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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: September 29, 2014

DUALS PLAN LETTER 14-005
SUPERSEDES DUALS PLAN LETTER 13-003

TO: CAL MEDICONNECT MEDICARE-MEDICAID PLANS

SUBJECT: FACILITY SITE REVIEWS / 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 the Duals Demonstration Project, referred to as 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 Letter (PL) 14-004.

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 Medicare-Medicaid Plans (MMPs) are required to meet the requirements of this DPL when Cal MediConnect is implemented in each county. Cal MediConnect is scheduled to implement according to the implementation schedule titled, "Coordinated Care Initiative (CCI) Enrollment Timeline by Population and County" that can be found at the following link: http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/ under the heading Enrollment Chart.

Prior to the initial implementation of Cal MediConnect in April 2014, MMPs expressed concerns regarding their ability to meet current FSR and PAR requirements due to the number of newly contracted providers becoming part of the Cal MediConnect networks and the timing of the three-way contracts between the Centers for Medicare & Medicaid Services, DHCS and the MMPs to implement Cal MediConnect. MMPs reported that they would not have sufficient time to complete all reviews between the date the contracts were to be executed and the date the program was to be implemented.

This DPL supersedes DPL 13-003 and provides updated due dates for MMP deliverables from the initial guidance published July 17, 2013. Because passive

enrollment begins in different months depending on the county, the due date for MMP deliverables has been updated to account for the varying start dates in each county.

BACKGROUND:
In January 2012, Governor Brown announced his intent to enhance health outcomes and enrollee satisfaction for low-income Seniors and Persons with Disabilities (SPDs) by shifting service delivery away from institutional care to home and community-based settings. To implement that goal, Governor Brown enacted the CCI by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012) and SB 94 (Chapter 37, Statutes of 2013).

The three major components of the CCI are:

1. A three-year Duals Demonstration Project (Cal MediConnect) for Duals that combines the full continuum of acute, primary, institutional, and home and community-based services into a single benefit package, delivered through an organized service delivery system;
2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of Long-Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD Duals.

CCI has/will become effective in the counties of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara according to the implementation schedule titled, "CCI Enrollment Timeline by Population and County" that can be found at the following link: http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/ under the heading Enrollment Chart.

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) for newly contracted providers no later than 12 months after implementation of Cal MediConnect in the provider's county. 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 newly contracted high-volume providers (see High-Volume Providers subsection below) no later than eight months after implementation of Cal MediConnect and for all other newly contracted providers up to 12 months after implementation in the relevant county.

- 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 were required to submit a list of all providers who had received a waiver of FSR attachments A and B through the quality assurance agency exception. The report was to 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 an MMP has assessed the provider or high-volume specialist or ancillary provider, as provided for in MMCD PL14-004. MMPs 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 14-004.

<u>High-Volume Providers</u>

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 14-004 related to SPDs; that 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 an 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 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.

During the readiness review process, the MMPs were required to submit initial documentation one and two above to DHCS by September 1, 2013. MMPs must submit initial documentation three through five above to DHCS no later than six months after passive enrollment has begun. For example, if passive enrollment began in April 2014, documentation for three through five above is due no later than September 30, 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 Cal MediConnect 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 Mari Cantwell

Mari Cantwell
Chief Deputy Director
Health Care Programs