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CalAIM Skilled Nursing Facility Long-Term Care Carve-In

Resources for Managed Care Plans

December 2022

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About This Document

Effective January 1, 2023, Medi-Cal Managed Care Plans (MCPs) in all California counties will become responsible for Skilled Nursing Facility (SNF) services. The California Department of Health Care Services (DHCS) developed the California Advancing and Innovating Medi-Cal (CalAIM) Contracting Requirements and Model Language for the SNF Long-Term Care (LTC) Carve-In document as a tool for MCPs and SNFs to use for the 2023 transition (see Background section below). DHCS included key issues that stakeholders have raised as challenges in Medi-Cal Managed Care Plan (MCP) and SNF contracting. This document is specific to SNFs and includes:

Background	Information about CalAIM, long-term care, and an implementation timeline.
SNF LTC Carve-In Contracting Requirements	References to existing policies and procedures for MCPs and SNFs providing and covering services for Medi-Cal members, including the All Plan Letter (APL), MCP outreach and engagement with SNFs, and network readiness requirements.
SNF LTC Carve-In Promising Practices	Lessons learned based on counties where LTC is already carved-in to managed care for MCPs and SNFs related to outreach and communications, payment and authorization terms, and care management. The lessons learned have been critical in helping DHCS identify requirements for the 2023 SNF LTC Carve-In, and the Department encourages MCPs and facilities to use this document when conducting outreach for contracting.

While this document highlights DHCS requirements for the SNF LTC Carve-In, the promising practices within this document are not requirements. Rather, they are intended to be a resource for stakeholders as the Medi-Cal health care delivery system in California transitions towards the LTC Carve-In.

I. Background

About California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multi-year DHCS initiative to improve the quality of life and health outcomes of Medi-Cal members by implementing broad delivery system, program, and payment reform across the Medi-Cal program. CalAIM seeks to address many of the complex challenges facing California's most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations with significant clinical needs, and the growing aging population. The reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and focuses on improving outcomes for all Californians.

CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality and health equity outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Specifically, CalAIM includes an effort to carve-in LTC to Medi-Cal managed care statewide, as part of an overall shift towards Managed Long-Term Services and Supports (MLTSS). Goals for this broad MLTSS effort include:

- Improved Care Integration;
- Person-Centered Care;
- Leverage California's Robust Array of Home and Community-Based Services (HCBS);
- Build on Lessons and Success of Cal MediConnect (CMC) and the Coordinated Care Initiative (CCI);
- Support the Governor's Master Plan for Aging; and
- Build a Multi-Year Roadmap to integrate CalAIM MLTSS, Dual Eligible Special Needs Plans (D-SNPs), and Community Supports policy, the Master Plan for Aging, and all HCBS, to expand and link HCBS to Medi-Cal managed care and D-SNPs.

About the Long-Term Care (LTC) Carve-In

As part of the CalAIM efforts to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility through the Benefit Standardization initiative, pursuant to Welfare & Institutions Code, section 14182.201(b)(2), MCPs will become responsible for SNF services effective January 1, 2023 across all counties. SNFs are "health

facility[ies] that provide skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis."[1]

Effective July 1, 2023, MCPs will become responsible for the LTC benefit in the following settings:

- Intermediate Care Facility for Developmentally Disabled (ICF-DD);
- ICF-DD/Habilitative;
- ICF-DD/Nursing;
- Subacute Care Facility, including a distinct part of a hospital or freestanding facility; and
- Pediatric Subacute Facility.

Note: ICF/DD-Continuous Nursing Care homes are not subject to the LTC Carve-In policy.

LTC in COHS and CCI Counties (Table 1)

Medi-Cal's LTC benefit for SNFs and subacute care facilities is currently carved-in to Medi-Cal managed care in certain counties, including County Operated Health System (COHS) plan model and in CCI counties. MCPs operating in the 27 COHS and CCI counties are contractually responsible for all medically necessary LTC services regardless of the length of stay in a facility. In these counties, MCP members requiring long-term stays at SNFs continue to stay enrolled in their plan and do not disenroll to Medi-Cal Fee-For-Service (FFS) in order to receive SNF services. Cal MediConnect plans, MCPs, SNFs, and other support services are required to coordinate care and transitions of care for beneficiaries. MCPs are also responsible for contracting with SNFs as licensed by the California Department of Public Health (CDPH), enrolled in Medi-Cal and other credentialing standards, as applicable. MCPs must pay SNFs rates that are not less than Medi-Cal FFS rates (Assembly Bill 133 – Chapter 143, Statutes of 2021).

LTC in All Other Counties (Table 2)

In all other California counties (non-COHS and non-CCI), institutional LTC coverage by MCPs is limited. MCPs are contractually responsible for medically necessary LTC services provided from the time of admission into a LTC facility and up to one month after the month of admission for LTC.[2] In these counties, MCPs are required to submit a disenrollment request to DHCS for beneficiaries who require LTC in a facility for longer than the month of admission plus one month. Until the disenrollment is approved by DHCS, MCPs must provide all medically necessary covered services to the member. Upon the effective date of disenrollment, MCPs are required to coordinate the member's transfer to the FFS program.

Table 1: LTC Carve-In in COHS and CCI Counties

[1] California Health and Safety Code (HSC) Section 1250(c).
[2] See Non-COHS, Non-CCI MCP boilerplate contracts at Ex. A, Att. 11, Prov. 18(A), located at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

MCP	Counties (* are CCI counties)
CalOptima	Orange*
CenCal Health	Santa Barbara, San Luis Obispo
Central California Alliance for Health	Santa Cruz, Monterey, Merced
Gold Coast Health Plan	Ventura
Health Plan of San Mateo	San Mateo*
Partnership Health Plan	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo
LA Care Health Plan, Health Net	Los Angeles*
Inland Empire Health Plan, Molina Healthcare	Riverside*, San Bernardino*
Anthem Blue Cross Partnership Plan, Santa Clara Family Health Plan	Santa Clara*
Aetna Better Health, Blue Shield, Community Health Group Partnership Plan, Health Net, Kaiser Permanente, Molina Healthcare, United Healthcare	San Diego*

Table 2: 2023 LTC Carve-In in All Other Counties

MCP	Counties
Alameda Alliance for Health, Anthem Blue Cross Partnership Plan	Alameda
Anthem Blue Cross Partnership Plan, California Health & Wellness	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba
Anthem Blue Cross Partnership Plan, Contra Costa Health Plan	Contra Costa
Anthem Blue Cross Partnership Plan, CalViva Health	Fresno, Kings, Madera
California Health & Wellness, Molina Healthcare of California Partner Plan	Imperial
Health Net Community Solutions, Kern Family Health Care	Kern

MCP	Counties
Aetna Better Health of California, Anthem Blue Cross Partnership Plan, Health Net Community Solutions, Kaiser Permanente, Molina Healthcare of California Partner Plan	Sacramento
Anthem Blue Cross Partnership Plan	San Benito
Anthem Blue Cross Partnership Plan, San Francisco Health Plan	San Francisco
Health Net Community Solutions, Health Plan of San Joaquin	San Joaquin, Stanislaus
Anthem Blue Cross Partnership Plan, Health Net Community Solutions	Tulare

2023 Policy in All Counties

Beneficiaries who enter a SNF after January 1, 2023, will remain enrolled in managed care ongoing and will no longer be disenrolled from the MCP after the second month of admission. In addition, all Medi-Cal-only and dual eligible beneficiaries in FFS residing in a SNF on January 1 or other LTC facility on July 1, 2023, will be enrolled in an MCP effective January 1 or July 1, 2023, respectively. Beneficiaries will be enrolled in the MCP of their choice.[3] However, if beneficiaries do not choose an MCP, DHCS will use an upfront provider linkage process that assigns a member to a MCP that works with their current LTC facility. If their LTC facility does not work with an MCP in the county, the default auto assignment process will be used.

The goal of the SNF LTC Carve-In is to better integrate care and make the LTC delivery model consistent across all counties in California. MCPs can offer complete care coordination, care management, and provide a broader array of services for Medi-Cal beneficiaries than the traditional Medi-Cal FFS system.

Beneficiary Demographics

Overall, based on 2021 data, the SNF population transitioning, like SNF residents overall, will likely be majority female and age 65 and older.

[3] Dual eligible members that reside in a county subject to the Medi-Cal Matching Plan Policy will be defaulted into a Medi-Cal managed care plan that matches their Medicare Advantage plan. The 12 counties that are subject to the Medi-Cal Matching Plan Policy include: Alameda, Contra Costa, Fresno, Kern, Sacramento, San Francisco, Stanislaus, Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara.

Table 3: Skilled Nursing Facility Residents, by Setting and County Type, January—June 2021

Resident Characteristic	COHS and CCI Counties		All Other Counties	
	Nursing Facility Level A	Nursing Facility Level B	Nursing Facility Level A	Nursing Facility Level B
Age				
0-17	0	--	0	0
18-64	--	3,660	0	4,910
65+	50	8,520	0	18,060
Sex				
Male	30	6,140	0	9,610
Female	20	6,050	0	13,350
Total				
Total	**50**	**12,190**	0	**22,970**

Source: Department of Health Care Services, internal data on skilled nursing residents by setting and county, 2022.

Notes: Numbers are rounded to the nearest 10 and may not sum to the total. The data has been suppressed in instances where values were at least one but less than 12, or whereby related data with values less than 12 not presented here could be deduced from the information in this table.

Table 4: SNF Residents in Counties Subject to Carve-In, by Setting, January—June 2021

COHS and CCI Counties			All Other Counties		
County	Nursing Facility Level A	Nursing Facility Level B	County	Nursing Facility Level A	Nursing Facility Level B
Del Norte	0	--	**Alameda**	0	4,130
Humboldt	0	--	**Amador**	0	60
Lake	0	30	**Butte**	0	700
Lassen	0	--	**Calaveras**	0	80
Los Angeles	--	5,190	**Colusa**	0	80
Marin	0	110	**Contra Costa**	0	2,020
Mendocino	0	--	**El Dorado**	0	210
Merced	0	40	**Fresno**	0	2,100
Modoc	0	--	**Glenn**	0	60
Monterey	0	60	**Imperial**	0	180
Napa	30	120	**Inyo**	0	80
Orange	0	1,000	**Kern**	0	1,500

COHS and CCI Counties			All Other Counties		
County	Nursing Facility Level A	Nursing Facility Level B	County	Nursing Facility Level A	Nursing Facility Level B
Riverside	0	940	**Kings**	0	210
San Bernardino	--	1,070	**Madera**	0	310
San Diego	--	1,680	**Mariposa**	0	20
San Luis Obispo	0	60	**Nevada**	0	290
San Mateo	0	230	**Placer**	0	670
Santa Barbara	0	80	**Plumas**	0	60
Santa Clara	0	840	**Sacramento**	0	2,900
Santa Cruz	0	70	**San Benito**	0	80
Shasta	0	150	**San Francisco**	0	2,000
Siskiyou	0	--	**San Joaquin**	0	1,910
Solano	0	60	**Stanislaus**	0	1,480
Sonoma	0	200	**Sutter**	0	360
Trinity	0	--	**Tehama**	0	80
Ventura	0	120	**Tulare**	0	1,150
Yolo	0	100	**Tuolumne**	0	190
			Yuba	0	70
Total	**50**	**12,190**	**Total**	**0**	**22,970**

Source: Department of Health Care Services, internal data on skilled nursing residents by setting and county, 2022.

Notes: Numbers are rounded to the nearest 10 and may not sum to the total. The data has been suppressed in instances where values were at least one but less than 12, or whereby related data with values less than 12 not presented here could be deduced from the information in this table.

II. SNF LTC Carve-In Requirements

All Plan Letter 22-018: SNF LTC Benefit Standardization and Transition of Members to Managed Care

DHCS has released All Plan Letter 22-018 that outlines the requirements for implementing the SNF LTC benefit standardization and the transition of members to managed care. DHCS has outlined the key requirements across the following domains:

- Benefits Requirements
- Network Readiness Requirements
- Leave of Absence or Bed Hold Requirements
- Continuity of Care Requirements
- Treatment Authorizations
- Facility Payment
- Population Health Management Requirements
- Policies and Procedures

While this document outlines promising practices within the same APL domains listed above, it is important to highlight that the SNF LTC Carve-In policy and requirements are detailed within the APL. The promising practices and model contract language represent lessons learned from the earlier CCI and COHS county implementation of transitioning LTC to managed care. DHCS recommends MCPs to consider the promising practices and the integration of the model contract language to inform provider contract amendments and/or for new provider contracts to support the LTC provider network. MCPs, providers, and stakeholders should reference the APL to obtain a comprehensive understanding of the SNF LTC Carve-In requirements.

Policy Context for Promising Practices

Rate Changes

The Long-Term Care Section of the Fee-for-Service Rates Development Division at DHCS conducts the annual study to develop the Medi-Cal rates for a variety of LTC providers. This section also conducts the necessary research to develop new or revised reimbursement methodologies necessary to meet changing policy or program needs.

The Medi-Cal LTC reimbursement rates are established under the authority of Title XIX of the federal Social Security Act. The specific methodology is described in the State Plan, a document prepared by DHCS staff which requires approval by the Centers for Medicare & Medicaid Services (CMS).

MCPs in counties where SNF services coverage is transitioning from the Medi-Cal FFS delivery system to the Medi-Cal managed care delivery system on January 1, 2023, must reimburse Network Providers of SNF services for those services at exactly the Medi-Cal FFS per-diem rates applicable to that particular type of institutional LTC provider, in accordance with WIC Section 14184.201(b), APL 18-018, and the terms of the CMS-approved State directed payment preprint.

As stated in APL 22-018, this reimbursement requirement only applies to SNF services as defined in 22 CCR Sections 51123(a), 51511(b), 51535, and 51535.1, as applicable, starting on the first day of a member's stay. It does not apply to any other services provided to a member receiving SNF services such as, but not limited to, services outlined in 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d), services provided by an Out-of-Network Provider of SNF services, or services that are not provided by a Network Provider of SNF services. Such non-qualifying services are not subject to the terms of this State directed payment and are payable by MCPs in accordance with the MCP's agreement with the Network Provider.

MCPs in counties where SNF services are already Medi-Cal managed care Covered Services prior to January 1, 2023, must reimburse Network Providers of SNF services for those services at no less than the Medi-Cal FFS per-diem rates applicable to that particular type of institutional LTC provider.

Prompt Claims and Payments

Federal [42 USC section 1396u-2(f)] and state [H&S Code sections 1371 - 1371.36] statute and their implementing regulations provide specific guidance to MCPs in claims payment timelines.

MCP/DHCS contract also specifies that the MCP "shall pay 90 percent of all clean claims from Providers, within 30 calendar days of the date of receipt, and 99 percent of all clean claims from Providers' claims, within 90 calendar days of the date of receipt."

Electronic Claims Payments

MCPs must provide a process for Network Providers to submit electronic claims and to receive payment electronically if a Network Provider requests electronic processing.

Leave of Absence and Bed Holds

Leaves of absence and bed holds are periods of time when a resident may leave the facility while retaining the ability to return, and the facility will continue to receive some payment. Medi-Cal requirements for bed hold and leave of absence are detailed in Title 22 CCR Sections 51535 and 51535.1. Additional guidance on payment and rules for bed holds and leaves of absence are available in the Medi-Cal Provider Manual. MCPs may require prior authorization for bed holds and leaves of absence.

Service Authorization Criteria

DHCS/MCP contract requires MCPs to follow specific state statute and guidelines for authorizing and covering LTC:

- Contractor must authorize and cover LTC. Contractor must ensure that Members in need of LTC services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, unless the Member has elected hospice care.

- Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6 and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

MCPs must implement a Population Health Management (PHM) Program that ensures all Medi-Cal managed care members, including those using SNF services, have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), care management programs, and Community Supports. MCPs are subject to the PHM requirements outlined within the PHM Program Guide, PHM APL, and Amended 2-23 MCP Contract.

Service Authorizations Timeline

DHCS/MCP contract includes specifics around authorization timeframes based on federal and state requirements, including:

- Routine Authorizations: Contractor must respond to routine requests as expeditiously as the Member's condition requires, but no longer than five Working Days from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 14 calendar days from the receipt of the request, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. Contractor may extend this deadline up to an additional 14 calendar days only if the Member or the Member's provider requests an extension or if Contractor justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest, in accordance with 42 CFR section 438.210. Contractor must notify Member's provider and the Member in writing of any authorization request delayed beyond the five Working Day time frame, including the anticipated date on which a decision may be rendered, in accordance with H&S Code section 1367.01.

- Expedited Authorizations: Contractor must make expedited authorization decisions for service requests where a Member's provider indicates, or Contractor, Subcontractor, Downstream Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. Contractor must provide its authorization decision as expeditiously as the Member's health condition requires, but no longer than 72 hours after receipt of the request for services. Contractor may extend this deadline up to an additional 14 calendar days only if the Member or the Member's provider requests an extension or if Contractor justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest, in accordance with 42 CFR section 438.210. Contractor must notify Member's provider and the Member in writing of any authorization request delayed beyond the 72-hour time frame, including the anticipated date on which a decision may be rendered, in accordance with H&S Code section 1367.01

SNF Network Readiness Requirements

Effective January 1, 2023 all MCPs will be required to have and maintain an adequate network consisting of SNFs, licensed and certified by the CDPH, that provide medically necessary rehabilitative, restorative, and/or ongoing skilled nursing care to members in need of assistance with activities of daily living. DHCS will be requiring MCPs to attempt to contract with all licensed SNFs in their area.

All MCPs must comply with the SNF Network Readiness requirements outlined in the DHCS Skilled Nursing Facility Network Readiness Requirements.

Medi-Cal Managed Care Plan Outreach and Engagement with SNFs

To ensure member access and continuity of care, MCPs will need to work closely with SNFs to transition operations to managed care and establish new partnerships and processes to support member needs. Two-way communication and joint transition planning between MCPs and SNFs is required. Given the minimum number of SNFs MCPs must contract with outlined within the MCP SNF Network Readiness Requirements Guidance, MCPs are also required to outreach to all SNFs to facilitate contracting and other policy development ahead of the transition.

MCP and SNF communication and engagement is key to ensuring member access and continuity of care for members affected by the SNF LTC Carve-In.

Population Health Management Requirements

In addition to Benefit Standardization, effective January 1, 2023, MCPs must implement a PHM Program that ensures all Medi-Cal managed care members, including those using SNF services, have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), care management programs, and Community Supports.

MCPs must, as a part of the PHM Program, provide strengthened transitional care services for all members across all settings and delivery systems to ensure that members are supported from discharge planning until they have been successfully connected to all needed services and supports. MCPs must ensure that a single point of contact, herein referred to as a care manager, can assist members throughout their transition and ensure all required services are complete. MCPs and their assigned care managers must ensure Member transitions to and from a SNF are timely and do not delay or interrupt any medically necessary services or care, and that all required transitional care activities are completed.

For more information about PHM, please refer to the DHCS PHM Website at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.

III. SNF LTC Carve-In Promising Practices

Medi-Cal Managed Care Plan SNF Outreach and Communications

Promising practices from CCI and COHS counties indicate that additional steps by MCPs and facilities can be helpful to ensure both are ready for a seamless transition.

- **Internal Knowledge Building by MCPs:** For MCPs new to the SNF LTC benefit, it will be important to build internal capacity and familiarity ahead of the transition. This will include ensuring that all staff including call center staff understand the LTC benefit, and that staff in specific area had LTC specific knowledge including the ways LTC claims and payments may differ from other providers. Additionally, ensuring care management staff are familiar with this new population joining the MCP as well as the range of LTC and home- and community-based services (HCBS) available to members.

- **Innovative Communications:** MCPs and facilities have reported that it is important to invest in developing communications channels between MCPs and facilities. During the CCI transition[4], some Cal MediConnect plans conducted "goodwill tours" and visited all facilities to begin developing relationships and lines of communications. It may also be helpful for MCPs to designate LTC-specific points of contact for facilities. For example, some MCPs in CCI counties created and maintained an updated list of health plan contacts for various needs (e.g., billing, member questions, and network decisions).

- **Proactive Integrated Transition Planning:** MCPs and facilities must meet ahead of the transition to conduct some joint planning for the transition. This may include:
    - **Identifying any potential continuity of care issues:** For medical supplies, transportation, or other Medi-Cal benefits not included in the per diem rate, facilities and MCPs should work together to proactively identify where facilities may be using providers or vendors not covered by the MCP so that all members have "day one" coverage of essential supplies and benefits.
    - **Community transitions:** MCPs should socialize with the SNFs any policies and procedures with facilities around how the MCP will be using enhanced care management, community supports, or other care management services to identify members who may be able to transition to the community and how the facility will be engaged in that process.

- **Long-Term Services and Supports (LTSS) Liaison:** Facilities have reported challenges in identifying MCP staff who understand and are specifically trained in LTC issues. In order to address this challenge and support the overall transition of SNF services within Medi-Cal managed care, MCPs are encouraged to consider formalizing

[4] CCI counties include: Los Angeles, Orange, Riverside, San Bernardino, San Mateo, San Diego, and Santa Clara.

an LTSS liaison role and ensuring facilities understand who their LTSS liaison is and how to communicate and partner with them. The LTSS liaison is intended to serve as an MCP single point of contact for facilities and serve in both a provider representative and care coordination representative role. This individual or set of individuals can assist facilities in addressing claims and payment inquiries and assist with care transitions among the LTSS provider community to best support a member's needs and their individualized care plans.

Payment and Authorization Terms

Rate Changes

Facility payments in CCI counties were historically required to be no less than Medi-Cal FFS rates. MCPs were required to apply any changes in rates in Medi-Cal FFS to MCP contracted facilities.

APL 22-018 requires that MCPs pay timely, in accordance with the prompt payment standards within their contract. If, as the result of retroactive adjustments to the Medi-Cal FFS per-diem rates by DHCS, additional amounts that are owed in accordance with this APL and the terms of the CMS-approved State directed payment to a Network Provider of SNF services, then MCPs must make such adjustments timely. A promising practice is including contract language specifying the timing of retroactive rate changes given that some facilities have reported challenges or delays in receiving updated rates from MCPs.

"Model" Contract Language
[For counties where coverage of SNF services is newly transitioning from the FFS delivery system to the managed care delivery system on January 1, 2023 only.] MCP must pay Facility for authorized Covered Services in accordance with APL-22-018. MCP will adopt and pay DHCS' published per diem rates, if applicable to Facility. ***MCP will make retroactive rate payments within XX days of the MCP receipt of notice of changes in the FFS per diem rate.*** *Facility accepts the applicable prevailing per diem rates as published by DHCS, as payment in full.*

Prompt Claims and Payment

LTC facilities often do not have the same financial reserves or diverse payer mix as other types of providers and rely on prompt payment from Medi-Cal FFS and MCPs. Additionally, MCPs and facilities have reported issues with facilities being able to submit clean claims in a timely manner. When MCPs are able to offer shorter payment timeframes for clean claims, that may help support provider operations. When possible, a promising practice is to expedite payments to LTC facilities.

Additionally, LTC facilities could benefit from outreach, education, and support from MCPs to understand how to submit clean claims and to meet clean claims requirements. See below for more information on how standardized billing codes and other administrative simplifications may also be able to help this issue.

"Model" Contract Language
MCP must pay Facility for Covered Services provided to Members when Claims are submitted in accordance with this Contract and MCP policies, and when MCP authorized the Member's admission or extended stay. Upon submission of a Clean Claim, MCP must pay Facility within XX calendar days.

Electronic Claims Payments

MCPs in CCI counties have been able to accept and pay electronic claims. Those plans who process claims manually are more likely to make errors, pay random claims out of sequence and create more work for the provider. APL 22-018 requires MCPs to provide a process for Network Providers to submit electronic claims and to receive payment electronically if a Network Provider requests electronic processing. A promising practice is to provide clear instructions on electronic claims processing systems to reduce errors and associated payment delays.

"Model" Contract Language
Facility must submit Claims for Covered Services in accordance with MCP Policies. Claims may be submitted electronically to MCP. If Facility chooses to electronically submit claims, Facility must complete a <MCP process>. If Facility chooses to receive payment electronically, Facility must complete an Electronic Fund Transfer ("EFT") Authorization Form.

Leave of Absence and Bed Holds

Clear communication about payment and payment timelines for leave of absences and bed holds help support facilities' compliance with these requirements and support smooth transitions for members. Leave of absence and bed hold policies are often new to MCPs taking on the LTC benefit. A promising practice is to have MCP authorization policies for bed holds and leave of absences stated in the provider/MCP contract. The MCP and facility should communicate often about how to timely and accurately request authorizations. The MCP must also ensure that internal plan staff including provider relations staff and claims and billing staff have specific knowledge regarding the leave of absence and bed hold LTC-specific benefit.

"Model" Contract Language
The MCPs must include as a covered benefit any leave of absence or bed hold that a NF provides in accordance with the requirements of Title 22, California Code of Regulations (CCR) Sections 51535 and 51535.1. <Describe MCP processes, if any, for leaves of absence or bed holds.>

Care Management

Service Authorization Criteria

MCPs new to covering LTC are not experienced with LTC authorization criteria and are required to build existing requirements into their utilization management policies and procedures. A promising practice is to include in the MCP/facility contract references the

guiding statutes and regulations. Consistent and continuous communication ensures both parties are operating from the same rule book.

As MCPs are developing their utilization management policies and procedures, they are required to consider how a person-centered approach should consider input and evidence of medical need for a particular LTC level of care from members, their responsible family members/guardians, or authorized representatives. The plan of care should include evidence of care needs from treating physicians, home caregivers, and/or family members.

Upon a member's transition to a new care setting or back to their home or community, DHCS MCPs are required to follow up with the member or their caregivers, family members/guardians, or authorized representations (if permitted by the member) or the SNF facility. A best practice is conducting a minimum of three attempts to confirm a member's needs are being met in a new setting within the first 30 days. Additionally, MCPs should also document the outcome of each attempt within their care management system in the member's record.

An additional promising practice as part of the authorization process, MCPs should share with facilities the SNF member placement acceptance criteria that helps ensure equitable placement of members at the appropriate level of care.

"Model" Contract Language
MCP's <UM or other applicable office> shall be responsible for all determinations of approval or denial of a Member's admission to and/or extended stay at Facility. As part of such review, MCP shall certify the medical necessity of institutional care as defined in, Title 22, sections 51335, 51335.5, 51335.6, and 51334 and as stated in the California Department of Health Care Services (DHCS) Long Term Care (LTC) Provider Manual and Manual of Criteria for Medi-Cal Authorization, and further defined in MCP's <Provider Manual or relevant document>.

Service Authorizations Timeline

Transition to an appropriate level of care without delay is important for optimal patient outcomes and avoiding unnecessary hospital costs.

DHCS provides additional detail on how LTC authorization requests are handled in Medi-Cal FFS through the Medi-Cal Provider Manual and Long Term Care Treatment Authorization Request (LTC TAR form 20-1). While MCPs are not required to follow the provider manual, it may be a useful reference for MCPs in developing policies and procedures.

Promising practices have identified areas that MCPs and facilities may want to use contracts or policies and procedures to ensure clarity and smooth authorization processes including:

- Easily understandable and readily available descriptions of the authorization request process and timeframe for LTC services.
- Ensuring staff at facilities have clear understandings of timing and processes to request reauthorization for a resident whose existing authorization is nearing the end date.

- Developing clear, specific, and available MCP escalation contacts for facilities and and/or members to escalate concerns when there are delays in pending authorizations.
- Creating and sharing retroactive authorization policies that allow providers more time to submit authorization requests.

"Model" Contract Language

An initial Long Term Care Treatment Authorization Request (LTC TAR form 20-1) must be required for each Skilled Nursing Facility admission. An initial Authorization may be granted for periods up to one year [or two years] from the date of admission. PLAN reserves the right, in its sole and absolute discretion, to initiate review of the need for the continued level of care and to reauthorize the services more frequently. An approved initial TAR is required prior to transfer of Members between Skilled Nursing Facilities.