

DEPARTMENT OF HEALTH SERVICES

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December 16, 1999

MMCD All Plan Letter 99016

TO: County Organized Health System Plans
 Geographic Managed Care Plans
 Prepaid Health Plans
 Primary Care Case Management Plans
 Two-Plan Model Plans

SUBJECT: **YEAR 2000 CONTINGENCY PLAN UPDATE**

PURPOSE

The purpose of this letter is to update Medi-Cal managed care plans (Plans) on the activities carried out by the Department of Health Services (Department) to assure Year 2000 (Y2K) readiness. This letter also addresses many of the questions raised through various Plan correspondence with the Department. Our goal in implementing the procedures and activities described below is to preclude any inconvenience or disruption of medically necessary services to Medi-Cal members (here forward referred to as member(s)) and to assure that Plans receive accurate and timely Medi-Cal membership information and contract payments. This letter also recommends steps the Plans should continue to take to mitigate any unforeseen processing problems.

BACKGROUND

Medi-Cal Managed Care Division (MMCD) All Plan Letter 99003, issued on January 27, 1999, defined the Department's criteria for Y2K readiness and advised Plans of the requirement to develop a Y2K readiness certification document and a Business Continuation and Contingency Plan (BCCP). An addendum to the All Plan letter (MMCD 99012) was issued on October 8, 1999. The letter clarified that the certification document and the BCCP were not subject to the Department's approval but copies should be kept on file with the Plan.

All Plan Letter (MMCD 99003) advised Plans that BCCPs must contain procedures that involve both risk mitigation (actions to be taken to avoid failures) and contingency

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planning (emergency workarounds implemented until failed systems can be brought back online). Contingency plans must focus on core business processes that affect the member's ability to receive medical services, including taking necessary steps to ensure that Y2K problems do not result in withholding necessary medications or treatments from members.

Most Plans have converted or are in the process of converting to the Fiscal Intermediary Access to Medi-Cal Eligibility (FAME) reporting system. This has been a complex and challenging effort and Plans are to be commended for their efforts and success in accomplishing this critical conversion. Files and reports generated by FAME are Y2K compliant and will eventually replace the files and reports currently provided to Plans. All plans must also have Y2K compliant software for eligibility processes in place and fully functional before January 1, 2000. Plans should notify the Department immediately if they will be unable to meet this deadline.

DEPARTMENT PREPARATIONS FOR Y2K READINESS

Mission Critical Systems

The Department has thoroughly tested its mission critical systems, including on-line eligibility, claims processing, and treatment authorization components of the Medi-Cal Program for Y2K readiness. The federal Health Care Financing Administration has also conducted an assessment of mission critical systems in the Department and has determined that these systems present a low risk for potential failure. A systems-wide problem appears unlikely; however, the Department has made necessary preparations and will continue to monitor its systems to ensure a successful roll over to the Year 2000.

Contractor Payments

The Department of Health Services and the State Controller's office have developed contingency plans to ensure that Plans will continue to receive capitation payments on a timely basis if a processing problem effects State contract payments to Plans. These plans include ensuring contract payments to Plans on a post-pay basis in December 1999 and prepay or post-pay basis for January and February 2000 and beyond, if necessary. The Department will make an electronic backup and hard copies of all capitation payment information and invoices for the month of December. In the event that a processing problem prevents the Department from accessing its payment systems electronically, invoices will be manually processed. The State Controller's office will also manually issue checks to the Plans in the event of a system failure.

If a processing problem prevents the Department's Information Technology Services Division from issuing a capitation report needed by MMCD to develop and process

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January or a subsequent month's payments, the Department will base its payments on the December 1999 capitation reports until current reports are available. Once the problem has been resolved and a corrected report can be issued for an affected month, the Department will reconcile the reports and adjust for underpayments and overpayments.

MMCD Y2K COMMAND CENTER

Plans are expected to notify the Department of any processing problem that prevents the Plan from accessing eligibility systems or providing medical services to members. During the weekend of January 1, 2000, the Medi-Cal Managed Care Division will operate a command center that will be accessible to Plans and Medi-Cal members through a toll-free number (1-888-452-8609) to handle member and Plan questions relating to processing problems. Contract management staff will be contacting the Plans during that weekend to verify that Plan systems are operating normally. This telephone line is not to be used by Plans or Plan providers to verify member eligibility for Medi-Cal services unless authorization is given by command center staff due to a processing problem that prevents a Plan from verifying Medi-Cal eligibility or Plan membership for members requiring covered medically necessary services.

PLAN PREPARATIONS FOR Y2K READINESS

Plans are encouraged to continue to implement contingency plans, including installing equipment and appropriately training staff to anticipate any potential processing problems. Plans that subcontract with other Plans or providers in order to meet their obligations under the Medi-Cal Managed Care program should ensure that these subcontractors have appropriate contingency plans in place to address potential processing problems.

In order to mitigate the impact of potential processing problems, the Department expects that Plans have developed their own internal systems for eligibility verification, using periodic data downloads from the Medi-Cal Eligibility Data System (MEDS). Plans should keep hard copies and backup eligibility files for the month of December. The Department also presumes that Plans have set up, tested and trained employees to utilize various alternative methods of accessing MEDS eligibility data on-line, in case their internal system becomes nonfunctional.

IDENTIFICATION OF POSSIBLE PROCESSING PROBLEMS

The following are some of the major areas in which processing problems could negatively impact the access and delivery of Plan covered medically necessary services by Plans or their providers. Alternatives are also identified to allow Plans to continue to provide uninterrupted care for medically necessary services in light of potential

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communications or system failures.

Enrollment

If the managed care enrollment or default assignment process for a beneficiary cannot be completed or the beneficiary cannot be notified of his/her managed care enrollment because of a disruption in MEDS or processing through the Department's enrollment contractor, the beneficiary will automatically continue under Fee-For-Service (FFS) Medi-Cal until the problem is resolved.

Eligibility Verification

Normal communications with members may be disrupted due either to mail delivery problems with the U.S. Postal Service or to internal problems with the systems or organizations that produce the mailings.

- If these disruptions prevent Plans from mailing the Plan membership card and information packet to the members, Plans should attempt to contact members through alternative methods, including telephone, courier, or other in-person delivery methods.
- If the member is unable to provide his or her Plan membership card when requesting services, the Plan provider should request the Medi-Cal Beneficiary Identification Card (BIC), or utilize the member's social security number, along with other appropriate identification, to access the member's current managed care Plan eligibility information.

An internal system or communication error may prevent the Plan or Plan providers from verifying the eligibility information of a member through MEDS.

- Use other online methods to obtain MEDS information. This may be through the Claims and Eligibility Real-Time System (CERTS), another proprietary software application, the Automated Eligibility Verification System (AEVS), a point of service (POS) device, or the Internet. While these systems will provide access to basic MEDS eligibility information, they may not provide all the information generally available on the Plan system.
- Plans that operate multiple administrative sites in different counties should attempt to obtain eligibility data from their other Plan sites if one site's internal system becomes inoperative.

A Plan or Plan provider is unable to download or access on-line MEDS eligibility information because the MEDS system is inoperative.

- If the Plan still has eligibility information from the previous month (or earlier) available on its own internal system, the Plan may utilize this old data and any available weekly updates to determine eligibility.
- The Department is in the process of obtaining approval for an emergency regulation. As soon as the regulation becomes final, it will be sent to you. The regulation will provide instructions concerning eligibility verification for FFS Medi-Cal providers and Plans in the event of a regional or statewide Y2K systems failure that results in a lack of access to standard eligibility verification methods maintained by the Department of Health Services. If these instructions are followed, a provider or Plan will receive appropriate reimbursement or capitation payment from the State. Plans must, in turn, reimburse their providers as appropriate under provider agreements.
- If the MEDS system is operative and Plans cannot access eligibility information due to an internal communication or system error, the Department is not financially responsible for the capitation payment for services provided to ineligible members.

Interruption of Services

Medi-Cal managed care Plan contractors are contractually obligated to assure the delivery of covered, medically necessary care to their Medi-Cal members in a timely manner. This obligation continues to exist even if a Plan processing problem prevents a Plan or essential contracting Plan providers from providing medically necessary services to their members in a timely manner. In this instance, the Plan would be obligated to attempt to arrange with other providers, on an alternative reimbursement basis if necessary, to assure delivery of services.

In extraordinary circumstances, in order to protect the health and welfare of members, the Department reserves the discretion to immediately disenroll these members from their Plan and place them on FFS Medi-Cal. If the Department exercises this discretion, the Plan will not be liable for the disenrollee's FFS expenses. However, the Plan will not receive the monthly capitation payment for these individuals. If the Plan has received the capitation payment as a prepayment, the Plan shall reimburse the Department for this amount or the Department may offset this amount from subsequent payments to the Plan. Disenrollment of members does not relieve the Plan from its contractual obligations to maintain a Y2K compliant system and to deliver timely medically necessary services to its members.

Plans would be expected to assist the Department to ensure that all affected disenrollees and Plan providers are informed of the switch to FFS. Plans would assist by

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notifying providers via fax, letter, telephone or some other method of communication that the disenrollees continue to be eligible for FFS Medi-Cal if a MEDS system failure or a connectivity outage prevents providers from determining that an individual has been disenrolled to FFS.

Plans should also develop a contingency plan for system problems that affect the timeliness of the Plan's prior authorization/treatment authorization review (TAR) process. Plans may choose to waive this process for a member if system problems delay the approval of a prior authorization/TAR request. If the Plan decides to waive this prior authorization process, the Plan must state its intention to do so in the contingency plan.

OTHER AVAILABLE RESOURCES

Additional Y2K readiness documents and information can be found at the following websites:

The Department of Health Services: <http://www.dhs.ca.gov/>

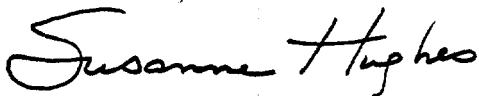
Medi-Cal Official Home Page: <http://medi-cal.ca.gov/>

California Department of Information Technology:

<http://www.year2000.ca.gov/main/>

Health Care Financing Administration: <http://www.hcfa.gov/y2k/default.htm>

Plans must submit to their contract manager, within 5 days of the date of this letter, a point of contact within the Plan for coordination of activities over the January 1, 2000 weekend. If you have any comments or questions regarding this letter, please contact your contract manager.



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Medi-Cal Managed Care Division