June 25, 2013

Department of Healthcare Services
Delivered via email to: info@calduals.org

Re: Comments on All Plan Letters: Interdisciplinary Care Team (ICT) Requirements; Facility Site Review/Physical-Accessibility Reviews

Thank you for the opportunity to comment on the All Plan Letters (APLs) addressing the Interdisciplinary Care Team (ICT) Requirements and the Facility Site Review/Physical-Accessibility Reviews for Cal MediConnect plans. The undersigned jointly submit these general comments and we have also attached the APLs with our suggested edits in track changes. As a preliminary matter, we are discouraged that stakeholders were provided less than a week to provide comments on these APLs. Many of the details and policies that will ultimately dictate how the Coordinated Care Initiative is operationalized will be outlined in APLs and similar documents. Stakeholders should be given sufficient time to review these policies to provide adequate and substantive feedback.

All Plan Letter: ICT Requirements for Cal MediConnect Plans

Consistency

The APL refers to Cal MediConnect as the "duals demonstration" and to Cal MediConnect plans as "Duals Demonstration Plans" or "DDPs." With the adoption of Cal MediConnect under the Memorandum of Understanding with the Centers for Medicare and Medicaid Services, we believe DHCS should use Cal MediConnect when referring to the duals demonstration and the plans participating in the demonstration to maintain consistency and minimize confusion. The acronyms should be used consistently across all APLs.

Enrollee's Right to an ICT

The APL states that all Cal MediConnect enrollees will have a right to request an ICT. However, it is not clear how an enrollee will know about this right and accordingly, exercise this right. The APL should include guidance to plans on informing enrollees of their right to an ICT. For example, the right to an ICT should be included in the plans' enrollment materials and notices, and plans should inform enrollees of this right during the Health Risk Assessment (HRA).

The APL also states that an ICT will be provided "when necessary." The term "when necessary" implies that plans may have a right to deny an enrollee the right to an ICT. We believe that every enrollee has the right to an ICT if requested. The primary goal of Cal MediConnect is to provide care coordination - the denial of the right to an ICT would fundamentally undermine this objective. The APL should make it clear that the plans will have no role in determining whether an ICT will be provided. The enrollee has the right to both receive and refuse the development of an ICT.

ICT Members

The MOU requires that the ICT be "built around the enrollee" and be "person-centered: built on the enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity." (MOU p. 70). To ensure that the ICT accomplishes these objectives, we believe it is essential that the enrollee, or his or her designee, be a required ICT member. Of the list of additional members of the ICT, family members and friends should be added. (MOU p. 70).

The APL does not address how plans should determine who, of the list of possible members, should be added as members of the ICT. At a minimum, the APL should require plans to include members on the ICT who, as described under the MOU, "are knowledgeable on key competencies including, but not limited to: person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles." (MOU p. 70). The APL should require plans to provide an enrollee with notice of who is on the ICT.

The APL should also make it clear that the ultimate decision of who is permitted to participate on the ICT lies with the enrollee. (MOU p. 73; DHCS Care Coordination Standards[1]).

Finally, the APL should require plans to create an internal appeal/grievance procedure that allows an enrollee to dispute what members are chosen for the ICT; file a complaint when the ICT fails to timely hold meetings or include core members in ICT meetings; file a complaint when a request for the development of an ICT takes an unreasonably long time.

Individual Care Plan

The ICT's primary responsibility is the construction of the Individual Care Plan (ICP). Yet, the APL does not provide plans guidance on how the ICP should be developed by the ICT. We urge DHCS to release an APL that specifically addresses the development of the ICP, which should be cross-referenced in this APL. In the event DHCS does not intend on releasing an APL on the ICP, we recommend including such guidance in this APL that addresses the following: a timeline for development of the ICP; required content of the ICP; how the ICP shall be shared; and required approval of the ICP. (See DHCS Care Coordination Standards). We have provided sample language in track changes on the APL.

Monitoring

With the transition of seniors and persons with disabilities into managed care in 2011, care coordination proved to be inadequate despite the fact that plans were required to provide case management and care coordination. We believe that the APL should require plans to monitor the extent the ICP has been successful in care coordination and meeting the objectives outlined by the ICT in the ICP.

[1] DHCS Care Coordination Standards, January 24, 2013. Available at, http://www.calduals.org/2013/02/20/cc_standards/

All Plan Letter: Facility Site Review/Physical-Accessibility Reviews

Ensuring Network Adequacy

The FSR/PAR will be a critical tool for enabling the state and CMS to comply with the requirement in the MOU to "meet enrollees' needs by contracting with a sufficient number of health facilities and providers that comply with applicable state and Federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats." (MOU p. 88). Moreover, one of the California-specified 1% quality withhold measures in the MOU relates specifically to "[e]nsuring physical access to buildings, services and equipment" which further indicates that "[t]he health plan has an established work plan and identified an individual who is responsible for physical access compliance." (MOU pp. 52-53).

The FSR/PAR APL should assist plans to clearly connect their administration of the existing FSR/PAR with what is expected of them under the MOU, and further clarify the State's own accessibility obligations under that same document. By its own terms, the APL "supplements the existing FSR Tool detailed in MMCD Policy Letter 02-002, which remains in effect," but there does not appear to be any indication of how plans' use of the FSR/PAR will differ from that outlined in past APLs relating to the revised FSR. In particular, the most recent APL relating to the revised FSR, MMCD Policy Letter 12-006 dated August 9, 2012, states that "[t]he results of FSR Attachment C are informational and unlike FSR Attachments A (Site Review Survey) and B (Medical Records Review Survey) do not require corrective action." (At p. 4). Similarly, "[p]lans are required to maintain all original documentation of their FSR attachments and make this information available to DHCS or its representative for contract monitoring or auditing purposes." A plan's accurate assessment of physical accessibility among its providers and retention of related documentation is merely the first step in achieving accessibility in its provider network. Accordingly, we have provided sample language in track changes in the APL to indicate how the Department can supplement the plans' obligations under the FSR and actively work with plans to ensure beneficiary access to "an appropriate provider network that includes an adequate number of specialists, primary care physicians, hospitals, long-term care providers and accessible facilities within each service area." (MOU at p. 83).

Timing

The draft APL currently extends the FSR/PAR implementation timeline past the current Cal MediConnect implementation date. The plan's stated concern appears to be with "the number of providers that will become a part of the Cal MediConnect network" as a consequence of plan outreach to new providers. This concern would merit a timeline extension for Attachments A and B (credentialing) implementation, as well as completion of FSR-C, for **newly contracted providers**. Existing providers in the network should already have become incorporated within the plan's ongoing three year FSR cycle since the incorporation of Attachment C first became effective for primary care providers and high volume specialists and ancillary providers February 1, 2011, or as soon thereafter as high volume benchmark documentation was submitted and approved. COHS plans were required to begin using FSR-C by November 2, 2012. We note that all of the Cal MediConnect plans were also Medi-Cal Managed Care

Health Plans and therefore subject to these earlier APLs regarding timelines for incorporation of the FSR-C. If there is an additional concern that the current implementation date for Cal MediConnect is set two or three months before the first full three-year FSR cycle that incorporates the FSR-C, then plans should be given an additional two or three months to complete that cycle of FSR/PAR, but there seems little reason to generally extend FSR timelines beyond those that were first established in 2011. We have provided sample language in track changes in the APL to indicate what a narrower timeline extension could look like.

Scope

We strongly agree with the second bullet point under the "Policy and Requirements" heading that indicates that all providers, including non-high volume providers are subject to the FSR-C. We have included track changes to clarify what we understand to be DHCS's decision to include non-high volume specialists and ancillary providers within the scope of the FSR-C. If in fact, this is regrettably not DHCS's intention, the language must be incorporated within the high volume benchmark requirements that plans must regularly review existing network and incoming providers to see if they meet high-volume criteria over time and therefore merit application of the FSR-C.

We have included suggested language in track changes in the APL to clarify that providers who have a current FSR/PAR passing score from within the past three years need not undergo an additional FSR/PAR before implementation of Cal MediConnect, but those providers are not thereby excused in perpetuity from ongoing review under FSR-C in accordance with the FSR three year cycle requirement. Providers can move location, make renovations, and sell and acquire diagnostic equipment. Something as simple as changing the arrangement of furniture in a waiting room can make eliminate the wheelchair turning radius required by wheelchair users for physical accessibility. The FSR-C needs to be consistently administered over time. Finally, we suggest that, just as prior APL 10-016 indicated that "health plans may also offer the opportunity for physical accessibility reviews to any provider that request to be evaluated, regardless of whether they are determined to be high volume," the current APL can encourage plans to provide FSR-C review to any provider that works with plan members, whether through a continuity of care arrangement or some other plan mechanism.

Thank you for the opportunity to comment.

Sincerely,

California Health Advocates
Disability Rights California
Disability Rights Education & Defense Fund
Legal Assistance for Seniors
National Senior Citizens Law Center
Neighborhood Legal Services
Western Center on Law and Poverty