May 9, 2014

Department of Health Care Services
Delivered via email:
Sarah Brooks: Sarah.Brooks@dhcs.ca.gov, info@calduals.org

Re: Dual Plan Letter: Requirements for Nursing Facility Services

Greetings:

Thank you for the opportunity to comment on the Dual Plan Letter (DPL) regarding requirements for nursing facility services. We have provided general comments below and redlined edits and comments on the attached DPL.

The shift in the delivery of nursing facility benefits from Medi-Cal fee-for-service to managed care plans constitutes a significant change warranting considerable attention. Our comments reflect areas we believe need to be developed further and we welcome the opportunity to collaborate with DHCS to develop guidance to ensure beneficiaries maintain access to nursing facility benefits.

Prompt Payment and Electronic Claims

We support the prompt payment and reimbursement of nursing facilities. We recognize that delays in payment to nursing facilities could result in closures of facilities that would impede adequate access to care.

The DPL states that 90% of "clean claims" will be paid within 30 days and 99% within 90 days. The DPL should define "clean claims" and provide guidance and timelines for the remaining 1% of claims not paid within 90 days.

Medi-Cal Share of Cost

Johnson v. Rank allows a beneficiary to use his or her share of cost funds to pay for necessary non-covered Medi-Cal services. Under fee-for-service, non-covered benefits are defined as such when

> "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 (1) a TAR is not submitted or (2) a TAR is submitted but is denied by Medi-Cal because the service is not considered medically necessary."

With the movement of nursing facility benefits into managed care, TARs are no longer the means employed to authorize or deny services. Rather, the Medicare-Medicaid Plans (MMPs) will be responsible for making these determinations. We have provided edits to the proposed language in the DPL to reflect this change, but we believe that this requires further development and clearer guidance.

Continuity of Care and Authorization of Medicare and Medi-Cal Services

We commend DHCS for extending continuity of care protections to allow beneficiaries to continue to reside in a non-contracted facility for the length of the demonstration as outlined In DPL 13-005. This is an important protection. We believe, however, that this protection may be eroded by the fact that MMPs only have to honor prior treatment authorizations for six months. For example, Mrs. Smith is enrolled into an MMP on July 1. She resides in a nursing facility not contracted with her MMP. Pursuant to the continuity of care protections, her MMP enters into a single case agreement with her facility. Mrs. Smith should be permitted to reside in the facility for the remainder of the demonstration if she so chooses. Yet, six months later, on January 1, her MMP concludes that Mrs. Smith no longer requires nursing facility services.

MMPs have a financial incentive to discharge individuals from higher-cost settings. While this is important in rebalancing services from institutional settings to home and community based settings, it is equally imperative that beneficiaries requiring nursing facility placement are not denied this medically necessary benefit because it would be more costly for the MMPs.

We believe that the DPL needs to more strongly and clearly lay out the standards MMPs must abide by in the authorization of Medicare and Medi-Cal benefits. The DPL should clearly cite the statutes, regulations, policies, and case law the MMPs must adhere to when determining a beneficiary's level of care. The DPL should also include the beneficiary's rights to appeal and the right to aid-paid-pending during the appeal.

We also urge DHCS to draft an APL that addresses continuity of care for MLTSS that mirrors the protections outlined for Cal MediConnect. Creating two different standards increases administrative complexity and beneficiary confusion. Most alarming, narrowing the continuity of care protection for MLTSS compared to Cal MediConnect forces a beneficiary to join a Cal MediConnect plan in order to obtain the better protection – Cal MediConnect is supposed to be a voluntary program, but for individuals in a nursing facility the choice to opt-out puts them at risk of losing their home after twelve months.

Change in Beneficiary's Condition and Discharge

All discharges must comply with both federal law and the appeals procedures available under Cal MediConnect. This includes the right for the resident to receive proper notice and the right to aid-paid-pending through the appeal process. We have included language in the DPL to reflect these requirements. We also encourage DHCS to provide additional clarification to MMPs – for example, what constitutes a "successful" discharge and what specific responsibilities do the MMP and nursing facility have in the discharge process.

Again, thank you for the opportunity to comment on this DPL. We look forward to continued collaboration an discussion regarding nursing facility services.

Sincerely,

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