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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: May 22, 2014

POLICY LETTER (PL) 14-004
SUPERSEDES PL 02-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: SITE REVIEWS: FACILITY SITE REVIEW AND MEDICAL RECORD REVIEW

PURPOSE:
The purpose of this PL is to inform all Medi-Cal managed care health plans (MCP) of the updates to the Department of Health Care Services' (DHCS) site review policy. DHCS previously published this policy in PL 02-002. This revised PL supersedes PL 02-002 and reflects changes made to the criteria and scoring of the Medi-Cal Managed Care Division's (MMCD) Facility Site Review (FSR) Survey Tool and Guidelines (Attachment A) and the Medical Record Review (MRR) Survey Tool (Attachment B) and the use of the Physical Accessibility Review Survey (PARS) Tool (see PL 12-006 Attachment C). PL 12-006 can be found at the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL12-006.pdf.

DHCS updated criteria to reflect current guidelines of professional organizations, unbundled these criteria groups to better identify deficiencies, and adjusted scoring methods to better generalize the scores.

DHCS conducts site reviews to ensure that all primary care provider (PCP) sites, used by MCPs to deliver health care services to MCP 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; and
- Operate in compliance with all applicable local, state, and federal laws and regulations.

BACKGROUND:
In 1991, the Centers for Medicaid and Medicare Services (CMS) stipulated that managed care organizations (MCOs) must adhere to all applicable local, state, and federal laws and regulations. When the MCO contracts with state Medicaid programs, the MCO must have an internal program for quality assurance. The site review process is part of an MCP's quality improvement program that focuses on the capacity of each PCP site to ensure and support the safe and effective provision of clinical services.

CMS requires MCPs to offer a range of services, including preventive and primary care services. Primary care services include all health care and laboratory services customarily provided by a general practitioner, family practice physician, internal medicine physician, pediatrician or obstetrician/gynecologist serving as a PCP in accordance with state licensure and certification laws and regulations (Title 42, Code of Federal Regulations, Section 438).

CMS requires MCPs to have adequate facilities and sufficient site locations available to meet contractual requirements for the delivery of primary care within their service areas. All PCP sites must have the capacity to support the safe and effective provision of primary care clinical services to MCP members (Title 22, California Code of Regulations [CCR], Section 56230).

In 1998, DHCS established a collaborative workgroup, containing representatives from each of the models of managed care, to revise DHCS's site review policy. In 2010, a DHCS workgroup updated the FSR and MRR Survey Tools and Guidelines. The objective of this workgroup was to develop a uniform, system-wide process that clarified the requirements and decreased duplicative site reviews for MCP providers who serve the Seniors and Persons with Disabilities (SPD) population. MCPs began to use the new FSR and MRR tools and guidelines in January 2012.

DHCS published PL 12-006 in 2012 that required MCPs to use the PARS Tool to assess the level of physical accessibility of provider sites, including specialist and ancillary service provider sites that provide care to SPDs. DHCS continues to monitor MCP use of the PARS Tool.

POLICY:
DHCS must review all MCP PCP sites (Title 22 CCR Section 56230). MCPs must ensure that PCP sites comply with all applicable local, state, and federal standards. Each provider site must be appropriately licensed and accredited. Before DHCS approves an MCP to provide services to its members, each of the MCP's contracted or subcontracted PCP sites is subject to an initial site review, and periodic site reviews thereafter consisting of an FSR and MRR, to evaluate the site's capacity to deliver quality services.

Accountability
MCPs are accountable for all activities on PCP sites, whether those services are provided by contracted or subcontracted health plans, independent physician association, or other delegated or sub-delegated entity. MCP accountability includes ensuring that the PCP sites comply with regulatory, contractual, and policy requirements, and that PCP sites complete all necessary corrective actions.

Delegation
DHCS must approve all delegated responsibilities. MCPs are responsible for:

- Identifying specific delegated functions;
- Overseeing and monitoring delegated activities;
- Ensuring that delegated functions are properly carried out; and
- Establishing a formal, mutually agreed upon document.

MCPs may choose whether or not to delegate site review responsibilities to another MCP or appropriate entity. Each collaborating MCP determines whether or not to accept the delegated entity's site review findings.

All delegated and sub-delegated entities must follow the current MMCD site review policy requirements. Site review personnel from delegated and sub-delegated entities must be trained, certified and supervised according to the policy standards established for MCPs.

Credentialing and Recredentialing
MCPs must ensure that providers are credentialed according to MMCD contractual and policy requirements. Each MCP must complete a site review as part of its initial credentialing process when the MCP adds a new provider to its provider network who works at a site the MCP has not previously reviewed. An MCP does not need to repeat a site review as part of the initial credentialing or recredentialing process if a new provider works at a provider site that has a current passing site review score. MCPs may consider a site review "current" if it is dated within the last three years. An MCP does not need to repeat a site review until the due date of its next scheduled site review unless the MCP, through its monitoring activities, determines a site review is necessary. Because network providers change over time, the timeline for provider recredentialing and subsequent site reviews may not be on a synchronized schedule.

Facility Site Review
A site review consists of the MMCD FSR and MRR Survey Tools. All MCPs and subcontracted entities must use MMCD survey criteria and scoring methods to audit facility sites and medical records.

MCPs must complete initial site reviews and subsequent periodic site reviews comprised of the FSR and MRR of all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications (Title 22 CCR Section 56230). MCPs must apply the same standard to conduct site reviews at each PCP site. The most current FSRs and MRRs will be shared among all MCPs contracting with a particular provider. Each MCP is responsible for tracking the survey status of all of its contracted provider sites. MCPs must collaborate locally to determine how they will notify each other of the survey status and results for their shared providers.

I. Initial Site Review

All PCP sites serving MCP members must undergo an initial site review and receive a minimum passing score of 80 percent on the FSR Survey Tool. An initial site review, which does not include an MRR, is the first onsite inspection of a site that has not had a previous review, or is a PCP site that is returning to the Medi-Cal managed care program and has not had a passing review in the past three years. The MCP may waive the initial site review for a pre-contracted provider site if the provider has documented proof that another local MCP completed a site review with a passing score within the past three years.

Prior to initiating operations in a service area, an MCP must complete initial site reviews consisting of the FSR, on five percent of the PCP sites in its provider network, or on 30 PCP sites, whichever is greater in number. The PCP sites reviewed must include a variety of providers from throughout the provider network and from each subcontracted entity. If there are 30 or fewer PCP sites in the network, the MCP must review 100 percent of the sites prior to beginning operations. The MCP must complete an initial site review on 100 percent of the remaining proposed PCP sites within the first six months of operation or expansion.

II. Subsequent Periodic Site Review

MCPs must conduct subsequent site reviews no later than three years after the initial reviews. MCPs may review sites more frequently per local collaborative decisions or when determined necessary based on monitoring, evaluation, or corrective action plan (CAP) follow-up issues.

MCPs must have a process in place that instructs providers to notify the MCP of a provider site relocation at least 30 days prior to the move so the MCP can conduct a site review on the new location. However, if the provider notifies the MCP after the move:

- The MCP must allow assigned MCP members to continue to see the provider;
- The MCP must not assign new members to the provider until the site review is completed; and
- The MCP must complete the review within 30 days of notification of the move.

Medical Record Review

MCPs review medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the patient received care. Incomplete records or lack of documentation implies the MCP's failure to provide care.

MCPs must review ten medical records using the most recent MRR Survey Tool at each provider site as part of the site review and every three years thereafter. During any MRR, reviewers must have the option to request additional records for review. If the MCP reviews additional records, the MCP must calculate the scores accordingly. Preventive care criteria cover pediatric, adult, and obstetric services. The medical record score is based on a survey standard of the ten randomly selected records per provider, consisting of five pediatric and five adult and/or obstetric records. For sites with only pediatric, only adult, or only obstetric patients, all ten records surveyed must be only in that preventive care area.

MCPs must review medical records of a new provider within 90 calendar days of the date the MCP first assigns members to a provider. An MCP may defer that review an additional 90 calendar days only if the new provider does not have enough assigned MCP members to complete a review of the ten medical records. At the end of six months, if the provider still has fewer than ten assigned member records, the MCP must complete an MRR on the total number of records available and adjust the scoring according to the number of records reviewed.

At PCP sites that document patient care performed by multiple PCPs in the same record, the MCP must consider these records a "shared" medical record system. The MCP must consider shared medical records those that are not identifiable as "separate" records belonging to any specific PCP. The MCP must review a minimum of ten records if two or three PCPs share records, 20 records if four to six PCPs share records, and 30 records if seven or more PCPs share records.

Scoring Facility Site Reviews and Medical Record Reviews

MCPs must base their survey scores on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel. If an MCP chooses to audit additional criteria not included on the FSR or MRR Survey Tool, the MCP must not add the additional criteria to the existing scoring method. MCPs must not alter scored criteria or assigned weights in any way. Score calculations are based on the total survey points, or on the adjusted survey points for "not applicable" items.

The minimum passing score for the FSR and the MRR is 80 percent of the total points available. A PCP site may earn up to 150 points for a site review with the following compliance level categories:

- Exempted Pass: 90 percent or above, without deficiencies in Critical Elements, Pharmaceutical Services or Infection Control;

- Conditional Pass: 80-89 percent, or 90 percent or above with deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control; and
- Not Pass: below 80 percent.

The MRR contains three general categories of Format, Documentation, and Coordination/Continuity of Care and three specific preventive categories of Pediatric Preventive, Adult Preventive, and Obstetrics (OB)/Comprehensive Perinatal Services Program (CPSP).

PCP sites may earn up to 23 points for the three general categories multiplied by the number of medical records reviewed, plus the points given for the preventive services categories, as follows:

- Pediatric Preventive: 19 points multiplied by the number of pediatric medical records reviewed;
- Adult Preventive: 15 points multiplied by the number of adult medical records reviewed; and
- OB/CPSP: 20 points multiplied by the number of OB/CPSP medical records reviewed.

PCP sites may earn a full point if the scored element meets the applicable criteria. MCPs must not award partial points for any scored element that the reviewer considers only "partially" met. PCP sites must earn zero points if an element does not meet the applicable criteria. The reviewer must determine the "not applicable" (N/A) status of each criterion based on a site-specific assessment. The reviewer must explain all criteria scored as zero points or assessed as N/A.

The MRR compliance levels are as follows:

- Exempted Pass: 90 percent or above;
- Conditional Pass: 80-89 percent; and
- Not Pass: below 80 percent.

For detailed scoring procedures, see the FSR Survey Tool and Guidelines (Attachment A) and the MRR Survey Tool and Guidelines (Attachment B).

If a site receives a non-passing score by one MCP, all other MCPs must consider the site as having a non-passing score. MCPs must use the local collaborative process to identify shared providers and to determine their methods for sharing survey information.

Critical Elements

Nine critical elements of the site review define the potential for adverse effects on patient health or safety and have a scored weight of two points. All other survey elements have a scored weight of one point. The PCP site must correct any critical element deficiency identified during a site review, focused survey, or monitoring visit within ten business days of the survey date and the MCP must verify the corrective

actions within 30 calendar days of the survey date. MCPs must ensure that sites that are found deficient in any critical element during a site review correct 100 percent of the survey deficiencies, regardless of the site's survey score. The nine critical elements are the following:

1) Exit doors and aisles are unobstructed and egress (escape) is accessible;
2) Airway management equipment, appropriate to practice and populations served, is present onsite;
3) Only qualified/trained personnel retrieve, prepare or administer medications;
4) Office practice procedures are utilized onsite that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results;
5) Only lawfully authorized persons dispense drugs to patients;
6) Personal protective equipment is readily available for staff use;
7) Needlestick safety precautions are practiced onsite;
8) Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazardous non-sharps) are placed in appropriate leak-proof, labeled containers for collection, processing, storage, transport or shipping; and
9) Spore testing of each autoclave/steam sterilizer is completed (at least monthly), with documented results.

Corrective Action Plan

A CAP is required on all cited deficiencies for sites with a Conditional Pass score on the FSR or MRR Survey Tool, on a focused review or for deficiencies identified by the MCP, or State through oversight and monitoring activities. MCPs must require all provider sites that receive a Conditional Pass to develop a CAP to correct 100 percent of cited deficiencies.

MCPs must not require PCP sites that receive an Exempted Pass for FSR to complete a CAP unless the MCP determines that one is needed.

MCPs must not require provider sites that receive an Exempted Pass for an MRR to complete a CAP. A CAP is required for a total MRR score below 90 percent. Also, any section score of less than 80 percent requires a CAP for the entire MRR, regardless of the total MRR score.

MCPs must establish a process for treating providers who pass the site review at 80 percent or higher but fail to respond to a request for a CAP or fail to complete the corrective actions. MCPs must remove a provider from the network regardless of survey scores if criteria are not met or corrective actions are not taken within the established CAP timeline. If removed from the network, providers may file a formal appeal to the MCP.

New provider sites with a score of less than 80 percent are not eligible to participate in the Medi-Cal managed care program. At its discretion, an MCP may decide to provide additional training, give technical assistance or develop a CAP with non-passing pre-contract provider sites. Pre-contract providers who do not pass the survey may correct deficiencies, reapply to the MCP and be resurveyed. If the provider passes, the MCP will follow the procedures outlined for implementing corrective actions for all cited deficiencies.

The MCP conducting the site review is responsible for follow-up, resurvey and closure of the CAP.

The CAP documentation must identify:

- The specific deficiency;
- Corrective actions needed;
- Projected and actual dates of the deficiency correction;
- Reevaluation of timelines and dates; and
- Responsible persons.

The closed CAP must include:

- Documentation of problems in completing corrective actions (if any);
- Training and technical assistance provided by the MCP;
- Evidence of the corrections;
- Completion and closure dates; and
- Name and title of the MCP reviewer.

MCPs must follow the timeline below for CAP notification and completion:

I. Providers with a Conditional-Pass Score

A) At the time of the survey: reviewers must notify providers of non-passing survey scores, critical element deficiencies, other deficiencies determined by the reviewer or MCP to require immediate corrective action and the CAP requirements for these deficiencies.

B) Within ten business days of the survey date:

1) Providers must submit a completed CAP with verification for all critical elements or other survey deficiencies requiring immediate correction to the requesting MCP; and

2) MCPs must provide a survey findings report and a formal written request for corrections of all other deficiencies (i.e., noncritical, non-immediate) to providers.

C) Within 45 days of the survey date, MCPs must reevaluate and verify that PCP sites have corrected critical element deficiencies and other site review deficiencies that require immediate correction.

D) Within 45 calendar days from the date of the written CAP request:

1) Providers must submit a CAP for all deficiencies (other than critical) to the MCP; and

2) MCPs must review, revise or approve the CAP and timelines.

E) Within 90 calendar days from the date of a written CAP request:

1) Providers must complete all other corrective actions; and

2) MCPs must provide educational support and technical assistance as needed, reevaluate or verify corrections and close the CAP.

F) Beyond 90 calendar days of the date of a written CAP request:

1) Providers may request a definitive, time-specific extension period. The period is not to exceed 120 calendar days from the date of the survey findings report and CAP notification, unless a longer extension is approved by DHCS to complete corrections if extenuating circumstances that prevented completion of corrections can be clearly demonstrated and if agreed to by the MCP; and

2) MCPs must resurvey any provider site that required an extension period beyond 120 calendar days to complete corrections prior to closing the CAP in 12 months.

II. Non-Passing Pre-Contract Provider

An MCP must not consider a pre-contract provider who scores below 80 percent as a network provider. The MCP must resurvey the provider before it approves the non-passing provider as a network provider. After the pre-contract provider achieves a score of 80 percent or higher, the MCP must complete the CAP as specified under CAP timeline requirements.

III. Non-Passing Contracted Network Provider

When a network provider receives a non-passing score, the MCP must notify the provider of the score, all cited deficiencies and CAP requirements. MCPs may remove any provider with a non-passing score from their provider networks. However, if an MCP allows a provider with a non-passing score to remain in its provider network, the provider must correct deficiencies and the MCP must verify that the provider has corrected the deficiencies within the CAP timelines established in this policy. MCPs must not assign new members to network providers that score below 80 percent on a subsequent site review until the MCP has verified that the provider has corrected the deficiencies and the CAP is closed.

IV. Noncompliant Provider

MCPs must not assign new members to providers who do not correct survey deficiencies within the established CAP timelines until the MCP verifies that the provider has corrected the deficiencies and the CAP is closed. MCPs must remove

any provider from the network who does not come into compliance with survey criteria within the established timelines, and the MCP must appropriately reassign that provider's MCP patients to other network providers. MCPs must provide affected members with a 30-day notice that it will remove the noncompliant provider 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 the MCP's ongoing monitoring, must be removed from the network and MCP members must be appropriately reassigned to other network providers. MCPs must provide affected members with a 30-day notice that it will remove the noncompliant provider from the network.

V. Provider Appeal Process

Providers removed from an MCP's provider network must have the right to appeal the decision with the MCP. MCPs must have a formal and fair process to resolve grievances and complaints submitted by providers of medical services. If verified evidence of corrections is acceptable to the MCP and the MCP reverses its decision, the MCP must repeat the site review or the MCP may accept the current survey and CAP as completed and resurvey the PCP site in 12 months. If the MCP does not reverse its decision, then the provider may reapply through the MCP's application process. All provider applicants must undergo an initial site review and must be required to adhere to the requirements and standards established by this policy.

Monitoring

MCPs must systematically monitor all PCP sites between each regularly scheduled site review. Monitoring methods may include site reviews, but must also include additional methods such as information gathered through established internal MCP processes and provider and program-specific reports from external sources. When MCPs monitor PCP sites between audits, they must use both internal systems (e.g., quality improvement) and external sources of information (e.g., public health). MCPs must monitor and evaluate the nine critical elements on all PCP sites between site reviews. When MCPs identify problems through monitoring, they must determine the appropriate course of action, such as repeating the site review or conducting additional focused reviews, to investigate and correct these problems in a timely manner.

Focused Review

A focused review is a "targeted" audit of one or more specific areas of the FSR or MRR, and MCPs must not substitute a focused review for a site review. MCPs 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 use the appropriate sections of FSR and MRR Survey Tools for the focused review or other methods to investigate identified problems or situations. All deficiencies found

in a focused review must require the completion and verification of corrective actions according to CAP timelines established in this policy.

Local Collaboration

Pursuant to Health and Safety Code Section 1342.8, MCPs must collaborate locally within each Medi-Cal managed care county to establish systems and implement procedures for the coordination and consolidation of site audits for mutually shared PCPs. All MCPs within a county have equal responsibility and accountability for participation in the local site review collaborative processes.

MCPs must submit an initial written description and periodic update reports (as requested by DHCS) to DHCS's Medical Monitoring Unit (MMU) describing the local collaboration processes, which include but are not limited to the following:

- Names and titles of participating personnel from each MCP;
- Work plan that includes goals, objectives, activities, and timelines;
- Scheduled meeting dates, times, and locations;
- Meeting processes and outcomes;
- Communication and information-sharing processes;
- Roles and responsibilities of each MCP;
- Delegated activities and use of delegated or subdelegated entities; and
- Memorandum of Agreement requirements established for MCPs and providers.

MCPs must establish policies and procedures to define local collaborative methodology for:

- Confidentiality, disclosure, and release of shared provider survey information;
- Oversight and monitoring of survey processes;
- Site review personnel and training processes;
- Collection and maintenance of a local survey information database system; and
- Evaluation processes.

Review Personnel

Each MCP's Medical Director and Chief Medical Officer are responsible for site review activities implemented by MCP personnel or contracted entities. Each MCP must retain responsibility for oversight of the site review whether the MCP retains its site review functions, delegates site review functions to another MCP or subcontracts site review functions to a third-party entity. MCPs must designate physicians or registered nurses (RN) as certified trainers responsible for training and supervising reviewers, certifying RN and physician reviewers, monitoring reviews and evaluating reviewers for reliability. Certified site review trainers may include personnel from subcontracted agencies.

MCPs must determine the composition of the teams performing site reviews. A variety of personnel may be part of the survey team, including pharmacists, dietitians and

others able to provide assistance and clarification. Each site review must have a certified reviewer (RN or physician) who must sign the FSR and/or MRR.

Reviewers must only examine site review criteria that are appropriate to their level of education, expertise, training, professional licensing and scopes of practice as determined by state law. MCPs must have written policies and procedures that clearly define the duties and responsibilities of all review personnel. MCPs must demonstrate that site review activities established for their reviewers comply with the reviewers' scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the reviewers' education and training.

Level of Reviewer

Physicians are responsible for the oversight and implementation of peer review determinations regarding the appropriateness of medical care and treatment. However, the California Legislature recognizes the overlapping functions between physicians and RNs and permits the sharing of functions within organized health care systems that provide for collaboration between them (Business and Professions [B&P] Code Section 2725). Activities that overlap the practice of medicine may require adherence to a standardized procedure when it is the RN who determines that they are to be undertaken.

The RN is the minimal level of reviewer acceptable for independently performing the site review. RN reviewers may independently make determinations regarding "direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients and the performance of disease prevention and restorative measures" (Title 16 CCR Section 1443.5). Additionally, RN reviewers may independently make determinations regarding implementation of appropriate reporting or referral of abnormal survey findings to initiate peer review procedures. An RN may only delegate tasks to a subordinate based on the subordinate's legal scope of practice and on the degree of preparation and ability required by the tasks the RN would delegate.

Licensed vocational nurses (LVN) must not be employed as independent practitioners. LVNs are described by the California Board of Licensed Vocational Nursing and Psychiatric Technicians as "dependent" practitioners and "entry-level health care providers responsible for rendering basic bedside nursing care under the direction of a physician or registered nurse." State law stipulates that the LVN must perform only manual skills under the direction of a licensed physician or licensed professional nurse and perform only basic data collection (B&P Code Section 2859). The performance of manual skills or basic data collection does not include evaluation, analysis, interpretation, or synthesis of survey information or data or of making determinations about the information or data that was collected. Although an LVN may collect basic explicitly defined data, he or she is not qualified to evaluate or analyze the data. Therefore, LVN reviewers must not independently review any facility site or medical record, but, as part of a survey team, may collect data on those survey elements that

DHCS and the California Board of Vocational Nursing and Psychiatric Technicians have identified as within the LVN scope of practice. Non-licensed, nonregistered, noncertified personnel and dependent licensed medical personnel may be members of a site review team as appropriate, but must not be employed as independent site reviewers.

Site Review Training and Certification

MCPs are responsible for ensuring that all reviewers conducting FSRs and MRRs are appropriately trained, monitored and evaluated. MCPs may collaborate to determine local systems for training and certifying reviewers. Training must include MMCD seminars, and may also include MCP classes, individual or small group training sessions provided by a certified site review trainer and self-study learning programs. MCPs must certify site review trainers and certify physicians and RNs as site reviewers and recertify them every three years thereafter.

Site Review Data Submission Procedures

MCPs must submit site review data to MMU's nurse evaluators every six months (due July 31 for the period January through June, and due January 31 for the period July through December). MCPs may submit data at their discretion more frequently than every six months. For preoperational and expansion site reviews, MCPs must submit site review data to MMU's nurse evaluators at least six weeks prior to site operation. MCPs must submit data in an approved Microsoft Excel format uploaded to a designated DHCS secure site. MMU will make available through its site review web portal an Excel database containing all necessary tables and data input forms for the mandatory biannual submission of FSR and MRR data. DHCS will reject site review data that MCPs submit in nonconforming formats.

Department of Health Care Services/Medi-Cal Managed Care Health Plan Responsibility

DHCS must collaborate with MCPs to develop, implement and evaluate site review training and certification, revise training curriculum and materials as needed and provide technical assistance to site review trainers. The training curriculum includes self-learning modules, lesson plans for didactic instruction and guidelines for trainer and reviewer certification.

DHCS must oversee and monitor MCPs for implementation of the site review policy. Monitoring areas may include, but are not limited to, oversight of MCP methods for monitoring provider sites between site reviews, use of the appropriate level of reviewer according to established scope of practice legislation and the standards outlined in this policy and local collaborative processes. Monitoring methods may include, but are not limited to, participating in local collaborative processes, observing reviewer training and certification processes, assessing data collection methods and evaluating aggregate reports.

As part of the DHCS's ongoing monitoring process, DHCS nurses conduct separate onsite site reviews of randomly chosen PCP sites to validate FSR and MRR processes

and to monitor MCP services. DHCS will provide MCPs with a written report of the DHCS-conducted review.

An MCP must, within 30 days from the report date of the DHCS-conducted site review, provide a CAP to DHCS responding to all cited deficiencies documented in the report. The MCP's CAP response must include:

- The deficiency;
- A description of action(s) taken to correct the deficiency; and
- The result of the action(s) taken.

If a deficiency is determined to require long-term corrective action, the MCP's CAP response must additionally include indication the MCP has:

- Initiated remedial action;
- Developed a plan to achieve an acceptable level of compliance; and
- Documented the date the provider is in full compliance or when full compliance will be achieved.

Additional supporting documentation and remedial action may be required if DHCS determines the CAP is insufficient to correct a deficiency.

When DHCS conducts a site review, DHCS notifies the affected MCP in advance. Each MCP must notify its providers in advance of site reviews whether the site review is conducted by DHCS or by the MCP. However, inspection of an MCP's facilities or other elements of a survey may be conducted **without prior notice**, in conjunction with the medical survey or as part of an unannounced inspection program (Title 28 CCR Section 1300.80).

If you have questions regarding this PL, please contact your assigned MMU nurse.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Acting Deputy Director
Health Care Delivery Systems

Attachments