State of California—Health and Human Services Agency

Department of Health Care Services

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DATE: February 12, 2015

ALL PLAN LETTER 15-004

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN REQUIREMENTS FOR NURSING FACILITY SERVICES IN COORDINATED CARE INITIATIVE COUNTIES FOR BENEFICIARIES NOT ENROLLED IN CAL MEDICONNECT

PURPOSE:
The purpose of this All Plan Letter (APL) is to clarify the responsibilities of Medi-Cal managed care health plans (MCPs) to provide coverage of nursing facility (NF) services as required under the Coordinated Care Initiative (CCI) for MCP beneficiaries in CCI counties who are not enrolled in the Duals Demonstration Project, herein referred to as Cal MediConnect.

BACKGROUND:
In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities 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). One component of the CCI is the provision of Long Term Services and Supports (LTSS), including NF services, by MCPs in CCI counties.

REQUIREMENTS:
The Department of Health Care Services (DHCS) is issuing this guidance in recognition that there will continue to be an ongoing need to ensure MCP readiness as well as a smooth implementation of the CCI and the transition of critical NF services to MCPs.

<u>PROVIDER CONTRACTS:</u>
MCP contracts with providers shall comply with all applicable CCI requirements.

<u>PROMPT PAYMENT AND ELECTRONIC CLAIMS:</u>
MCPs shall pay providers, including institutional providers, in accordance with the prompt payment provisions contained in each MCP's contract with DHCS, including the ability to accept and pay electronic claims. This requirement is established under

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Welfare and Institutions Code (W&I) Section 14186.3(c)(5) that applies to NF services provided through MCPs in CCI counties.

For NF services provided through MCPs in CCI counties, MCPs shall pay 90 percent of all clean claims from contracted NF service providers within 30 calendar days after the date of receipt of the claim, and 99 percent of all clean claims within 90 calendar days, unless the contracted provider and MCP have agreed in writing to a faster alternate payment schedule. The date of receipt shall be the date the MCP receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment. MCPs shall also pay all claims submitted by contracted NF service providers in accordance with Health and Safety Code (H&S) Sections 1371 – 1371.39 if:

1) The timeline provided by these sections is less than the timeline provided above; and

2) The contracted provider and MCP have not agreed in writing to a faster alternate payment schedule.

MCPs shall pay non-contracted provider claims in accordance with H&S Sections 1371–1371.39 and/or other applicable laws and regulations. An MCP shall be subject to any remedies, including interest payments, provided for in these sections if the MCP fails to meet the standards specified in these sections.

For NF services provided through MCPs in CCI counties, if the submitting provider requests electronic processing, the MCP shall accept the submission of electronic claims and pay claims electronically.

REIMBURSEMENT FOR MEDI-CAL NF SERVICES:
For Medi-Cal NF services provided through MCPs in CCI counties, MCPs shall reimburse providers at rates that are not less than Medi-Cal Fee-for-Service (FFS) rates, as published and revised by DHCS, including retroactive payment of any additional rate increment based on DHCS retroactive rate adjustments, for equivalent services for the date(s) of service.

LEAVE OF ABSENCE AND BEDHOLDS:
Pursuant to W&I Code Section 14186.1(c)(4), for NF services provided through MCPs in CCI counties, MCPs shall include as a covered benefit any leave of absence or bedhold

that a NF provides in accordance with the requirements of Title 22, California Code of Regulations (CCR), Section 72520 or California's Medicaid State Plan.[1]
Medi-Cal requirements for bedhold and leave of absence are detailed in Title 22, CCR, Sections 51535 and 51535.1.

MEDICARE COINSURANCE AND DEDUCTIBLES:
For long term care (LTC) services, MCPs shall pay the full Medicare coinsurance and deductibles. Please see APL 13-003[2] for more information about this requirement.

MEDI-CAL SHARE OF COST:
MCPs shall process claims submitted by NFs consistent with Medi-Cal guidelines for share of cost (SOC), as outlined in the Medi-Cal Long-Term Care Provider Manual.[3]
When a Medi-Cal beneficiary has an LTC aid code and an SOC, an NF will subtract the SOC that is paid or obligated to be paid from the claim amount. The MCP shall pay the balance.

In addition, as required by the *Johnson v. Rank* settlement agreement, if a beneficiary spends part of the SOC on "non-covered" medical services or remedial services or items, the NF will subtract those amounts from the beneficiary's SOC. The NF will adjust the amount on the claim, and the MCP shall pay the balance.

As a result of the *Johnson v. Rank* lawsuit, Medi-Cal beneficiaries, not their providers, can elect to use the SOC funds to pay for necessary, non-covered, medical or remedial-care services, supplies, equipment, and drugs (medical services) that are prescribed by a physician and part of the plan of care authorized by the beneficiary's attending physician. The physician's prescriptions for SOC expenditures must be maintained in the beneficiary's medical record. A "medical service" is considered a non-covered benefit if either of the following is true:

1) The medical service is rendered by a non-Medi-Cal provider; or

2) The medical service falls into the category of services for which an authorization request must be submitted and approved before Medi-Cal (DHCS or the MCP) will pay, and either an authorization request is not submitted or an authorization

[1] The California State Plan can be accessed at the following link:
http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx
[2] APL 13-003 can be accessed at the following link:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-003.pdf.
[3] DHCS guidelines regarding *Johnson v. Rank* requirements, and additional SOC requirements that are not listed in this APL, are available in the Medi-Cal Provider Manual at the following links:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/shareltc_l00.doc.
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc.

request is submitted but is denied by Medi-Cal (DHCS or the MCP) because the service is not considered medically necessary.

CONTINUITY OF CARE:

MCPs must provide continuity of care with an out-of-network provider, including NF service providers, for up to 12 months when:

1) The MCP is able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider). An existing relationship means the beneficiary has resided in an out-of-network NF at least once during the 12 months prior to the date of his or her initial enrollment in the MCP, unless otherwise specified in this APL;

2) The provider is willing to accept the higher of the MCP's contract rates or Medi-Cal FFS rates; and

3) The provider meets the MCP's applicable professional standards and has no disqualifying quality-of-care issues (W&I Code Section 14182.17 and APL 14-021).[4]

If a beneficiary was residing in an out-of-network skilled nursing facility (SNF) when the beneficiary transitioned into the MCP, the MCP shall offer the beneficiary the opportunity to return to the out-of-network SNF after a medically necessary absence, such as a hospital admission, for the duration of CCI. This requirement does not apply if the beneficiary is discharged from the SNF into the community or a lower level of care.

For more information regarding provider continuity of care requirements that apply to beneficiaries receiving NF services, including a definition of "quality-of-care issues" and methods to verify an ongoing provider relationship, please see APL14-021.[5]

In addition to the requirements in APL 14-021,[6] the following requirements apply:

1) MCPs in CCI counties shall maintain continuity of care by recognizing any treatment authorizations made by DHCS for NF services that were in effect when the beneficiary enrolled into the MCP. MCPs shall honor such treatment authorizations for 12 months or for the duration of the treatment authorization if

[4] APL 14-021 can be accessed at the following link:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-021.pdf.

[5] See link above

[6] See link above

the remaining authorized duration is less than 12 months, following enrollment of a beneficiary into the MCP; and

2) A beneficiary who is a resident of an NF prior to enrollment under CCI will not be required to change NFs during the duration of CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and MCP agree to Medi-Cal rates in accordance with the MCP contract with DHCS. This provision is automatic (a beneficiary does not have to make a request to the MCP to invoke this provision).

CHANGE IN BENEFICIARY'S CONDITION AND DISCHARGE:
W&I Code Section 14186.3(c)(4) applies to NF services provided through MCPs in CCI counties. Pursuant to this section, an NF may modify its care of a beneficiary or discharge the beneficiary if the NF determines that the following specified circumstances are present:

1) The NF is no longer capable of meeting the beneficiary's health care needs;

2) The beneficiary's health has improved sufficiently so that he or she no longer needs NF services; or

3) The beneficiary poses a risk to the health or safety of individuals in the NF.

The MCP may request documentation from the NF to verify that the facility's care modification was made for the allowable reasons noted above. When these circumstances are present, the MCP shall arrange and coordinate a discharge of the beneficiary and continue to pay the NF the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting. NFs retain current responsibility for discharge planning.

The MCP may also arrange and coordinate a discharge of the beneficiary if the MCP determines that one, or more, of the three circumstances noted above are present, or if the facility does not meet the MCP's network standards because of documented quality of care concerns.

AUTHORIZATION OF MEDI-CAL SERVICES:
W&I Code Section 14186.3(c)(2) applies to NF services provided through MCPs in CCI counties. Pursuant to this section, MCPs shall authorize utilization of NF services for their beneficiaries when medically necessary. The MCP shall maintain standards for determining levels of care and authorizing services for Medi-Cal services that are consistent with policies established by the federal Centers for Medicare and Medicaid

Services (CMS) and with the criteria for authorizing Medi-Cal services specified in Title 22, CCR, Section 51003.

DELEGATION OVERSIGHT:
MCPs are responsible for ensuring that delegates comply with all applicable state and federal laws and regulations and other contract requirements and DHCS guidance, including APLs.

MONITORING:
DHCS will closely monitor beneficiary access to Medi-Cal NF services and quality outcomes. DHCS will enforce appropriate prime plan oversight of delegate compliance with the prime plan's policies and procedures. DHCS also monitors quality through regular MCP submission of DHCS-specified health care service quality data.

For additional information about this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah C. Brooks

Sarah Brooks, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services