**DATE:** April xx, 2014

DUAL PLAN LETTER 14-xxx

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN CAL MEDICONNECT

**SUBJECT:** REQUIREMENTS FOR NURSING FACILITY SERVICES

**PURPOSE:**

The purpose of this Dual Plan Letter (DPL) is to clarify the responsibilities of Medicare-Medicaid Plans (MMPs) to provide expanded coverage of nursing facility services as established under the Coordinated Care Initiative (CCI) for MMP members in CCI counties.

**BACKGROUND:**

In 2012, Governor Brown signed Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012), which enacted the CCI. A key intent of the CCI is to improve coordination of long term services and supports (LTSS), including nursing facility services, in the CCI demonstration counties.

**PROMPT PAYMENT AND ELECTRONIC CLAIMS:**

MMPs shall pay providers, including institutional providers, in accordance with the prompt payment provisions contained in each MMP’s contract with DHCS, including the ability to accept and pay electronic claims. This requirement is established under Welfare and Institutions Code (W&I) Section (§)14186.3(c)(5), which applies to nursing facility services provided through MMPs in CCI counties.

For nursing facility services provided through MMPs in CCI counties, MMPs shall pay 90% of all clean claims from contracting nursing facility service providers within 30 days of the date of receipt of the claim, and 99% of all clean claims within 90 days, unless the contracting provider and MMP have agreed in writing to an alternate payment schedule. The date of receipt shall be the date the MMP 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. MMPs shall also pay all claims submitted by contracting nursing facility services providers in accordance with Health and Safety Code (H&S) §§1371–1371.36 if:

1. The timeline provided by these sections is less than the timeline provided above; and
2. The contracting provider and MMP have not agreed in writing to an alternate payment schedule.

MMPs shall be subject to any remedies, including interest payments, provided for in these sections if the MMP fails to meet the standards specified in these sections.

For nursing facility services provided through MMPs in CCI counties, if the submitting provider requests electronic processing, the MMP shall accept the submission of electronic claims and pay claims electronically.

**REIMBURSEMENT FOR MEDI-CAL NURSING FACILITY SERVICES:**

For Medi-Cal nursing facility services provided through MMPs in CCI counties, MMPs shall reimburse contracted providers at rates that are not less than Medi-Cal Fee-for-Service rates, as published and revised by DHCS, for equivalent services for the date(s) of service.

**LEAVE OF ABSENCE AND BEDHOLDS:**

Pursuant to, W&I Code §14186.1(c)(4), for nursing facility services provided through MMPs in CCI counties, MMPs shall include as a covered benefit any leave of absence or bedhold that a nursing facility provides in accordance with the requirements of California Code of Regulations (CCR), Title 22, §72520 or California’s Medicaid State Plan.

Medi-Cal requirements for bedhold and leave of absence are detailed at CCR, Title 22, §§51535 and 51535.1.

**MEDICARE COINSURANCE AND DEDUCTIBLES:**

Pursuant to DHCS APL 13-003, for long term care services, MMPs shall pay the full Medicare coinsurance and deductibles. DHCS All Plan Letter 13-003 is available at the following link:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-003.pdf>.

**MEDI-CAL SHARE OF COST:**

MMPs shall process claims submitted by nursing facilities consistent with Medi-Cal guidelines for share of cost (SOC), as outlined in the Medi-Cal Long-Term Care Provider Manual and the SOC Frequently Asked Questions (FAQ) for Cal MediConnect & Managed Long-Term Services and Supports. To request a current copy of the SOC FAQ, please contact your DHCS MMP contract manager.

When a Medi-Cal beneficiary has a long term care aid code and a SOC, nursing facilities will subtract the SOC that is paid or obligated to be paid from the claim amount. The MMP shall pay the balance.

In addition, as required by the *Johnson v. Rank* settlement agreement, if a beneficiary spends part of the SOC on “noncovered” medical services or remedial services or items, the nursing facility will subtract those amounts from the Beneficiary’s SOC. The nursing facility will adjust the amount on the claim and the MMP 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, noncovered, 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 patient’s medical record. A “medical service” is considered a noncovered benefit if either of the following is true:

* The medical service is rendered by a non-Medi-Cal provider; or,
* The medical service falls into the category of services for which a Treatment Authorization Request (TAR) must be submitted and approved before Medi-Cal will pay and either a TAR is not submitted or a TAR is submitted but is denied by Medi-Cal because the service is not considered medically necessary.

DHCS guidelines regarding *Johnson v. Rank* requirements are available in the Medi-Cal Long-Term Care Provider Manual at the following link:

<http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/shareltc_l00.doc>.

**CONTINUITY OF CARE:**

MMPs in CCI counties shall maintain continuity of care by recognizing any treatment authorizations made by DHCS for nursing facility services that were in effect when the beneficiary enrolled into the MMP. MMPs shall honor such treatment authorizations for not less than six months following enrollment of a beneficiary into the MMP. This requirement is established under W&I Code §14186.3(c)(3).

For additional information regarding provider continuity of care requirements that may apply to beneficiaries receiving nursing facility services in CCI counties, please see the section regarding H&S Code §1373.96 in DHCS All Plan Letter 13-023, available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-023.pdf>.

For information regarding additional continuity of care requirements that are applicable for Cal MediConnect services, please see DHCS Duals Plan Letter 13-005 at the following link: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-005.pdf>.

**CHANGE IN BENEFICIARY’S CONDITION AND DISCHARGE:**

W&I Code §14186.3(c)(4) applies to nursing facility services provided through MMPs in CCI counties. Pursuant to this section, a nursing facility may modify its care of a beneficiary or discharge the beneficiary if the nursing facility determines that the following specified circumstances are present:

1. The nursing facility 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 nursing facility services, or
3. The beneficiary poses a risk to the health or safety of individuals in the nursing facility.

When these circumstances are present, the MMP shall arrange and coordinate a discharge of the beneficiary and continue to pay the nursing facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

**AUTHORIZATION OF MEDICARE AND MEDI-CAL SERVICES:**

W&I Code 14186.3(c)(2) applies to nursing facility services provided through MMPs in CCI counties. Pursuant to this section, MMPs shall authorize utilization of nursing facility services for their members when medically necessary. The MMP shall maintain standards for determining levels of care and authorizing services for both Medicare and 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 CCR, Title 22, §51003.

**DELEGATION OVERSIGHT:**

The MMP contracted with DHCS is responsible for ensuring that its delegated MMPs and Independent Practice Associations comply with all applicable State and federal laws and regulations and other contract requirements and DHCS guidance, including provisions of DHCS APLs and Dual Plan Letters (DPLs).

**MONITORING:**

DHCS will closely monitor beneficiary access to Medicare and Medi-Cal nursing facility services and quality outcomes.

**PLAN POLICIES AND PROCEDURES:**

MMPs shall submit to DHCS the applicable policies and procedures for nursing facility services within 45 calendar days from the date of this DPL being issued. DHCS will review the policies and procedures for compliance with the guidelines provided in this DPL.

If you have any questions regarding this DPL, please contact Sarah Brooks, Chief, Program Monitoring and Medical Policy Branch at sarah.brooks@dhcs.ca.gov.

Sincerely,

Margaret Tatar

Acting Deputy Director

Health Care Delivery Systems