DATE:                     DUALS PLAN LETTER 13-XXX

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 Review/Physical Accessibility Reviews (FSR/PARs) conducted by Medi-Cal managed care 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 Tool detailed in MMCD Policy Letter 02-002, as well as the requirements set out in MMCD Policy Letters 10-106 and 12-006 which apply generally to all Medi-Cal Managed Care Health Plans, all of which remain in effect.

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

2 MMCD Policy Letter 12-006 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2012/PL12-006.pdf. APL 12-006 requires plans to make the results of FSR Attachment C available to members through their websites and provider directories. The information provided must, at a minimum, display the level of access results met per provider site as either Basic Access or Limited Access. Additionally, Plans must indicate whether the site has or does not have access in the following categories: parking, building exterior, building interior, exam room, restroom, and medical equipment.
CMCPCMPs have expressed concerns regarding their ability to meet current FSR/PAR requirements due to the number of newly contracted (those who join the plan four months before, or after, the implementation date of Cal MediConnect) providers that will become a part of the Cal MediConnect network and the timing of the three-way contracts between the Centers for Medicare and Medicaid Services (CMS), DHCS, and the CMCPCMPs to implement Cal MediConnect. CMCPCMPs have reported that they have no authority to conduct FSR/PARs 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.

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 CMCPCMPs. Dual-eligible beneficiaries will be passively enrolled into CMCPCMPs, 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 CMCMP concerns, DHCS is offering the following mutually exclusive option(s) to CMCMPs, they which they:

- May complete Attachments A and B of the FSR (credentialing) for newly contracted providers no later than 12 months after implementation of Cal MediConnect, as long as they meet all of the credentialing requirements outlined...
in the DDP Readiness Review process (as verified by the National Opinion Research Center (NORC));

- May complete Attachment C (physical accessibility) for newly contracted high-volume providers no later than six months after implementation of Cal MediConnect and for all other newly contracted providers, including specialists and ancillary providers, up to 12 months after implementation;

- May waive completion of an FSR/PAR for a provider that has a current passing score. A passing score of an FSR/PAR shall be considered “current” if it is dated within the last three years. That provider will still undergo the FSR/PAR in accordance with the current FSR three year cycle requirement; and

  MCPs are not required to complete an FSR/PAR for a provider that has a current passing score. A passing score of an FSR/PAR shall be considered “current” if it is dated within the last three years; and

- MCPs are only required to complete an FSR/PAR for all primary care providers, and high volume specialist and ancillary providers which are included in the MCPs provider directory. The plan will offer the opportunity for PARs and assessment under FSR-C to any provider who is contracting with the plan through Continuity of Care or another mechanism.

These requirements are similar to those described in MMCD Policy Letter 10-016 and Policy Letter 12-0061-013 related to SPDs; they allow CMCPs, in part, to determine which specialist and ancillary providers served a high volume of Duals within the four month period prior to Cal MediConnect’s implementation. A CMCP will be required to submit to DHCS for review and approval initial documentation of the following:

1. The benchmark it has established to determine what constitutes high volume for each category of specialty and ancillary providers included in the CMCP’s provider directory. One of the following benchmarks must be selected and defined to determine what constitutes high volume for each category of specialty and ancillary service providers included in the Plan’s provider directory:

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3 MMCD Policy Letter 10-016 is available at: http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx
• Establish an average number of visits made per month or per 12-months made by unique member to a specialty or ancillary service provider, group, or site.

• Establish a “frequency of use” benchmark based on more-or-less than a specified number of visits per day and the number of lines of claims or services provided during the specified number of visits.

• Establish a benchmark based on the percentage of the Plan’s members who have seen a specialist within a 12-month timeframe or ancillary providers that have had more than a specified number of encounters with the Plan’s members during a 12-month timeframe.

• Establish a benchmark based on 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, develop an average number of claims for each specialty or ancillary provider type, and determine that any specialty or ancillary provider with claims greater than the average would be considered high volume.

• Decide to use FSR Attachment C on all specialty and ancillary sites, not differentiating between low and high volume providers. If this approach is used, then no other documentation is needed for approval.

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

3. A summary of the utilization or other data used to support the methodology.

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

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

Under California’s MOU with the Centers for Medicare and Medicaid, plans are required to maintain an appropriate provider network that includes an adequate number of
specialists, primary care physicians, hospitals, long-term care providers and accessible facilities. The FSR/PAR will provide a baseline for establishing a workplan to achieving physical access to buildings, services and equipment. As in prior policy, plans are required to maintain original documentation of its FSR assessments. In addition, plans must review the FSR assessments to ascertain if there are sufficient providers with basic access, including specialists and ancillary providers, to ensure that beneficiaries who require accessible facilities and equipment within the plan's service area receive effective health care in accordance with state and federal law. Plans will annually submit their FSR reviews to DHCS, including a workplan that indicates how provider accessibility will be improved and achieved if a majority of network providers at any given point in time have no or only limited access.

All documentation must be submitted to MMCD contract managers for review and approval. For yearly submissions, if no changes have been made, a letter stating this must be submitted to the contract managers. If there are changes, they must be submitted in a red-line document which clearly identifies the changes.

DHCS will review this initial documentation and provide feedback to CMCPs regarding any area of concern and required changes. If you have any questions regarding this DPL, please contact Nathan Nau at nathan.nau@dhcs.ca.gov.

Sincerely,

Margaret Tatar, Chief
Medi-Cal Managed Care Division

Enclosure