PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPCR700</td><td colspan="3">Lead Department: Network Services
Business Unit: Credentialing</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Assessment of Organizational Providers</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/23/2018</td><td colspan="4">Next Review Date: 04/08/2027
Last Review Date: 04/08/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">Employees</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☐ QUAC</td></tr>
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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☐ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☒ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Mark Netherda, MD</td><td colspan="3">Approval Date: 04/08/2026</td></tr>
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I. RELATED POLICIES:

A. CMP38 Escalation and Corrective Action
B. MPCR400 Provider Credentialing and Re-credentialing Verification Process and Record Security
C. MPQP1022 Site Review Requirements and Guidelines
D. MCQP1025 Substance Use Disorder (SUD) Site Review and Medical Record Review
E. MPUG3011 Criteria for Home Health Services
F. MCAP7001 CalAIM Services Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

II. IMPACTED DEPTS:

A. Provider Relations
B. Health Services
C. Claims

III. DEFINITIONS:

Electronic Visit Verification (EVV); A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home health care services for in-home visits by a provider. In California, this is known as CalEVV.

IV. ATTACHMENTS:

A. Credentialing Verification Sources used by Partnership HealthPlan for Organizational Providers

V. PURPOSE:

To describe the initial and ongoing assessment of all organizational providers contracted with Partnership HealthPlan of California (Partnership)

VI. POLICY / PROCEDURE:

All healthcare delivery providers will be credentialed in accordance with Partnership policy MPCR400, before they provide care or services to Partnership members. Thereafter, Partnership re-assesses its organizational providers every thirty-six (36) months. Unless otherwise stated. The re-credentialing cycle begins on the date of the previous credentialing decision and is tracked on the appropriate organizational provider grid within the Network Services department.

Partnership will contract with providers who have a federal, state or Partnership site review. The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau and the state or CMS has conducted a site review.

A. Types of Organizational Providers

Partnership credentials and re-credentials all of the types of providers listed below:

1. Hospitals
2. Skilled Nursing Facilities/Long Term Care Facility
3. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD, ICF/DD-H, ICF/DD-N)
4. Free Standing Surgical Center

5. Free-standing Urgent Care Center
6. PCP Providing Urgent Care
7. Home Health Agency/Hospice Provider
8. Acute Rehabilitation Facility
9. Behavioral Healthcare Providers, including Ambulatory, Residential and Inpatient Facilities
10. Substance Use Disorder Providers, including Ambulatory, Residential, and Inpatient
11. Community Based Adult Services (CBAS)
12. Free-standing Birth Center
13. Dialysis Center
14. Free-standing Radiology Center
15. Clinical Laboratory
16. Stand Alone Laboratory
17. Rural Health Clinic
18. Federally Qualified Health Center
19. Transplant Programs

B. Verification Sources

Partnership uses the sources listed on Attachment A, "Credentialing Verification Sources used by Partnership HealthPlan of California for Organizational Providers" to confirm providers are in good standing with state and federal requirements.

1. Initial Assessment Criteria

   All provider types are required to submit the following documentation:

   a. Hospitals
      1) A completed signed application
      2) Copy of current Department of Health Care Services (DHCS) license
      3) Copy of current liability coverage certificate in the amounts defined in the provider contract
      4) A completed and signed W-9
      5) Proof of Medi-Cal enrollment
      6) Copy of accreditation from one of the following:
         i. The Joint Commission (TJC)
         ii. HFAP (Healthcare Facilities Accreditation Program)
         iii. DNV▪GL (Det Norske Veritas)
         iv. CIHQ (Center for Improvement in Healthcare Quality)

   b. Skilled Nursing Facilities/Long Term Care Facility
      1) A completed signed application
      2) Copy of current DHCS license
      3) Copy of current liability coverage certificate in the amounts defined in the provider contract
      4) A completed and signed W-9
      5) Proof of Medi-Cal enrollment
      6) Copy of Centers for Medicare and Medicaid Services (CMS) Site Review form CMS 2567.

   c. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes
      1) A completed signed application
      2) Copy of current DHCS license
      3) Copy of current Liability coverage certificate in the amount defined in the provider contract

4) A completed and signed W-9
5) Proof of Medi-Cal Enrollment
6) Copy of Centers for Medicare and Medicaid Services (CMS) Site Review form CMS 2567.
7) A signed ICF/DD Credentialing Attestation

This provider type requires a two year (24 month) re-credentialing cycle.

a. A change to any requirement attested to between credentialing cycles necessitates re-credentialing of the provider. It is the provider's responsibility to report changes within 90 days of when the change occurred.

d. Free-standing Surgical Center
1) A completed signed application
2) Copy of current DHCS license
3) Copy of current liability coverage certificate in the amounts defined in the provider contract
4) A completed and signed W-9
5) Proof of Medi-Cal enrollment
6) Copy of accreditation from one of the following:
i. The Joint Commission (TJC)
ii. Accreditation Association for Ambulatory Health Care (AAAHC)
If facility is not accredited, Partnership will accept a copy of a current CMS or State review (within 3 years).

e. Free-standing Urgent Care Center
1) A completed signed application[1]
2) Copy of current DHCS license
3) Copy of current liability coverage certificate in the amounts defined in the provider contract
4) A completed and signed W-9
5) Proof of Medi-Cal enrollment
6) Partnership conducts an onsite quality assessment facility site review and medical record review. See policy MCQP1022.

f. PCP providing Urgent Care to non-assigned members
1) A completed signed application for Urgent Care Services
2) Supplemental Medical Record Review will be conducted at a minimum of every three years in accordance with Policy MCQP1022

g. Home Health Agency/Hospice Provider
1) A completed signed application
2) Copy of current DHCS license
3) Copy of current liability coverage certificate in the amounts defined in the provider contract
4) A completed and signed W-9
5) Proof of Medi-Cal enrollment
6) Copy of accreditation from one of the following:
i. The Joint Commission (TJC)
ii. Community Health Accreditation Program (CHAP)
iii. Accreditation Commission for Health Care (ACHC)
i. If facility is not accredited, Partnership will accept a copy of a current CMS or State review (within 3 years). If the site does not have a current CMS or State Review Partnership will conduct an onsite quality assessment.
7). Plan will strongly recommend providers use the California Electronic Visit Verification (EVV) system. If Provider uses an alternate EVV system they must comply with all business requirements and technical specifications, including the ability to capture and transmit the

[1] Partnership will evaluate each applicant based on the needs of the network locally and the qualifications and capabilities of the applicant. The application is Partnership policy MCUG3044 Attachment A and may be found here.

required data elements to the EVV Aggregator per APL 22-014

8). Plan will monitor providers for compliance with the EVV requirements and Information Notice and alert DHCS to any compliance issues.

9). Plan will deny payment if the provider is not complying with EVV requirements and arrange for the participants to receive services from a provider who does comply per APL 22-014.

i. Providers found to be non-compliant with EVV may be subjective to corrective action consistent with Partnership policy CMP38 Escalation and Corrective Action

h. Acute Rehabilitation Facility

1) A completed signed application
2) Copy of current DHCS license
3) Copy of current liability coverage certificate in the amounts defined in the provider contract
4) A completed and signed W-9
5) Proof of Medi-Cal enrollment
6) Copy of accreditation from one of the following:
   i. The Joint Commission (TJC)
   ii. Commission on Accreditation of Rehabilitation Facilities (CARF)
      i. If facility is not accredited, Partnership will accept a copy of a current CMS or State review (within 3 years).

i. Behavioral Healthcare Providers– including ambulatory, residential, and inpatient facilities

1) A completed signed application
2) Copy of current DHCS license
3) Copy of current liability coverage certificate in the amounts defined in the provider contract
4) A completed and signed W-9
5) Proof of Medi-Cal enrollment
6) Copy of accreditation from one of the following:
   i. The Joint Commission (TJC)
   ii. Commission on Accreditation of Rehabilitation Facilities (CARF)
      i. If the facility is not accredited, Partnership will accept a copy of a current CMS or State review (within 3 years).

j. Substance Use Disorder Providers - including ambulatory, residential, and inpatient facilities

1) A completed signed application
2) Copy of current DHCS license or copy of a current business license.
   i. County programs that do not have either license are waived.
3) Copy of current liability coverage certificate in the amounts defined in the provider contract
4) A completed and signed W-9
5) Proof of Drug Medi-Cal Certification
6) A site review conducted by Partnership. The site must receive a passing score as defined in policy MPQP1025 - Substance Use Disorder (SUD) Site Review and Medical Record Review

k. Community Based Adult Services (CBAS)

1) A completed signed application
2) Copy of current CBAS approval from DHCS
3) Copy of current liability coverage certificate in the amounts defined in the provider contract
4) A completed and signed W-9
5) Copy of accreditation from one of the following:
   i. The Community Health Accreditation Program (CHAP)
   ii. Commission on Accreditation of Rehabilitation Facilities (CARF)
      i. If facility is not accredited, Partnership will accept a copy of a current CMS or State review (within 3 years). If the site does not have a current CMS or State Review Partnership will conduct an onsite quality assessment.

l. Free-standing Birth Centers
   1) A completed signed application
   2) Copy of current DHCS license, or copy of a current business license
   3) Copy of current liability coverage certificate in the amounts defined in the provider contract
   4) A completed and signed W-9
   5) Proof of Medi-Cal enrollment
   6) Copy of accreditation from the Commission for the Accreditation of Birth Centers (CABC)
   7) Verification of a transfer agreement with a local hospital
   8) A document containing the name, address and National Provider Identifier (NPI) number of a consulting OB/GYN physician who is currently credentialed with Partnership who has agreed to provide consulting services to the birthing center.
      Partnership will verify this arrangement with the consulting physician.
      i. If the site does not have a current CMS or State Review, Partnership will conduct an onsite quality assessment.

m. Free Standing Radiology Centers
   1) A completed signed application
   2) Copy of current DHCS license, or copy of a current business license
   3) Copy of current liability coverage certificate in the amounts defined in the provider contract
   4) A completed and signed W-9
   5) Proof of Medi-Cal enrollment
   6) For centers offering advanced diagnostic imaging (MRI, CT, Nuclear Medicine Imaging, including PET), a copy of accreditation from one of the following:
      i. The Joint Commission (TJC)
      ii. American College of Radiology (ACR)
      iii. Intersocietal Accreditation Commission (IAC)
         i. If the facility is not accredited, Partnership will accept a copy of a current CMS or State review (within 3 years).

n. Dialysis Center
   1) A completed signed application
   2) Copy of current DHCS license
   3) Copy of current liability coverage certificate in the amounts defined in the provider contract
   4) A completed and signed W-9
   5) Proof of Medi-Cal enrollment
   6) Copy of accreditation from one of the following:
      i. The Joint Commission (TJC)
      ii. Accreditation Association for Ambulatory Health Care (AAAHC)
      iii. National Dialysis Accreditation Commission (NDAC)
         i. If facility is not accredited, Partnership will accept a copy of a current CMS or State review (within 3 years). If the site does not have a current CMS or State Review Partnership will conduct an onsite quality assessment.

o. Clinical Laboratory
   Accreditation is required. Partnership will not contract with any clinical lab vendor that does not meet the criteria.
   1) A completed signed application
   2) Copy of current DHCS license
   3) Copy of current liability coverage certificate in the amounts defined in the provider contract
   4) A completed and signed W-9
   5) Proof of Medi-Cal enrollment
   6) Copy of CLIA Certificate

7) Copy of accreditation from one of the following:
   i. The Joint Commission (TJC)
   ii. American Association for Laboratory Accreditation (AALA)
   iii. College of American Pathologists (CAP)

p. Stand Alone Laboratory
Accreditation is required. Partnership will not contract with any clinical lab vendor that does not meet the criteria.
1) A completed signed application
2) Copy of current DHCS license
3) Copy of current liability coverage certificate in the amounts defined in the provider contract
4) A completed and signed W-9
5) Proof of Medi-Cal enrollment
6) Copy of CLIA Certificate
7) Copy of accreditation from one of the following:
   i. The Joint Commission (TJC)
   ii. American Association for Laboratory Accreditation (AALA)
   iii. College of American Pathologists (CAP)

q. Rural Health Clinic
1) A completed signed application
2) Copy of current DHCS license
3) Copy of current liability coverage certificate in the amounts defined in the provider contract A completed and signed W-9
4) Proof of Medi-Cal enrollment
5) Verification or copy of Health Resources & Services Administration Program (HRSA)
6) Passing Score for Partnership Site Review as mandated by DHCS

r. Federally Qualified Health Center
1) A completed signed application
2) Copy of current DHCS license
3) Copy of current liability coverage certificate in the amounts defined in the provider contract
4) A completed and signed W-9
5) Proof of Medi-Cal enrollment
6) Verification or copy of Health Resources & Services Administration Program (HRSA)
7) Passing Score for Partnership Site Review as mandated by DHCS

s. Transplant Programs
1) Must be a Medi-Cal approved Center of Excellence (COE) transplant program that operates within a hospital setting.
2) Must be certified and licensed through the Centers for Medicare and Medicaid Services (CMS).
3) Must meet Medi-Cal state and federal regulations consistent with 42 CR, pars 405,482,488,498 and Section 1138 of the Social Security Act (SSA).

4) The Hospital within which the program is located must meet DHCS' criteria and hospital is enrolled to participate in the Medi-Cal program.
5) Solid Organ transplant programs must meet the Center for Medicare and Medicaid Services (CMS) Conditions of Participation (CoP) for a specific organ type and must maintain an active membership with the Organ Procurement and Transplantation Network (OPTN) administered by the United Network for Organ Sharing (UNOS).
6) Bone Marrow transplant programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy (FACT).
7) Pediatric organ transplants that qualify as a California Children's Services (CCS) eligible condition are required to be performed only in a CCS-approved Special Care Center (SCC) and must meet the following criteria:
   i. Have both a CCS program approved center for the specific organ and appropriate pediatric subspecialists on the hospital staff;
   ii. Include the participation of the CCS-paneled pediatric subspecialists with the appropriate specialty for the specific organ, for the care of all patients under the age of 18 years; and
   iii. Admit all patients under the age of 14 years to a pediatric unit or floor
8) Partnership will monitor, no less than annually, to validate the transplant program requirements are met by contracted hospital.

C. Documents submitted by providers will be verified, using the sources identified on Attachment A, Credentialing Verification sources used by Partnership for Organizational Providers.
D. The additional credentialing requirements listed below will be verified, using the sources identified on Attachment A.
   1. Possession of a valid National Provider Identifier (NPI)
   2. Possession of a current Medi-Cal license number.
   3. Freedom from any Medicare/Medi-Cal sanctions.
E. Organizational providers will be researched to identify if they are an approved California Children Services (CCS) paneled provider as part of the credentialing process. CCS approved is not a requirement for credentialing, but the verification of each organization is required to identify and report providers in accordance with APL 23-034. All provider credentialing files will be processed in accordance with policy MPCR400 to ensure compliance prior to presentation to the Credentials Committee for approval.
F. In order to participate in Partnership Advantage, a provider must be enrolled in and able to bill the Medicare program.
G. Re-Assessment Requirements
   1. All provider types are required to submit the following documentation:
      a. A completed signed application
      b. Copy of current business or DHCS license
      c. Copy of current professional liability coverage certificate
      d. Proof of Medi-Cal enrollment
      e. Copy of applicable accreditation(s)

H. Documentation will be verified in the same manner, using the same sources listed in Attachment A, Credentialing Verification sources used by Partnership HealthPlan for Organizational Providers, as the initial assessment process to ensure the provider has remained current and in good standing.
I. If at the time of re-assessment, the organization's TJC or CMS review has not been completed, Partnership will document the scheduled date of the next survey. Partnership will follow-up to insure compliance based on that date.
J. Partnership Quality Improvement performance monitoring reports will be pulled and reviewed for all organizational provider types contracted with Partnership.
K. All provider credentialing files will be processed in accordance with policy MPCR400 to ensure compliance prior to presentation to the Credentials Committee for approval.

VII. REFERENCES:

A. National Committee for Quality Assurance (NCQA) 2026 CR7 Elements A-E
B. DHCS, DMHC, CMS
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015 California Children's Services Whole Child Model Program (12/2/24) *supersedes* APL 23-034
D. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/22)

VIII. DISTRIBUTION:

Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPELEMNTING PROCEDURE: Director, Network Services

X. REVISION DATES:

Medi-Cal
05/09/2018, 08/08/2018, 08/14/2019, 02/12/2020, 09/09/2020, 06/09/2021, 1/12/2022, 8/10/2022; 01/11/23, 01/10/2024, 02/12/25, 07/09/25. 04/08/26

Partnership Advantage (effective Jan. 1, 2027)

XI. PREVIOUSLY APPLIED TO:

A. MPCR10 (Archived 07/01/2018)
H. 42 CFR 424, subpart P – Requirements for Establishing and Maintaining Medicare Billing Privileges