



California  
Department of  
Health Services  
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Director

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



GRAY DAVIS  
Governor

June 23, 2003

MMCD All Plan Letter No. 03006

TO: County Organized Health Systems (COHS)  
Geographic Managed Care (GMC) Plans  
Prepaid Health Plans (PHP)  
Primary Care Case Management (PCCM) Plans  
Two-Plan Model Plans

FROM: Luis R. Rico, Acting Chief  
Medi-Cal Managed Care Division

SUBJECT: FACILITY SITE REVIEW CLARIFICATION #2

The purpose of this letter is to clarify questions raised from the enclosed January 21, 2003, Medi-Cal Managed Care Division All Plan Letter entitled Facility Site Review.

**Collaboration:**

***Do all plans need to participate in a county/plan collaboration?***

A plan that does not share common providers does not need to be part of a collaborative. Kaiser or County Organized Health Systems (COHS) do not necessarily have shared providers; therefore, they do not have to be part of a collaborative.

**Quality Provider Site Certification:**

***Requirements for issuing a Quality Provider Site certificate.***

An All Plan Letter will be released with a template for the Certified Quality Provider Site certificate. The certificate will be issued by the plans performing the review. It will be up to the plan as to whose signature will be on the certificate. The plans are not to put their name in the language of the certificate; however, they can put the plan name(s) on the bottom of the certificate if desired. The certificate will be issued on white paper with



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blue coloring. There will be no expiration dates on the certificate, because the certificate is good for up to three years. No certificate will be issued until the plan closes out the Corrective Action Plan (CAP). The issuing plan will number the certificate.

**Clinics:**

***Can a clinic be a primary care provider?***

Clarification was requested on member assignment to "clinics." The definitions of a primary care provider, primary care physician, and a clinic are defined in the following statutes (enclosed):

- **Welfare and Institutions Code 14088(b)(1)(A) and (B)** defines a primary care provider.
- **Health and Safety Code, Section 1200**, defines a clinic.
- **Welfare and Institutions Code 14254** defines a primary care physician.
- **Welfare and Institutions Code 14087.305(b)(a) and (2) and (3)** defines methods of receiving Medi-Cal benefits in a prepaid health plan for a COHS, a Local Initiative, and a Geographic Managed Care Plan.

**Scoring:**

***This section clarifies the scoring from the January 21, 2003 letter.***

If there are deficiencies in Infection Control and Pharmacy, a CAP is still required, no matter what the score is. A CAP is required if there is only one critical element out of compliance. If the plan can verify that the provider has corrected the critical elements, a follow-up onsite visit is not required.

Monitoring sites between provider certification visits is based on the plan's policies on how that plan wants to establish oversight of the site survey process in between provider certification visits. The plan will have to establish some method to make sure that providers with critical element deficiencies have corrected them, that they stay corrected, and that all providers maintain compliance with the critical elements. How the plan monitors depends on the plan's own process for oversight. The process for oversight must be approved by the State.

If a provider scores between 80-89 on either the site survey or the medical record review, it is the responsibility of the nurse reviewer to determine whether an onsite CAP visit is required. An onsite CAP visit is not necessary if the nurse reviewer makes that determination. If an onsite visit is not done, the documentation must support that decision.

The providers are required to address all site survey/medical record review deficiencies in a CAP; however, the deficiencies do not need to be corrected to 100 percent. There is no re-scoring of the CAP as the deficiencies are corrected. The expectation is for the plans to: 1) work with the providers to correct as much of the deficiencies as soon as possible, 2) provide education and training to each provider to assist them in understanding the requirements, 3) monitor implementation of the CAP, 4) seek eventual full compliance, and, 5) maintain documentation of oversight activities. The only score that is required is the initial score from the site survey tools.

If you have any questions regarding this All Plan Letter, please contact Dori Childress, R.N., Chief of the Medical Monitoring Unit, at (916) 657-4837.

Enclosure



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GRAY DAVIS  
Governor

January 21, 2003

To: Medical Directors

Subject: Facility Site Review

The purpose of this letter is to clarify recent policy decisions regarding the facility site review process by the Medi-Cal Managed Care Division. The policies set forth in this letter are effective January 9, 2003.

#### Collaboration Clarification

Due to the indirect contract relationship with the Department of Health Services (DHS), County Organized Health Systems are not required to participate in a collaborative. Geographic Managed Care contractors and Two Plan Model contractors are expected to form local collaborations with the other DHS direct contracted plans within their counties of operation.

#### Facility Site Review Certificates

The plan, or local plan collaborative will issue the provider site review certificate once the provider has achieved a passing score. The plan or local plan collaborative may use a modified version of the current MMCD site certificate as a template.

#### Clinics

AB 2674 provides that "any beneficiary, subscriber, or enrollee of a program or plan who affirmatively selects, or is assigned by default to...would be assigned directly to the federally qualified health center or rural health clinic and not to an individual provider performing services on behalf of the federally qualified health center or rural health clinic." In lieu of this bill and other clinic arrangements in which a provider is not assigned, it may not be possible for a reviewer to fill an identifier for an individual provider when doing facility site or medical record review, in this instance the facility or provider ID would be the clinic identifier.

#### Scoring and Corrective Action Plans

Facility sites that receive an Exempted Pass (90% or above, without deficiencies in critical elements) will not be required to complete a corrective action plan (CAP), unless required by the plan or local plan collaborative. All sites that receive a Conditional Pass (80-89%, or 90% or above with deficiencies in critical elements) will be required to establish a CAP that addresses each of the noted deficiencies. The compliance level



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categories for both the facility site review and medical record review are the same as listed below:

- Exempted Pass: 90% or above,
- Conditional Pass: 80-89%
- Not Pass: below 80%

Facility sites that receive an Exempted Pass (90% or above) for medical record review will not be required to complete a CAP for medical record review. On-site CAP follow up visits are intended to verify that processes are in place to remedy deficiencies.

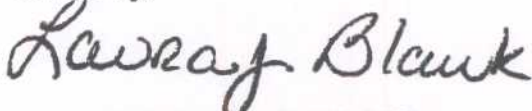
The corrective action plan will not be submitted to DHS for approval. DHS will however, ask for a sample of completed CAPs in order to monitor the plan's CAP process. DHS will also utilize the facility site review database to monitor trends and the effectiveness of the plan's CAP process.

**PM 160**

The PM160 is considered adequate documentation for all areas covered on the form. The name of the referring provider does not need to be identified on the PM160. However, where applicable, a report from the referring provider (e.g., radiologist, oncologist, orthopedist, etc.) should be within the chart. For dental referrals either the PM160 or completed Head, Ears, Eyes, Nose, and Throat, as provided in the medical record, may be used to satisfy documentation requirements.

If you have any comments, please call Dori Childress, R.N., at (916) 657-4837.

Sincerely,



Laura Blank, Chief, RN, MSN  
Office of Clinical Standards and Quality

CALIFORNIA CODES  
WELFARE AND INSTITUTIONS CODE  
SECTION 14088-14088.25

14088. (a) It is the purpose of this article to ensure that the Medi-Cal program shall be operated in the most cost-effective and efficient manner possible with the optimum number of Medi-Cal providers and shall assure quality of care and known access to services.

(b) For the purposes of this article, the following definitions shall apply:

(1) "Primary care provider" means either of the following:

(A) Any internist, general practitioner, obstetrician/gynecologist, pediatrician or family practice physician or any primary care clinic, rural health clinic, community clinic or hospital outpatient clinic holding a valid and current Medi-Cal provider number, which agrees to provide case management to Medi-Cal beneficiaries.

(B) A county or other political subdivision that employs, operates, or contracts with, any of the primary care providers listed in subparagraph (A), and that agrees to use that primary care provider for the purposes of contracting under this article.

(2) "Primary care case management" means responsibility for the provision of referral, consultation, ordering of therapy, admission to hospitals, follow up care, and prepayment approval of referred services.

(3) "Designation form" or "form" means a form supplied by the department to be executed by a Medi-Cal beneficiary and a primary care provider or other entity eligible pursuant to this article who has entered into a contract with the department pursuant to this article, setting forth the beneficiary's choice of contractor and an agreement to be limited by the case management decisions of that contractor and the contractor's agreement to be responsible for that beneficiary's case management and medical care, as specified in this article.

(4) "Emergency services" means health care services rendered by an eligible Medi-Cal provider to a Medi-Cal beneficiary for those health services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which if not immediately diagnosed and treated could lead to disability or death.

(5) "Modified primary care case management" means primary care case management wherein capitated services are limited to primary care physician office visits only.

(6) "Service area" means an area designated by either a single federal Postal ZIP Code or by two or more Postal ZIP Codes that are contiguous.

CALIFORNIA CODES  
HEALTH AND SAFETY CODE  
SECTION 1200-1209

DIVISION 2 LICENSING PROVISIONS  
CHAP. 1 CLINICS

1200. As used in this chapter, "clinic" means an organized outpatient health facility which provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours, and which may also provide diagnostic or therapeutic services to patients in the home as an incident to care provided at the clinic facility. Nothing in this section shall be construed to prohibit the provision of nursing services in a clinic licensed pursuant to this chapter. In no case shall a clinic be deemed to be a health facility subject to the provisions of Chapter 2 (commencing with Section 1250) of this division. A place, establishment, or institution which solely provides advice, counseling, information, or referrals on the maintenance of health or on the means and measures to prevent or avoid sickness, disease, or injury, where such advice, counseling, information, or referrals does not constitute the practice of medicine, surgery, dentistry, optometry, or podiatry, shall not be deemed a clinic for purposes of this chapter.

References in this chapter to "primary care clinics" shall mean and designate all the types of clinics specified in subdivision (a) of Section 1204, including community clinics and free clinics. References in this chapter to specialty clinics shall mean and designate all the types of clinics specified in subdivision (b) of Section 1204, including surgical clinics, chronic dialysis clinics, and rehabilitation clinics.

1200.1. (a) As used in this chapter, "clinic" also means an organized outpatient health facility which, pursuant to Section 1204.1, provides direct psychological advice, services, or treatment to patients who remain less than 24 hours, and which may also provide diagnostic or therapeutic services authorized under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code to patients in the home as an incident to care provided at the clinic facility.

(b) Psychological clinics, as defined in Section 1204.1, shall not be considered primary care clinics for the purposes of any state grants, state loans, or other state aid.

Nothing contained in this section shall prohibit psychological clinics from receiving payment to which they are otherwise entitled from the state or in which the state participates financially, for services rendered pursuant to their license.

(c) Any reference in any statute to Section 1200 shall be deemed and construed to also be a reference to this section.

on the number of beneficiaries so determined.

14252. "Medi-Cal beneficiary" means a person who is eligible to receive benefits under Chapter 7 (commencing with Section 14000) of this part.

14253. "Subcontract" means an agreement entered into by the prepaid health plan with any of the following:

(a) A provider of health care services who agrees to furnish such services to Medi-Cal beneficiaries enrolled in the prepaid health plan.

(b) A marketing organization.

(c) Any other person or organization who agrees to perform any administrative function or service for the operation of the prepaid health plan specifically related to securing or fulfilling its contractual obligations with the department.

14254. "Primary care physician" is a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. A primary care physician shall be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

W+I code



14087.305. (a) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3 and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or Aid to Families with Dependent Children (AFDC) applicant or beneficiary shall be informed of the managed care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.

(b) The managed care options information described in subdivision (a) shall include the following elements:

(1) Each beneficiary or eligible applicant shall be provided with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty, or clinic, participating in each prepaid health plan option. This information shall be presented under geographic area designations, in alphabetical order by the name of the primary care provider and clinic. The name, address, and telephone number of each specialist participating in each prepaid health plan shall be made available by contacting the health care options contractor or the prepaid health plan.

(2) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider or clinic contracting with any of the prepaid health plan options available and has available capacity and agrees to continue to treat that beneficiary or applicant.

(3) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a prepaid health plan.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible for Medi-Cal, the beneficiary shall indicate his or her choice, in writing, from among the available prepaid health plans in the region and his or her choice of primary care provider or clinic contracting with the selected prepaid health plan.

(d) At the time the beneficiary or eligible applicant selects a prepaid health plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected prepaid health plan.

(e) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3, and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or AFDC beneficiary who does not make a choice of managed care plans, shall be assigned to and enrolled in an appropriate Medi-Cal prepaid health plan providing service within the area in which the beneficiary resides.

(f) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select any primary care provider who is available, the prepaid health plan that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.