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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: July 17, 2013

DUALS PLAN LETTER 13-003

TO: CAL MEDICONNECT DEMONSTRATION SITES

SUBJECT: FACILITY SITE REVIEW / PHYSICAL-ACCESSIBILITY REVIEWS

PURPOSE

The purpose of this Duals Plan Letter (DPL) is to establish standards for Facility Site Reviews (FSR) and FSR Attachment C, Physical-Accessibility Reviews (PAR), conducted by Medi-Cal managed care health plans (MCPs) that participate in Cal MediConnect. The Department of Health Care Services (DHCS) developed these requirements pursuant to Welfare and Institutions Code (W&I Code) Section 14182(b)(9). This DPL supplements the existing FSR policy detailed in Medi-Cal Managed Care Division (MMCD) Policy Letters (PL) 02-002 and12-006[1], which remain in effect.

This DPL incorporates requirements that address the level of physical accessibility of provider sites that serve Cal MediConnect beneficiaries—individuals who are eligible for both Medicare and Medi-Cal (Duals). All Cal MediConnect Medicare-Medicaid Plans (MMPs) are required to meet the requirements of this DPL when Cal MediConnect is implemented, scheduled for no sooner than January 1, 2014.

MMPs have expressed concerns regarding their ability to meet current FSR and PAR requirements due to the number of providers who will become a part of the Cal MediConnect network and the timing of the three-way contracts between the Centers for Medicare & Medicaid Services, DHCS, and the MMPs to implement Cal MediConnect. MMPs have reported that they have no authority to conduct an FSR or PAR without a contract in place and will not have sufficient time to complete all reviews between the date the contracts are executed and the date the program is implemented.

[1] MMCD PLs, including PLs 02-002 and 12-006, are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx.

BACKGROUND:

In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities (SPDs) by shifting service delivery away from institutional care and into home and community-based settings. Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).

A component of the CCI is a three-year Duals Demonstration Project, referred to as Cal MediConnect, which will be implemented no sooner than January 1, 2014, in the following eight counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, Alameda, Santa Clara, and San Mateo. Cal MediConnect will combine the full continuum of acute, primary, institutional, and home and community-based Medicare and Medi-Cal services into a single benefit package delivered through an organized service delivery system administered by MMPs. Unless exempted, Duals will be passively enrolled into MMPs, but may choose to opt out.

Cal MediConnect will include unified Medicare and Medi-Cal processes, including network adequacy requirements, outreach and education, marketing, quality measures, and grievances and appeals processes.

POLICY AND REQUIREMENTS:

In response to MMP concerns, DHCS is offering the following option(s) to MMPs:

- Complete Attachments A and B of the FSR (credentialing) no later than 12 months after implementation of Cal MediConnect. MMP providers must meet all of the credentialing requirements outlined in the MMP Readiness Review process (as verified by the National Opinion Research Center).

- Complete Attachment C (physical accessibility) for high-volume providers (see *High-Volume Providers* subsection below) no later than eight months after implementation of Cal MediConnect and for all other providers up to 12 months after implementation.

- Waive completion of Attachments A and B of the FSR for a provider that has a current passing MMP score or a passing FSR score from a DHCS approved quality assurance agency, such as the National Committee for Quality Assurance. The waiver will only be good three years from the date the FSR was completed by the quality assurance agency. By December 1, 2013, the MMPs

must submit a list of all providers who have received a waiver of FSR attachments A and B through the quality assurance agency exception. The report must include, at a minimum, the National Provider Identification number, the quality assurance agency name, and the date the FSR was completed.

- Waive completion of a PAR if a MCP has assessed the provider or high-volume specialist or ancillary provider, as provided for in MMCD PL 12-006. MCPs must continue to meet all policy requirements, including timeframes and publication of the PAR available on MMP websites and in provider directories, as required in MMCD PL 12-006.

High-Volume Providers

MMPs are only required to comply with FSR or PAR policy requirements for all primary care providers, and for any high-volume specialist and ancillary providers who are included in the MMP's provider directory.

These requirements are similar to those described in MMCD PL 10-016 and PL 12-006 related to SPDs; they allow MMPs, in part, to determine which specialist and ancillary providers served a high volume of Duals. DHCS will require each MMP to submit the following initial documentation to DHCS for review and approval:

1. The benchmark the MMP has established to determine what constitutes high volume for each category of specialty and ancillary providers included in the MMP's provider directory. Each MMP must select and define one of the following benchmarks to determine what constitutes high volume for each category of specialty and ancillary service providers included in the MMP's provider directory:

    - An average number of visits made per month or per 12-month period made by a unique member to a specialty or ancillary service provider, group, or site.

    - A "frequency-of-use" benchmark based on a specified number of visits (e.g. greater than five visits) per day and the number of lines of claims or services provided during the specified number of visits.

    - The percentage of the MMP's members who have visited a specialist within a 12-month timeframe or ancillary providers who have had more than a specified number of encounters with the MMP's members during a 12-month period.

- The number of specialty or ancillary providers with a specified volume of claim lines during a 12-month period and add additional providers to this list if they appear to be significant providers of services to SPDs even though their number of claim lines was lower than the benchmark.

- Determine the highest-to-lowest number of claims over a 12-month period for all specialty and ancillary providers and develop an average number of claims for each specialty or ancillary provider type: any specialty or ancillary provider with claims greater than the average is high volume.

- Use FSR Attachment C on all specialty and ancillary sites, without differentiating between low and high-volume providers. If a MMP uses this approach, then it does not need other documentation for approval.

2. The methodology the MMP used to develop the benchmark.

3. A summary of the utilization or other data used to support the methodology. A MMP must develop the benchmark using the Medicare utilization data provided by DHCS and the utilization data it collects during the first four months from the date it implements Cal MediConnect.

4. Any categories of specialty and ancillary providers that do not have enough utilization to qualify for as high-volume.

5. A list of the specific high-volume specialty and ancillary providers for whom the MMP will administer the FSR Attachment C within the initial six months of Cal MediConnect.

MMPs must submit initial documentation one and two above to DHCS by September 1, 2013; MMPs must submit initial documentation three through five above to DHCS by June 2, 2014. MMPs must email all documentation to pmmp.monitoring@dhcs.ca.gov for DHCS review and approval. For annual submissions, if the MMP has made no changes, the MMP must submit a letter stating this to its DHCS contract manager. If the MMP has made changes, the MMP must submit a letter that shows the changes using lined-out old text and inserted new text in red type.

DHCS will review this initial documentation and provide feedback to MMPs regarding any area of concern or required changes. If you have any questions regarding this DPL, please contact Sarah Brooks at sarah.brooks@dhcs.ca.gov.

Sincerely,

Original signed by Margaret Tatar

Margaret Tatar, Chief
Medi-Cal Managed Care Division