



JENNIFER KENT  
*Director*

State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
*Governor*

DATE: July 25, 2016

DUALS PLAN LETTER 16-003

TO: CAL MEDICONNECT MEDICARE-MEDICAID PLANS

SUBJECT: DISCHARGE PLANNING FOR CAL MEDICONNECT

**PURPOSE:**

The purpose of this Duals Plan Letter (DPL) is to clarify the responsibilities for Medicare-Medicaid plans (MMPs) that are participating in the Duals Demonstration Project, referred to as Cal MediConnect, when they are writing discharge plans and transitioning members to receiving-care, which may include long-term services and supports (LTSS), while living in the community. This DPL is intended to clarify the roles and responsibilities of MMPs as part of the discharge planning process as indicated in the three-way contract<sup>1</sup> (contract) between the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the MMPs.

**BACKGROUND:**

In January 2012, Governor Brown announced his intent to enhance health outcomes and member satisfaction for low-income Seniors and Persons with Disabilities (SPDs) by shifting service delivery away from institutional care to home and community-based settings. To implement this goal, the Legislature passed and Governor Brown signed Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012), and SB 94 (Chapter 37, Statutes of 2013), which authorized the implementation of the Coordinated Care Initiative (CCI). Welfare and Institutions (W&I) Code Section (§) 14182.17(h) authorizes the issuance of this DPL.

The three major components of the CCI are:

1. A three-year Duals Demonstration Project (Cal MediConnect) for dual-eligible (individuals eligible for Medicare and Medicaid) members (Duals) that combines the full continuum of acute, primary, institutional, and home and

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<sup>1</sup> Three-way contract can be found at the following link: <http://www.calduals.org/wp-content/uploads/2014/02/CACContractwithoutSub1.pdf>

community-based services into a single benefit package, delivered through an organized service delivery system;

2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of LTSS as a Medi-Cal managed care benefit for SPD members who are eligible for Medi-Cal only, and for SPD Duals.

The seven CCI counties participating in Cal MediConnect are Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

### **POLICY AND REQUIREMENTS:**

Consistent with Section 2.5.1.15 and all applicable subsections of the contract, a member must have all necessary supports and services arranged upon discharge from a hospital or institution, such as a Skilled Nursing Facility (SNF), to living in the community. MMPs are responsible for ensuring the provision of a member's medical needs, supports, and services are completed throughout the post-discharge and transition to community-based care period. In accordance with the contract, the minimum criteria for discharge planning include:

- Documentation of pre-admission or baseline status;
- Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community-based LTSS programs;
- Initial coordination of care, as appropriate with the member's caregiver, other agencies and knowledgeable personnel, as well as ensuring the member's care coordinator contact information is readily available for hospitals; and
- Provision of information for making follow-up appointments.

MMPs are responsible for ensuring that all medically necessary services are provided in a timely manner upon discharge, and that a member's transition to the most appropriate level of care and community-based care occurs, from the hospital or institution, that meets the member's medical and social needs. MMPs must ensure that members have access to the full spectrum of Medicare and Medi-Cal covered benefits across all levels of care, including inpatient rehabilitation facilities, long-term care hospitals, the partial hospitalization program, nursing facilities, and the full range of home and community-based services and supports.

Pursuant to W&I Code § 14186.3(c)(2)<sup>2</sup>, MMPs must authorize utilization of nursing facility services or subacute facility services for their members when medically

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<sup>2</sup> Welfare and Institution Code § 14186 can be found at the following link:

[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=14186.3.&lawCode=WIC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14186.3.&lawCode=WIC)

necessary. MMPs must maintain the standards for determining levels of care and authorization of services for both Medicare and Medi-Cal that are consistent with policies established by CMS and the criteria for authorization of Medi-Cal services. As specified in the contract Section 2.11.4.5, MMPs must provide members and providers with a written Integrated Denial Notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

During the MMPs' readiness review process<sup>3</sup>, all MMPs signed the SNF attestation and network adequacy readiness review worksheet confirming that they have the ability to place a patient in a SNF within 72 hours from the date of the request. Consistent with this attestation and confirmation, the MMPs must demonstrate their ability to place a patient in a SNF within 72 hours from the request. Should placement exceed 72 hours, MMPs, or their delegated entities to which their members are assigned, must coordinate with hospitals to facilitate discharge as soon as possible to the most appropriate level of care based on medical necessity, and incorporate a member's preferences when medically appropriate. Pursuant to Health and Safety Code § 1262.5<sup>4</sup> and contract Section 2.5.1.15.2, the member or his or her representative has the opportunity to provide input on discharge planning and receive counseling on the final discharge plan. MMPs may place members at a SNF appropriate for their needs located in the service area. If a SNF bed in the service area is not available, MMPs may contract with SNFs outside the service area in order to place the member in a SNF, as specified in the contract, which meets the basic credentialing standards as defined the contract Section 2.6.1.4.

MMPs are responsible for ensuring that their delegated entities comply with the three-way contract per Section 2.9.9 and Appendix C, as well as all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, and DPLs.

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<sup>3</sup> The Readiness review process is available at:  
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CARRTool.pdf>

<sup>4</sup> Health and Safety Code 1262.5 can be found at:  
[http://leginfo.legislature.ca.gov/faces/codes\\_displaySection.xhtml?sectionNum=1262.5.&lawCode=HSC](http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1262.5.&lawCode=HSC)

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If you have any questions regarding this DPL, please contact your Managed Care Operations Division contract manager.

Sincerely,

*Original Signed by Nathan Nau*

Nathan Nau, Chief  
Managed Care Quality and Monitoring Division