CAP timeline.)
- Within 10 business days of the survey date:
  - Providers must submit a completed CAP with evidence of correction for all CE deficiencies.
- Within 30 calendar days of the survey report date (date[s] the CE or non-CE FSR/MRR findings and initial CAP request are issued):
  - All CE CAPs must be closed
  - The Reviewer must verify that all aspects of CE CAPs are completed
  - The PCP site must submit a CAP and evidence of corrections for all non-critical element deficiencies to the MCP
  - The Plan must provide educational support and technical assistance to PCP sites as needed
  - Providers may request a definitive, time-specific extension period to the Plan for any extenuating circumstances that prevented completion of a CAP within the established timeline, not to exceed 60 calendar days from the date of FSR (See CAP Extension Request section below)
- Within 60 calendar days of the survey report date (date the non-CE FSR/MRR findings and initial CAP request are issued):
  - The Reviewer shall verify that non-critical CAPs are completed which may be completed on-site if evidence of correction(s) is/are insufficient or deficiency cannot be verified in writing or by photographs.
  - The Reviewer shall review, approve, or request additional information on the submitted CAP(s) for non-critical findings.
  - The Plan shall continue to provide educational support and technical assistance to PCP sites as needed.
  - For those sites that were granted an extension for CE CAPs, the MCP must verify that all CE CAPs are closed on or before the new due date. Past due CE CAPs beyond 60 calendar days of the survey date:
    - The Plan must request approval from DHCS to complete a CAP for any extenuating circumstances that prevented completion of a CE CAP within the established timeline.

        - If DHCS approves the extension, the Plan must verify that the PCP site has corrected the deficiencies and the CE CAP is closed on or before the new due date.
        - Once all the CE CAP are corrected and verified, the Plan must conduct another full scope FSR/MRR, within 12 months of the FSR/MRR date.
    - Within 90 calendar days of the survey report date (date the non-CE FSR/MRR findings and initial CAP request are issued):
        - All non-CE CAPs must be closed.
        - Providers may request a definitive, time-specific extension period to the Plan for any extenuating circumstances that prevented completion of a CAP within the established timeline, not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
        - If the extension period is granted beyond the 90 days, the Plan shall conduct another full scope FSR/MRR, within 12 months of the FSR/MRR date.
    - Beyond 120 calendar days of the survey report date (date the non-CE FSR/MRR findings and initial CAP request are issued):
        - The Plan must request approval from DHCS to complete a non-CE CAP for any extenuating circumstances that prevented completion of a non-CE CAP within the established timeline.
        - If DHCS approves the extension, the Plan must verify that the PCP site has corrected the deficiencies and the non-CE CAP is closed on or before the new due date.
        - Once all the non-CE CAP are corrected and verified, the Plan must conduct another full scope FSR/MRR, within 12 months of the FSR/MRR date.

The Plan is responsible for conducting follow-up, verification, and closure of CE, FSR, and MRR CAPs to ensure that the site has implemented a process and/or procedures to make corrections as noted on the CAP. All CAP (CE, FSR, MRR) verifications may be performed via review of document submission via fax or email, virtual platform, or an onsite review, per nurse reviewer discretion. DHCS reserves the right to require the Plan to conduct CAP verification onsite.

CAP approval is communicated (via approval letter and DHCS approved certificate) to the PCP sites and to the health plans through the monthly data exchange of FSR and MRR audit activities.

D. Non-Compliance with CAP Timelines

Throughout the CAP completion process, the Reviewer and/or Plan representatives shall notify appropriate internal Plan representatives, Collaborating Health Plans, and PMGs, if applicable to assist with bringing the site into compliance. The Plan shall follow the CAP timeline protocols established by their respective Medi-Cal Managed Care Plan Collaboratives in their counties to bring the provider into compliance, which may include on-site focused reviews (see most current CAP Tracking form).

Critical Element CAP

Prior to the 10th business day (excludes weekends and state and federal holidays) from the date of review, the Reviewer shall send a reminder to the provider to submit their Critical Element CAP. If the Critical Element CAP is not received by end of the 10th business day from the date of review, the Reviewer sends the following letter by close of business day or the following business day via certified mail advising the provider that the CAP is overdue.

- Overdue CAP for Critical Elements Letter

The letter states that the CE CAP and evidence of corrections are overdue, closure of the site's Medi-Cal member assignment and notification of all Collaborating Health Plans in the county has resulted. Continued non-compliance with CAP timelines may result in the provider's administrative termination from the Plan network for non-compliance with contractual agreements and members will be appropriately re-assigned.

The Plan's Medical Director may choose to contact the provider to bring them into compliance. If CE deficiencies are not corrected and verified within 30 calendar days from the survey date, the provider shall be terminated as described in Policy CA_QMXX_004 Termination of Providers for Non-Compliance with Facility Site or Medical Record Reviews. Any documents or material submitted by the provider(s) site beyond 30 days shall not be accepted for review and/or approval. DHCS, internal Plan representatives, the Collaborating Health Plans, and the PMG(s), if applicable, shall be notified.

Non-Critical Element CAP

Prior to the 30th calendar day from the survey report date, the Reviewer shall send a reminder to the provider to submit their non-Critical Element CAP.

If the non-CE CAP is not received by end of the 30th calendar day from the survey report date, the Reviewer sends the following letter by close of business day or the following business day via certified mail advising the provider that the CAP is overdue.

- Overdue CAP for Non-Critical Elements Letter

The letter states that the non-CE CAP and evidence of corrections are overdue, closure of the site's Medi-Cal member assignment and notification of all Collaborating Health Plans in the county has resulted. Continued non-compliance with CAP timelines may result in the provider's administrative termination from the Plan network for non-compliance with contractual agreements and members will be appropriately re-assigned.

The Plan's Medical Director may choose to contact the provider to bring them into compliance.

If non-CE deficiencies are not corrected and verified within 90 days from the date of the written CAP request, the provider shall be terminated as described in policy CA_QMXX_004 Termination of Providers for Non-Compliance with Facility Site or Medical Record Reviews. Any documents or material submitted by the provider(s) site beyond 90 days will not be accepted for review and/or approval. DHCS, internal Plan representatives, the Collaborating Health Plans, and PMG(s), if applicable, shall be notified.

CAP Extension Request

The provider may request a definitive time-specific extension period to complete the CAP due to extenuating circumstances, not to exceed 60 days from the survey date for CE deficiencies and 120 days from the review findings report and CAP notification date for non-CE deficiencies, unless a longer extension is approved by DHCS. The provider must submit the written extension request to the Plan prior to 30 calendar days from the survey date for CE deficiencies, and prior to 90 calendar days of the survey report date for non-CE deficiencies. If the Reviewer feels the request for an extension is reasonable (i.e. fire, floods or other instances that prevent the site from opening their practice to see members) and there is no imminent risk of harm to their members, an extension shall be granted.

The Reviewer shall mail the provider the CAP Extension Approval Letter via certified mail. The letter states that if the CAP is not corrected and verified by the new due date, the provider may be subject for administrative termination from the Plan's network for non-compliance with DHCS CAP timelines and members will be appropriately re-assigned. The letter also states that a subsequent full scope FSR and

MRR is required in 12 months if the CAP is extended past 30 days (for CE CAP) and 90 days (for non-CE CAP) from the date of the FSR/MRR.

VIII. Office Hours Monitoring

In addition to meeting facility site and medical record criteria, PCP offices shall be evaluated and monitored to ensure they meet office hour access requirements as described in Policy *CA_PNXX_005 Primary Care Physician (PCP) Access Hours*. Providers who fail to meet the minimum hours requirements shall be terminated from the network.

Los Angeles County providers who fail to meet the minimum required hours shall be reported to LA Care for follow-up. At the request of LA Care, the Plan shall work with the provider to come into compliance as described in the policy.

IX. Interim Monitoring

A. Overview

The Plan has accountability for the completion of interim monitoring reviews for Plan assigned provider sites. An interim review shall be conducted between each regularly scheduled Full Scope Review. The Plan is responsible for conducting interim reviews at sites holding a unique contract with the health plan and assigned sites shared with the Collaborating Health Plans.

The interim review shall include an on-site or a clinic's self-assessment of, at a minimum, the fourteen (14) critical elements. This assessment is considered part of the overall monitoring process. The Plan may conduct on-site interim reviews to monitor providers who have compliance issues (i.e., repeat conditional passing scores in MRR, potential quality of care issues, etc.).

B. Process

The Clinical Quality Program Specialist shall produce and distribute a report to the Reviewers, which identifies all sites due for an interim monitoring review.

All assigned sites are expected to undergo an interim monitoring review. Reviewers are responsible for coordinating the process.

The components of the interim review include, at a minimum, an assessment review of critical elements using the approved *Interim FSR Form*.

Self-Assessment - Interim FSR: Based on the PCP site's performance during their previous Full Scope Review, those who are requested to complete a self-assessment Interim FSR shall be faxed/emailed an Interim FSR and a Frequently Missed Standards Attestation Form with instructions for completing and returning the form within 10 business days to the assigned Reviewer. The provider will document information to verify compliance with critical elements standards. When the Reviewer identifies deficiencies through monitoring, they must determine the appropriate course of action, such as conducting a site review or additional focused reviews, to educate and correct the deficiencies according to established CAP timelines.

On-Site Assessment - Interim FSR: Interim monitoring review conducted on-site shall follow the Focused Review process described in the next section.

The Reviewer shall forward the completed survey to the Clinical Quality Program Specialist. The interim monitoring completion date for the site shall be entered in the FSR Tracker database. A copy of the Interim FSR Form shall be scanned and uploaded to database. Interim monitoring completion dates shall be shared with Collaborating Health Plans, as requested.

X. Focused Reviews

A. Overview

The Plan may conduct focused reviews of PCP provider sites at any time for the following reasons:

- Scores achieved by the PCP site during the Full Scope FSR and MRR shall determine the type of follow-up review that is warranted:
  - If the PCP site had a prior site review score of ≥ 80% and an exempted score in MRR, the Reviewer/coordinator shall send the PCP office the self-assessment Interim FSR and Frequently Missed Standards Attestation Form to attest to their compliance with all critical element criteria.
  - If the PCP site had a prior site review score of > 80% and a conditional score in MRR, an onsite and/or virtual Interim monitoring visit using the Interim FSR Form shall be conducted between each regularly scheduled Full Scope Review to evaluate all Critical Elements and any additional deficiencies in FSR and/or MRR criteria identified during their last review. A focused medical record review shall be conducted consisting of a review of half the number of the records typically reviewed during the site's periodic

review, reviewing all applicable sections of the MRR to evaluate the site's compliance with current MRR standards.
    - If the PCP site had a prior site or medical review score of ≤ 79%, the PCP office shall receive an annual Full Scope Review to monitor improvement and compliance with DHCS and L.A. Care's site review guidelines and standards.
    - At the discretion of the Reviewer(s), an on-site follow-up visit may be conducted to assess the compliance of any criteria from the FSR and/or MRR tools.
- Issues identified by member complaints, quality of care investigations, risk management activities, or interim monitoring, regardless of practitioner specialty
- Upon the recommendation of the Medical Director, Medical Advisory or Peer Review Committee(s). FSR and/or MRRs may be requested as a result of substantiated quality of care or quality of service issues.
- Focused review outcomes shall be reported back to the Medical Director and applicable departments or committees
- In response to a request from external regulatory bodies such as the California DHCS or the California Department of Managed Care (DMHC). Review results are reported to the Clinical Quality Program Specialist and submitted to the Medical Director and Compliance Department. The Compliance Department is responsible for forwarding the information to the regulatory body
- To verify ongoing compliance with previous CAPs

B. Process

The Reviewer shall conduct the focused review using the FSR and/or MRR Tools, as necessary. The review shall focus on all areas of deficiency or concern.

Any deficiencies found in a focused review shall require the completion and verification of corrective actions according to established CAP timelines as described in this policy.

A focused review may not be substituted for the full scope review.

XI. Facility Site Review Process for Non-Clinical Member Complaints

A. Overview

The Plan has developed processes to monitor the quality of provider office sites in response to non-clinical issues or complaints raised by members. Performance standards have been established to assess physical accessibility, physical appearance, adequacy of the waiting/examination rooms and medical/treatment recordkeeping practices.

If the complaint cannot be resolved within 24 hours (e.g. possible PCP change), the issue is escalated to the Grievance and Appeals department for handling.

The Clinical Quality Program Specialist monitors member grievances on a quarterly basis to identify those providers and practice sites meeting established thresholds requiring onsite reviews.

B. Process for Identifying and Tracking Non-Clinical Complaints

A site visit shall be performed when there are 3 member complaints or grievances about the same practice location within a rolling 6-month time frame regarding the following issues:

- Physical Accessibility
- Physical Appearance
- Adequacy of the examining and waiting room space

A report of all complaints and grievances regarding the above criteria shall be sent to the Clinical Quality Program Specialist area on a monthly basis.

The Clinical Quality Program Specialist staff shall determine if the threshold has been met and identify the appropriate staff member to conduct the site review. Since no clinical element is reviewed, the auditor does not need to be licensed clinical staff.

All site reviews shall be completed within 60 days after receipt of the grievance from the member.

C. Site Reviews for Non-Clinical Member Complaints

The Reviewer shall:

- Complete the facility site review within 60 days of notification from the Quality Management Department
- Explain the reason for the review to the provider/office manager at the time of the review

- Evaluate the office using the applicable sections of the FSR Attachment A and/or B tool. In addition to a review of the issues listed above, the onsite visit may include a review of medical record-keeping practices and access to care
- Meet with the provider/office manager to review and discuss the results of the site review and furnish the provider/office manager a copy of the review results and opportunities for improvement, if any

D. Scoring

Any site with identified issues in the applicable FSR Attachment A and/or B sections shall require a CAP. If the provider site scores 100%, no further action is required, and the issue is closed.

The Reviewer shall notify the Clinical Quality Program Specialist of the score by emailing the results to the Clinical Quality Program Specialist following the audit.

The Clinical Quality Program Specialist shall evaluate the effectiveness of the actions related to opportunities for improvement at least every 6 months until the deficiencies are resolved. If the provider fails to resolve the deficiencies in the appropriate time frame, the issue shall be reported to the Medical Director.

If the complaint threshold(s) is met again, whether for the same office criterion or a different criterion, another site review shall be conducted. The same procedure listed above shall be followed.

All grievances including office site complaints are reported quarterly to the Quality Operations Committee by the G&A Department and reported annually to the Medical Advisory Committee in the state's annual evaluation.

XII. Physical Accessibility Review Survey

The Facility Site Physical Accessibility Review Survey (FSR Attachments C, D & E) is conducted for providers servicing the SPD population. Results of the Facility Site Physical Accessibility Review Survey (FSR Attachments C, D & E) are informational only for inclusion in the provider directory and unlike FSR Attachments A and B; do not require a CAP from the site.

An FSR Attachments C, D or E survey is required at least every three years for all PCPs, high-volume specialists, ancillary providers and CBAS facilities. In lieu of an FSR

Attachment C, D or E survey, the Reviewer may sign an attestation that there have been no changes in the physical accessibility of the office since the previous survey.

DHCS All Plan Letter 15-023 identifies two additional physical assessment review survey (PARS) assessment tools: Attachment D is used for Ancillary Services and Attachment E is used for Community Based Adult Service (CBAS) providers.

The Plan shall submit its methodology used to define high-volume specialists, ancillary providers, and CBAS facilities to DHCS annually. LA Care determines the methodology used to define high-volume providers in LA County for Anthem Blue Cross Medi-Cal.

The Plan shall also offer the opportunity for the physical accessibility reviews to any provider that requests to be evaluated, regardless of whether they are determined to be high volume.

The Plan shall make the results of the FSR Attachments C, D & E available to members in its online and paper directories. The physical accessibility results shall be displayed in accordance with MMCD Policy Letter 12-006 and DHCS All Plan Letter 15-023.

While there is no CAP for sites that do not meet the criteria outlined in the FSR Attachments C, D & E surveys, sites are expected to meet minimum safety accommodations for persons with physical disabilities. These criteria are included in the Full Scope Facility Site Review (FSR Attachment A). A CAP shall be created for sites that do not meet the minimum criteria.

The Reviewer shall work with the office site staff to determine reasonable alternative methods that are achievable to ensure compliance with regulatory requirements.

Member complaints and grievances received directly from members are monitored for issues related to access for those with disabilities and investigated as described above. Members may request reassignment to another PCP if they feel a site does not adequately meet their access needs.

XIII. Supplemental Facilities - Mobile, Satellite, School Based, and Other Extension Clinics

A. Overview

Supplemental facilities assist in the care delivery of primary care services to geographically remote areas that lack health care services, as well as assist the underserved population in areas where there may be access to care concerns.

Supplemental facilities may offer a variety of clinical services including, but not limited to: preventive care, immunizations, screenings, and/or chronic care management (excluding specialty services).

Mobile clinics are self-contained units including vans, recreational vehicles, and other vehicles that have been repurposed to provide space for various clinic services and may also serve to deliver equipment to locations that operate temporary clinics.
In general, supplemental facilities that provide primary care services may serve as an extension of a PCP site, a community-based clinic, a Federally Qualified Health Center county facility, or a standalone clinic with Members assigned.

B. Site Review and Medical Record Review Requirements

MCPs must conduct an initial site review and subsequent site reviews of supplemental facilities at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.

All collaborating Health Plans within a county shall enforce processes established through MOUs regarding oversight of supplemental facilities.

PCP sites that operate, assign membership and see their members at their own supplemental facilities shall undergo a full scope review at those specific locations using the most current DHCS tools and standards and shall be assigned their own unique DHCS site ID. Satellite, mobile and school-based clinics operating as supplemental facilities only, without direct membership assignments, shall be reviewed as part of the main PCP sites' full scope review.

XIV. Street Medicine Providers

A. Overview

Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. The fundamental approach of street medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Typically, street medicine is provided to an individual experiencing unsheltered homelessness in their lived environment, places that are not intended for human habitation. Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed, specified location does not qualify as street medicine, it is considered mobile

medicine, as it requires people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location. Mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered street medicine.

Street medicine provider refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas). For a non-physician medical practitioner (PA, NP, and CNM), the Plan ensures compliance with state law and contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of street medicine, a supervising physician must be a practicing street medicine provider, with knowledge of and experience in street medicine clinical guidelines and protocols. Contracted street medicine providers may choose to serve as the member's assigned PCP upon member election, similar to how obstetrician-gynecologist (OB/GYN) providers can elect to serve as PCPs. In order to serve as a PCP, the street medicine provider must meet the Plan's eligibility criteria for being a PCP, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice, and agree to serve in a PCP role. Street medicine providers, when elected by members to act as their assigned PCP, are responsible for providing the full array of Primary Care services, including but not limited to, preventive services, and the treatment of acute and chronic conditions.

If the street medicine provider does not have the capability to provide primary care services on the street, the street medicine provider must be affiliated with a brick-and-mortar facility (e.g., primary care medical office, Federally Qualified Health Center (FQHC), clinic, etc.). In this case, The Plan shall assign members to the affiliated brick-and-mortar facility to which the street medicine Provider is affiliated. MCPs may assign their members to the street medicine Provider as the assigned PCP directly, or to the street medicine Provider's affiliated brick-and-mortar location, but must make clear the member's care is being overseen by a street medicine provider PCP.

If the street medicine Provider is willing to serve in the member's assigned PCP capacity, the Plan shall enroll and credential the street medicine provider.

B. Site Review and Medical Record Review Requirements

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, the MCP must conduct the full review process of the street medicine Provider and affiliated facility in accordance with APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review.
- For street medicine providers serving as an assigned PCP, and that are not affiliated with a brick-and-mortar facility or mobile unit/RV, the Plan shall conduct a condensed initial Facility Site Review (FSR) and a full Medical Record Review (MRR) of the street medicine provider and subsequently at least every three years thereafter using the most current approved DHCS tools and standards to ensure member safety. The condensed FSR requirements shall be based on and reflective of the full FSR requirements as outlined in APL 22-017. The street medicine provider PCP shall be assigned their own unique DHCS site ID.

Street medicine providers serving as PCPs must develop and maintain protocols for identifying and transferring members to a higher level of care if needed when the member's service needs are beyond the capabilities and/or qualifications of the street medicine provider. PCPs must ensure protocols include providing access to urgent and emergency care, specialty care, mental health and substance use disorder treatment, ancillary services, and appropriate non-emergency medical and non-medical transportation services. PCPs must also ensure their street medicine protocols allow for expeditious referrals to Enhanced Care Management and Community Supports.

All collaborating Health Plans within a county shall enforce processes established through MOUs regarding oversight of street medicine providers.

XV. Public Health Emergencies (PHE) – COVID 19

A. Overview

Pursuant to DHCS MCQMD All Plan Letter (APL) 20-011: *Governor's Executive Order N-55 in Response to COVID-19* and other future APLs offering guidance during PHEs, DHCS may temporarily suspended the contractual requirement for in-person site reviews, medical audits of MCP subcontractors and network providers, and similar

monitoring activities that would require in-person reviews. DHCS may allow MCPs to explore alternatives to in-person site reviews, such as site reviews that are conducted virtually. However, the Reviewer reserves the right to require PCPs, as DHCS requires MCPs to complete follow-up onsite site reviews when concerns arise.

B. FSRs and PARS Due During a PHEs

Based on APL 20-011 and other future APLs that temporarily suspend in-person site reviews, FSRs and PARS that are due during the suspension period shall be conducted virtually, if feasible. Sites that are due earlier in the PHE shall be completed first. If virtual review is not feasible (i.e., PCP site is closed to the public and solely offers telehealth visits, paper chart practice, etc.), the in-person review shall be deferred until after the suspension period has ended and when it is safe to do so.

C. Virtual FSR (Attestations/Interim Monitoring) During PHEs

Based on APL 20-011 and other future APLs that temporarily suspend in-person FSRs, the Plan may use alternative methods such as site reviews that are conducted virtually (via WebEx, Teams, Facetime, etc.). Starting with reviews due earlier in the PHE, all PCP sites shall be offered a virtual review based on their ability to accommodate the virtual FSR requirements stipulated on the *Virtual Facility Site Review Attestation* form (i.e., reliable WIFI, equipment, EMR, etc.). PCP sites shall indicate their ability (Option 1) or inability (Option 2) to accommodate the virtual review in writing on the attestation form and shall complete and submit it to the reviewer within 10 business days. PCP sites that can accommodate a virtual review shall be encouraged to have their review completed within 30 days. PCP sites that do not have the ability to have a virtual review conducted shall complete an Interim Facility Site Review self-assessment within 10 business days of the signed attestation and have the Plan conduct a full scope onsite FSR/MRR after the termination of the executive order's suspension period and when it is safe to do so. Provider sites that decline the virtual review shall indicate the reason(s) for the declination on the attestation form.

Virtual FSRs (Attachment A) and MRRs (Attachment B) scores shall be accepted during the executive order's suspension period. Sites that do not achieve an Exempt Pass in FSR and/or MRR is required to submit a CAP following the CAP timeline stipulated in the DHCS All Plan Letter 22-017.

D. Loading New Providers to Existing Network PCP Sites during PHEs

Based on APL 20-011 and other future APLs that temporarily suspend in-person FSRs, "DHCS is permitting MCPs to temporarily suspend the contractual requirement for in-

person site reviews, medical audits of MCP subcontractors and network providers, and similar monitoring activities that would require in-person reviews." The Plan may add providers to an existing PCP site that is in good standing with previous passing scores even though their periodic full scope review is past-due because of the PHE.

E. Reviewer Training & Certification during PHEs

Based on APL 20-011 and other future APLs that temporarily suspend in-person FSRs, the Plan may conduct CSR certifications virtually during PHEs with post PHE verification done in person for the FSR portion (MRR portion done virtually does not require verification). The Plan shall follow certification requirements stipulated in the APL 22-017.

XVI. Data Submission Procedures

A. Overview

The Plan shall submit site review data to DHCS every six months (July 31 for the period January - June, and January 31 for the period July - December) in an approved format uploaded to a designated DHCS secure site. The Plan may submit data more frequently than every six months. For preoperational and expansion site reviews, the Plan shall submit site review data to DHCS at least six weeks prior to site operation. DHCS will make available the database containing all necessary tables and data input forms for the mandatory bi-annual submission of site review data. When DHCS rejects site review data that the Plan submits in nonconforming formats, the Plan shall correct all formatting errors and resubmit the data to DHCS in a timely manner.

B. Protected Health Information (PHI)

The Plan is required to collect PHI as part of the MRR process and shall include the PHI in the bi-annual data submission to DHCS.

XVII. DHCS-Conducted Site Reviews

A. Overview

DHCS conducts separate site reviews to validate the MCPs' FSR and MRR processes. Prior to a new MCP's operation, or an MCP expansion to a new county, DHCS conducts initial FSRs, followed by initial MRRs upon an MCP beginning operations and assignment of Members, as outlined in this APL, of randomly chosen PCP sites in the MCP's Network. DHCS also conducts subsequent site reviews on PCP sites within MCP

Networks. DHCS will notify MCPs of critical findings in writing via email within 10 business days following the date of the FSR and/or MRR and provide a written report summarizing all of DHCS' review findings within 30 calendar days following the date of the FSR and/or MRR.

Each MCP will be notified approximately four weeks in advance of DHCS-conducted site reviews. The Plan notify its Providers in advance of site reviews, whether the site review is conducted by DHCS or by the Plan. However, inspection of an MCP's facilities or other elements of a review may be conducted without prior notice, in conjunction with other medical surveys or as part of an unannounced inspection program. DHCS-conducted site reviews do not replace full scope periodic site reviews that MCPs are assigned to conduct. If the DHCS-conducted site review was conducted within the last three years, the MCP will adjust the FSR and/or MRR review "look-back" period based on the date of the DHCS-conducted FSR and/or MRR to avoid citing the PCP site twice for the same deficiencies that have previously been cited by DHCS and corrected by the PCP site.

B. Corrective Action Plan (CAP) from DHCS-conducted Site Review

Within 30 calendar days from the date of the Plan's receipt of the DHCS-conducted site review report, the Plan shall provide a CAP to DHCS responding to all cited deficiencies documented in the report. The Plan's CAP response shall include:

- The identified deficiency (ies).
- A description of action(s) taken to correct the deficiency (ies).

If a deficiency is determined to require long-term corrective action, the Plan's CAP response shall include indication that the Plan has:

- Initiated remedial action(s).
- Developed a plan to achieve an acceptable level of compliance.
- Documented the date the Provider is in full compliance or when full compliance will be achieved.

REFERENCES:

- Anthem Blue Cross Credentialing Policy #7: *Site Visits*
- CA_PNXX_005: *Primary Care Physician (PCP) Access Hours*
- CA_QMXX_004: *Termination of Providers for Non-Compliance with Facility Site or Medical Record Review Process*
- CA_QMXX_045: *Medical Record Documentation and Confidentiality Standards*
- CA_QMXX_083: *Monitoring the Facility Site Review Collaborative Process*

- California Code of Regulations, Title 22, Section 56230
- California Dept. of Health Services Contracts
- CAP Tool (available from the Quality Management Dept.)
- CAP Tracking Form (available from the Quality Management Dept.)
- CR 6 Provider Office Site Quality, Elements A & B
- DEL 101: *Enterprise Performance Management Entity Oversight*
- DHCS MCQMD All Plan Letter 20-011 (Revised) *Governor's Executive Order N-55-20 In Response To COVID-19*
- DHCS MCQMD All Plan Letter 22-017 *Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review*
- DHCS MCQMD All Plan Letter 22-023: *Street Medicine Provider: Definitions and Participation in Managed Care*
- DHCS MCQMD All Plan Letter 22-030: *Initial Health Appointment*
- DHCS MMCD Policy Letter 12-006 *Revised Facility Site Review Tool* (Physical Accessibility Site Review)
- *Frequently Missed Standards Attestation* form (available from the Quality Management Dept.)
- *Interim Facility Site Review* form (available from the Quality Management Dept.)
- LA Care Policies and Procedures
- Memorandum of Understanding (MOU) agreements by county, as applicable
- MMCD All Plan Letter No. 03-006 *Facility Site Review Clarification #2*
- MMCD All Plan Letter No. 15-023 *Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers*
- NCQA 2016 Standards and Guidelines for the Accreditation of Health Plans
- Policy CA_QMXX_071: *Facility Site Reviewer Certification and Inter-rater Process (Previous approved version 2-4-19)*
- *Virtual Facility Site Review Attestation form* (available from the Quality Management Dept.)

RESPONSIBLE DEPARTMENTS:

Primary Department:
Quality Management

Secondary Department(s):
Customer Care Center
Grievance and Appeals

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **Facility Site and Medical Record Review Process - CA**

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes

08/17/12	• Changed SSB to Medicaid
	• Changed PCDA to PDO
	• The following corrections were made to address recommendations made by LA Care:
	  ○ Updated FSR Exempted Pass definition
	  ○ Clarified that a new provider joining a practice that scores below 80% will not be assigned members until the corrections are verified and the CAP is closed
	• Corrected statement that the CAP form was developed in collaboration by the collaborative health plans

08/31/12	• PL 11-013 changed to PL 12-006 • Added requirement for CSR to submit FSR results within two weeks of the review
09/21/12	• Added section on LA Care office hours monitoring to address recommendation made by LA Care
04/03/13	• Added Medicare-Medicaid Plan to the plans covered by this policy • Changed policy to be more generic to be inclusive of both Medi-Cal and Medicare-Medicaid Plan processes
08/20/13	• FSR Survey scope changed to include hospitals
01/22/15	• Change made to clarify the requirement to perform a site review every 3 years by the expiration date of the original review
06/23/15	• Added requirement regarding compliance with the Children's Vaccine Storage Regulations for LA County to comply with LA Care CAP
10/14/15	• Removed Member Grievances survey tool • Added CSR provides training and education to appropriate office staff on the FSR process • Added section on Medicare-Medicaid Plan (MMP) Oversight, Monitoring and Reporting
11/09/16	• Certified Site Reviewer (CSR) replaced the Clinical Quality Compliance Administrator (CQCA) title • Quality Management Consultant title replaced the former Clinical

Review Date	Changes
	Entity Compliance & Clinical Investigations (CEC & CI) Department • Added specific reference to the DHCS All Plan Letter 15-023 on conducting Physical Accessibility Review Surveys (PARS) at Ancillary and CBAS provider facilities (LA Care CAP) • Revised the definition of FSR B as a Medical Record Review (LA Care CAP) • Added provisions for the MAC to establish higher passing threshold (>80%) for poor performing providers requesting to join the network (to be in line with other collaborative plan partners) • Added provisions for the MAC to approve or deny requests by sites to be re-audited after two consecutive non-passing Initial FSRs • Extended reapplication process for terminated providers in LA County from 12 months to 36 months as required by LA Care • Updated other minor FSR and CAP processes to reflect current practices state-wide
12/28/17	• Replaced the term “Plan Partner” with “Managed Care Plan” throughout the policy • Clarified MRR Conditional Passing category • Added on-site monitoring in between triennial full scope reviews for non-compliant providers • Added methodology for determining high-volume SPD providers in LA County
04/23/18	• Off-cycle edits
01/14/19	• Annual review – no changes.
02/17/20	• Annual review – edits based on LA Care policy revisions and requirements • Changed Provider Database Management to Provider Experience • References updated
05/05/20	• Off-cycle edits based on the release of DHCS All Plan Letter 20-006 (e.g. updated Definitions, Procedure, and References sections, updated CAP timelines, etc.) • Reorganized all sections to follow the order of the APL 20-006. • “Reviewer” replaced the “CSR” title to allow reference to both CMT and CSR reviewer types • Updates made to the policy, definitions, procedure, and references

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **Facility Site and Medical Record Review Process - CA**

Review Date	Changes
01/19/21	• Annual review • Updated the Scoring Methodology and CAP sections based on DHCS and county collaborative standards • Updated References section by replacing MMCD with MCQMD as the source of APL 20-006
08/06/21	• Off-cycle edits based on the Public Health Emergency and the release of DHCS All Plan Letter 20-011 (e.g. added procedures for addressing FSR backlog, virtual FSRs, CSR certification, etc.) • Added methodology for MRR selection: Anthem reviewer's discretion to select records to pull when concerns arise • Added MRR process for OB-GYN/PCP sites based on recent DHCS guidance • Added process for auditing mobile, satellite and school-based clinics based on recent DHCS guidance. • Updated References Section accordingly • Removed Provider Experience as a secondary department
01/11/22	• Annual review • Revised procedures under XIV Public Health Emergencies to include updates from APL 20-011 and DHCS • Updated the References section based on recent updates
11/15/22	• Annual Review • Updated Policy, Definitions, and Procedure, and Secondary Department(s) sections • Alphabetized and updated References section • All edits based on the release of the DHCS MCQMD All Plan Letter 22-017 Updated PHE citations to reflect current process and DHCS guidance. • Removed all references to DHCS APL 20-006 • Removed DHCS MMCD Policy Letter 14-004 Site Reviews: Facility Site Review and Medical Record Review from references • Removed DHCS MMCD Policy Letter 03-02 Certification of Managed Care Plan Staff Responsible for the Conduct of Primary Care Provider Site Reviews from references • Added Memorandum of Understanding (MOU) agreements by county, as applicable to references • Revised Anthem references to either Anthem Blue Cross Medi-Cal and/or Plan as applicable to comply with branding guidelines.
02/17/23	• Off-Cycle Review

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **Facility Site and Medical Record Review Process - CA**

Review Date	Changes

	• Updated Policy, Definitions, Procedure, and References sections
	  ○ Attachments A through E under Definitions section updated to reflect that the most recent FSR and MRR tools and standards are utilized.
	  ○ Added Street Medicine Provider section: Overview and FSR/MRR Requirements and reference to DHCS MCQMD All Plan Letter 22-023: Street Medicine Provider: Definitions and Participation in Managed Care
	  ○ Deleted reference to DHCS MMCD Policy Letter 08-003 Initial Comprehensive Health Assessment as it was retired effective 1/1/23.
	  ○ Added reference to the new DHCS MCQMD APL 22-030 Initial Health Appointment
	  ○ Added reference to include APL 22-023: *Street Medicine Provider: Definitions and Participation in Managed Care*

06/23/23	• Off-cycle Review • Updated "Critical Element (CE)" under Definitions section • Updated Procedure and References sections • Updated the Initial FSR/MRR and the Interim/Focused Review procedures to reflect current process and APL 22-017. • Updated the CAP Process section regarding CAP extensions based on the final version of the CAP Tracking Form approved at the last LA Care FSR Task Force and LA County Collaborative Meetings. • Updated the Street Medicine Provider section to reflect the use of a condensed tool in FSR only per work group recommendations. • Added recently finalized *Frequently Missed Standards Attestation* form to the Interim Monitoring and References sections.
10/11/23	• Annual Review • Updated Procedure section • Clarified circumstances that require Initial FSRs when there are changes in ownership • Added guidance for contracted PCPs that have extenuating circumstances that prevent the completion of their periodic FSRs • Updated subsequent PARS timeframe to "at least" every three years • Updated DHCS-conducted site reviews based on recent guidance from DHCS FAQs Committee

Section (Primary Department) **Quality Management**	**SUBJECT (Document Title)** **Facility Site and Medical Record Review Process - CA**

Review Date	Changes
	• Removed Accreditation Survey Management as a Secondary Dept.