**DATE:** April xx, 2014

ALL PLAN LETTER 14-xxx

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** REQUIREMENTS FOR NURSING FACILITY SERVICES IN COORDINATED CARE INITIATIVE COUNTIES

**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 services as required under the Coordinated Care Initiative (CCI) for MCP members in CCI counties who are not enrolled in 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 that the MCPs in CCI counties now provide the Long Term Services and Supports (LTSS), including nursing facility services.

The Department of Health Care Services (DHCS) is issuing this guidance, and requesting resubmission of certain MCP Policies and Procedures (P&Ps), in recognition that there will continue to be an ongoing need to ensure MCP readiness and to ensure a smooth implementation of the CCI and the transition of critical nursing facility services to coverage under MCPs.

**PROVIDER CONTRACTS**

MCP contracts with providers shall comply with all applicable CCI requirements.

**PROMPT PAYMENT AND ELECTRONIC CLAIMS:**

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 Welfare and Institutions Code (W&I) Section 14186.3(c)(5), which applies to nursing facility services provided through MCPs in CCI counties.

For nursing facility services provided through MCPs in CCI counties, MCPs shall pay 90 percent of all clean claims from contracting nursing facility 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 contracting 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 contracting nursing facility services providers in accordance with Health and Safety Code (H&S) Sections 1371 through 1371.36 if:

1. The timeline provided by these sections is less than the timeline provided above; and
2. The contracting 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 1371–1371.36 and/or other applicable law and regulation. 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 nursing facility 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 NURSING FACILITY SERVICES:**

For Medi-Cal nursing facility services provided through MCPs in CCI counties, MCPs shall reimburse contracted 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 nursing facility services provided through MCPs in CCI counties, MCPs shall include as a covered benefit any leave of absence or bedhold that a nursing facility provides in accordance with the requirements of 22 California Code of Regulations (CCR) Section, Title 22, §72520 or California’s Medicaid State Plan.

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

**MEDICARE COINSURANCE AND DEDUCTIBLES:**

For long term care services, MCPs shall pay the full Medicare coinsurance and deductibles. Please see DHCS APL 13-003 at the following link for more information about this requirement:

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

**MEDI-CAL SHARE OF COST:**

MCPs 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 (see internet link below) 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 Medi-Cal Managed Care Division contract manager.

When a Medi-Cal beneficiary has a long term care aid code and a SOC, a nursing facility 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 “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 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, 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 beneficiary’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 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 request is submitted but is denied by Medi-Cal (DHCS or the MCP) 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:**

MCPs must provide continuity of care with an out-of-network provider, including nursing facility 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);
2. The provider is willing to accept the higher of 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 [Cal. Welf. & Inst. Code §14182.17; APL 13-023 (December 24, 2013)].

If a beneficiary was residing in an out-of-network 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 term of the demonstration. 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 nursing facility services, including a definition of “quality-of-care issues” and methods to verify an ongoing provider relationship, please see DHCS APL 13-023, available at:

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

In addition to the requirements in APL 13-023, the following requirements apply:

1. MCPs 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 MCP. MCPs shall honor such treatment authorizations for 12 months, or for the duration of the treatment authorization if the authorization duration is less than 12 months, following enrollment of a beneficiary into the MCP.
2. A beneficiary who is a resident of a nursing facility prior to enrollment will not be required to change nursing facilities during the duration of the CCI Demonstration Project if the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the facility and MCP agree to Medi-Cal rates in accordance with the MCP-DHCS contract. 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 §14186.3(c)(4) applies to nursing facility services provided through MCPs 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.

The MCP may request documentation from the nursing facility 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 nursing facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

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 14186.3(c)(2) applies to nursing facility services provided through MCPs in CCI counties. Pursuant to this section, MCPs shall authorize utilization of nursing facility services for their members 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 22 CCR Section 51003.

**DELEGATION OVERSIGHT:**

The MCP is responsible for ensuring that its delegates comply with all applicable State and federal laws and regulations and other contract requirements and DHCS guidance, including provisions of DHCS APLs.

**MONITORING:**

DHCS will closely monitor beneficiary access to Medi-Cal nursing facility services and quality outcomes. DHCS will review and provide ongoing monitoring of MCP P&Ps. DHCS will enforce appropriate prime plan oversight of delegate compliance with the prime plan’s policies and procedures. DHCS monitors compliance through the activities of the Medi-Cal Managed Care Division Contract Managers, the DHCS Managed Care Office of the Ombudsman, and other activities. 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 Medi-Cal Managed Care Division contract manager.

Sincerely,

Mari Cantwell

Chief Deputy Director

Health Care Programs