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

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DATE: December 27, 2022

ALL PLAN LETTER 22-018 *(REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: SKILLED NURSING FACILITIES -- LONG TERM CARE BENEFIT STANDARDIZATION AND TRANSITION OF MEMBERS TO MANAGED CARE

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care health plans (MCPs) on the Skilled Nursing Facility (SNF) Long Term Care (LTC) Benefit Standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of beneficiaries to managed care.[1] Revised text is found in *italics*.

BACKGROUND:
CalAIM seeks to move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility through Benefit Standardization.

The Medi-Cal program provides benefits through both a fee-for-service (FFS) and managed care delivery system. While Medi-Cal managed care is available statewide, the benefits vary among counties depending on the managed care plan model. Variations in benefits include coverage of the SNF benefit. Currently, only County Organized Health System (COHS) MCPs, as well as MCPs and Cal MediConnect Plans operating in the seven Coordinated Care Initiative (CCI) counties, cover most SNF benefits under the institutional LTC services benefit.[2] Conversely, managed care Members in non-COHS, non-CCI counties are disenrolled from managed care to Medi-Cal FFS if they require institutional LTC services.

To further CalAIM's goals to standardize and reduce complexity across the state and reduce county-to-county differences, the Department of Health Care Services (DHCS) is implementing Benefit Standardization across MCPs statewide. Benefit Standardization

[1] The CalAIM proposal can be found on DHCS' website at the following link: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf.
[2] The seven CCI Counties are: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

will help ensure consistency in the benefits delivered by managed care and FFS statewide.[3]

Currently, MCPs operating in non-COHS, non-CCI counties must cover medically necessary SNF services for Members from the time of admission into a SNF and up to one month after the month of admission into the SNF.[4] Members are disenrolled from the MCP to Medi-Cal FFS after this time.

Effective January 1, 2023, DHCS will require most non-dual and dual LTC Members (including those with a Share of Cost) to enroll in an MCP and receive their LTC benefits from their MCP. This APL focuses on the LTC benefit for SNF services (services included in the SNF rate).[5]

Effective July 1, 2023, the remaining LTC Members receiving the LTC benefit in a Subacute Facility or Intermediate Care Facility for the Developmentally Disabled must be enrolled in an MCP. APLs specific to the Subacute LTC benefit (both freestanding and hospital-based, as well as pediatric and adult subacute care facilities) and Intermediate Care Facility for the Developmentally Disabled LTC benefit will be released at a later date.[6]

DHCS will ensure MCP readiness before the transition of these populations into managed care by, including but not limited to, requiring MCPs to submit data and information to DHCS to confirm there is an adequate network in place to meet anticipated utilization for their Members. Additionally, a deliverables matrix will be provided to MCPs with all plan readiness requirements.

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[3] See Attachment 1 of APL 21-015 for more detailed information on Mandatory Managed Care Enrollment, available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015-Attachment-1-MMCE.pdf.
[4] See Non-COHS, Non-CCI MCP boilerplate contracts at Ex. A, Att. 11, Prov. 18(A), located at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[5] Health and Safety Code (HSC) Section 1250(c). State law is searchable at: https://leginfo.legislature.ca.gov/.
[6] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

POLICY:

I. Benefits Requirements

1. Effective January 1, 2023, MCPs in all counties must authorize and cover medically necessary services provided in SNFs (both freestanding and hospital-based facilities), consistent with definitions in the Medi-Cal Provider Manual and any subsequent updates.[7] All MCPs must ensure that Members in need of SNF services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, as outlined in the MCP contract and as documented by the Member's Provider(s).[8] This means that, beginning January 1, 2023, Members who are admitted into a SNF will remain enrolled in managed care instead of being disenrolled from the MCP and enrolled in FFS Medi-Cal.

   MCPs must coordinate benefits with other health coverage (OHC) programs or entitlements in accordance with APL 21-002, Cost Avoidance and Post-Payment Recovery for Other Health Coverage, or any superseding APL, including recognizing OHC as primary, and the Medi-Cal program as the payer of last resort. MCPs must coordinate benefits by exercising cost avoidance; billing OHCs, such as Medicare or private health coverage, as primary when the coverage is known; and conducting post-payment recovery for the reasonable value of the services if the OHC is identified retroactively, if the Member has an OHC indicator of A, or if the service is required to be pay and chase.[9] Additional information is available in APL 21-002, or any superseding APL. The existence of OHC must not be a barrier to accessing SNF services.

   MCPs must ensure that the SNF and its staff have appropriate training on benefits coordination, including balanced billing prohibitions. For more information on benefits coordination, see Section VII on Population Health Management (PHM) later in this APL.

2. Consistent with guidance in APL 22-012, Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx, or any superseding APL, the financial responsibility for prescription

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[7] Accommodation codes for LTC facilities are listed at: https://medi-cal.ca.gov/file/manual?fn=accomcdltc.pdf.

[8] MCP boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

[9] A "pay and chase" arrangement is when Medi-Cal pays for the Member's services and then seeks reimbursement from the Member's OHC.

drugs is determined by the claim type on which they are billed. If certain drugs are dispensed by a pharmacy and billed on a pharmacy claim, they are carved out and paid by Medi-Cal Rx. If the drugs are provided by the SNF and billed on a medical or institutional claim, the MCP is responsible.

For MCPs newly covering SNF services effective January 1, 2023, financial responsibility for prescription drugs is determined by claim type, as discussed above, since the Medi-Cal FFS SNF per diem rate does not include legend drugs (prescription drugs).[10] MCPs may choose to cover drugs not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered.

MCPs must comply with PHM requirements, as outlined in this APL, which include the coordination of medically necessary drugs or medications on behalf of the Member.

More information on coverage of Medi-Cal pharmacy services through Medi-Cal Rx is available at: https://medi-calrx.dhcs.ca.gov/home/ and https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/9D62951D-8E23-4C70-8CEE-7070EA1BB6C3/ratefacilmisc.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

MCPs must cover all medically necessary services for Medi-Cal managed care Members residing in or obtaining care in a SNF, including facility services; professional services; ancillary services; and the appropriate level of care coordination, including carved-out Medi-Cal services, as outlined in this APL.

II. Network Readiness Requirements

As part of readiness, all MCPs are encouraged to offer a contract to all SNFs within the MCP's service area that meet the licensing, enrollment, and credentialing requirements. DHCS issued MCPs SNF Network Readiness Requirements guidance and a reporting template with a list of approved and active SNFs to assist with network readiness and provide contracting options for MCPs to develop SNF networks. MCPs must contract only with SNFs enrolled and licensed by the California Department of Public Health (CDPH) that are enrolled in Medi-Cal. MCPs must ensure contracted SNFs are enrolled and credentialed in accordance with APL 22-013, Provider Credentialing/Re-Credentialing and Screening/Enrollment, or any superseding APL, before contracting with SNFs. A list of approved and active SNFs can be found on CDPH's website.[11]

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[10] Title 22, California Code of Regulations (CCR) Section 51510 – 51511. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.

[11] The list of enrolled and licensed SNFs can be found on CDPH's website at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/CalHealthFind/Pages/SearchResult.aspx.

MCPs must develop sufficient network capacity to enable Member placement in SNFs within 5 business days, 7 business days, or 14 calendar days of a request, depending on the county of residence, as outlined in Welfare and Institutions Code (WIC) Section 14197.

In accordance with APL 21-003, Medi-Cal Network Provider and Subcontractor Terminations, or any superseding APL, MCPs must comply with requirements relating to CDPH-initiated facility decertifications and suspensions to ensure that impacted Members are transitioned appropriately and do not experience disruption in access to care.

III. Leave of Absence or Bed Hold Requirements

MCPs must provide continuity of care for Members that are transferred from a SNF to a general acute care hospital, and then require a return to a SNF level of care due to medical necessity.[12] Requirements regarding leave of absence, bed hold, and continuity of care policies apply.[13]

MCPs must ensure the provision of a leave of absence/bed hold that a SNF provides in accordance with the requirements of 22 CCR Section 72520 or California's Medicaid State Plan.[14] MCPs must allow the Member to return to the same SNF where the Member previously resided under the leave of absence/bed hold policies in accordance with the Medi-Cal requirements for leave of absence and bed hold, which are detailed in 22 CCR Sections 51535 and 51535.1. MCPs must ensure that SNFs notify the Member or the Member's authorized representative in writing of the right to exercise the bed hold provision.[15]

MCPs must regularly review all denials of bed holds. Additionally, MCPs must provide transition assistance and care coordination to a new SNF when a SNF claims an exception under the bed hold regulations or fails to comply with the regulations.

MCPs must ensure that the SNF and its staff have appropriate training on leave of absence and bed hold requirements, including knowledge of the required clinical documentation to exercise these rights.

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[12] SNF and general acute care hospital are defined in HSC Section 1250(a).
[13] See HSC Section 1367.09 (Return to skilled nursing) and HSC Section 1373.96 (Completion of covered services).
[14] The California Medicaid State Plan can be accessed at the following link: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx.
[15] See the California Medicaid State Plan for more information.

IV. Continuity of Care Requirements

Effective January 1, 2023, through *June 30*, 2023, for Members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care, MCPs must automatically provide 12 months of continuity of care for the SNF placement. Automatic continuity of care means that if the Member is currently residing in a SNF, they do not have to request continuity of care to continue to reside in that SNF. While Members must meet medical necessity criteria for SNF services, continuity of care must be automatically applied.

MCPs must allow Members to stay in the same SNF under continuity of care only if all of the following applies:

- The facility is enrolled and licensed by CDPH;
- The facility is enrolled as a provider in Medi-Cal;
- The SNF and MCP agree to payment rates that meet state statutory requirements;[16] and
- The facility meets the MCP's applicable professional standards and has no disqualifying quality-of-care issues.[17]

MCPs must determine if Members are eligible for automatic continuity of care before the transition by identifying the Member's SNF residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the Member or Provider. A pre-existing relationship means that the Member has resided in the SNF at some point during the 12 months prior to the date of the Member's enrollment in the MCP.

Following their initial 12-month automatic continuity of care period, Members may request an additional 12 months of continuity of care, following the process established by APL 18-008, Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care, or any superseding APL.

A Member newly enrolling in an MCP and are residing in a SNF after June 30, 2023, does not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 18-008, or any superseding APL. MCPs must notify the Member or their authorized representative, and furnish a copy of the notification to the SNF in which the Member resides, of the Member's right to request continuity of care, consistent with APL 18-008, or any superseding APL.

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[16] WIC Section 14184.201(b).
[17] WIC Section 14182.17.

If a Member is unable to access continuity of care as requested, the MCP must provide the Member or their authorized representative, with written notice of action of an adverse benefit determination in accordance with APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates, or any superseding APL. A copy of the notification must also be provided to the SNF in which the Member resides.

MCPs must also comply with the discharge requirements in HSC Section 1373.96 and WIC Section 14186.3(c)(4).

V. Treatment Authorizations

Effective January 1, 2023, for Members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care, MCPs are responsible for treatment authorization requests (TAR) approved by DHCS for SNF services provided under the SNF per diem rate for a period of 12 months after enrollment in the MCP or for the duration of the treatment authorization, whichever is shorter.

Effective January 1, 2023, for Members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care, MCPs are responsible for all other DHCS-approved TARs for services in a SNF exclusive of the SNF per diem rate for a period of 90 days after enrollment in the MCP, or until the MCP is able to reassess the Member and ensure provision of medically necessary services.

Effective January 1, 2023, all MCPs in all counties, prior authorization requests for Members who are transitioning from an acute care hospital are to be considered expedited, requiring a response time of no greater than 72 hours, including weekends.[18]

V. The Preadmission Screening and Resident Review (PASRR)

To prevent an individual's inappropriate nursing facility admission and retention of individuals, federal law requires proper screening and evaluation before such placement. These PASRR requirements are applicable for all Medicaid-certified nursing facilities for all admissions (regardless of payer source). The PASRR process is required to ensure that individuals who may be admitted into a nursing facility for a long-term stay be preliminarily assessed for serious mental illness and/or intellectual/developmental disability or related conditions. MCPs are required to work with DHCS and Network Providers, including discharging facilities or admitting nursing

[18] MCPs remain subject to timely access obligations under HSC Section 1367.03 and 28 CCR Section 1300.67.2.2(c).

facilities, to obtain documentation validating PASRR process completions. Further implementation guidance is forthcoming.[19]

VI. Facility Payment

In accordance with WIC Section 14184.201(b)(2), for contract periods from January 1, 2023, to December 31, 2025, inclusive, each MCP must reimburse a Network Provider furnishing SNF services to a Member, and each Network Provider of SNF services must accept, the payment amount the Network Provider would be paid for those services in the FFS delivery system, as defined by the Department in the Medi-Cal State Plan and as authorized by WIC Section 14184.102(d). This reimbursement requirement is subject to approval by the Centers for Medicare and Medicaid Services *(CMS)* as a State directed payment arrangement in accordance with Title 42, Code of Federal Regulations (CFR), Part 438.6(c), and is subject to future budgetary authorization and appropriation by the California Legislature.[20]

MCPs in counties where coverage of SNF services is newly transitioning from FFS to managed care on January 1, 2023,[21] must reimburse Network Providers of SNF services for those services at exactly the Medi-Cal FFS per-diem rates applicable to that particular type of institutional LTC provider for dates of service from January 1, 2023, through December 31, 2025, in accordance with WIC Section 14184.201(b)(2), this APL, and the terms of the CMS-approved State directed payment preprint.[22]

MCPs in counties where SNF services are already Medi-Cal managed care Covered Services prior to January 1, 2023, must reimburse Network Providers of SNF services for those services at no less than the Medi-Cal FFS per-diem rates applicable to that particular type of institutional LTC provider for dates of service from January 1, 2023, through December 31, 2025, in accordance with WIC Section 14184.201(b)(2), this

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[19] *Additional information regarding the PASRR process can be found at: https://www.dhcs.ca.gov/services/MH/Pages/PASRR.aspx*
[20] The CFR is searchable at: https://www.ecfr.gov/search.
[21] This requirement applies to MCPs in the following 31 counties: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, and Yuba.
[22] FFS per diem rates for SNFs, subacute facilities, pediatric subacute facilities, and intermediate care facilities are available at: https://www.dhcs.ca.gov/services/medi-cal/Pages/LTCRU.aspx and https://www.dhcs.ca.gov/services/medi-cal/Pages/AB1629/LTCAB1629.aspx.

APL, and the terms of the CMS-approved State directed payment preprint as applicable.[23]

MCPs are expected to comply with these reimbursement requirements as of January 1, 2023. Should CMS require any modification to this policy, DHCS will issue further conforming guidance at that time.

This reimbursement requirement only applies to SNF services as defined in 22 CCR Sections 51123(a), 51511(b), 51535, and 51535.1, as applicable, starting on the first day of a Member's stay. It does not apply to any other services provided to a Member receiving SNF services such as, but not limited to, services outlined in 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d), services provided by an Out-of-Network Provider of SNF services, or services that are not provided by a Network Provider of SNF services. Such non-qualifying services are not subject to the terms of this State directed payment and are payable by MCPs in accordance with the MCP's agreement with the Network Provider.

MCPs must coordinate benefits with OHC programs or entitlements as described elsewhere in this APL. For SNF services provided to Members who are dually eligible for Medi-Cal and Medicare, MCPs must pay the full deductible and coinsurance in accordance with APL 13-003, Coordination of Benefits: Medicare and Medi-Cal, or any superseding APL.

MCPs must provide a process for Network Providers to submit electronic claims and to receive payment electronically if a Network Provider requests electronic processing including, but not limited to, processing automatic crossover payments for Members who are dually eligible for Medicare and Medi-Cal.

MCPs must pay timely, in accordance with the prompt payment standards within their Contract. If, as the result of retroactive adjustments to the Medi-Cal FFS per-diem rates by DHCS, additional amounts are owed in accordance with this APL and the terms of this State directed payment to a Network Provider of SNF services, then MCPs must make such adjustments timely.

Additional details regarding Network Provider payment requirements for Distinct Part Nursing Facilities will be forthcoming.

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[23] This requirement applies to MCPs in the following 27 counties: Del Norte, Humboldt, Lake, Lassen, Los Angeles, Marin, Merced, Mendocino, Modoc, Monterey, Napa, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.

Assembly Bill (AB) 186 (Chapter 46, Statutes of 2022)[24] establishes a new Workforce and Quality Incentive Program (WQIP) performance-based State directed payment under the managed care delivery system for Network Providers of SNF services.

MCPs must ensure that Network Providers of SNF services receive reimbursement in accordance with these requirements for all qualifying services regardless of any Subcontractor arrangements. MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

VII. Population Health Management (PHM) Requirements

In addition to Benefit Standardization, effective January 1, 2023, MCPs must implement a PHM Program that ensures all Medi-Cal managed care Members, including those using SNF services, have access to a comprehensive set of services based on their needs and preferences across the continuum of care, including Basic Population Health Management (BPHM), *transitional care services (TCS),* care management programs, and Community Supports.

BPHM applies an approach to care that ensures needed programs and services, including primary care, are made available to each Member at the right time and in the right setting. In contrast to care management, which is focused on populations with significant or emerging needs, all MCP Members receive BPHM, regardless of their level of need. BPHM replaces DHCS' previous "Basic Case Management" requirements.

As part of their PHM Program, MCPs must provide strengthened TCS that will be implemented in a phased approach. By January 1, 2023, MCPs must implement timely prior authorizations for ***all Members****, and know when* ***all Members*** *are admitted discharged, or transferred from facilities, including SNFs. MCPs must also ensure that all TCS are completed for* ***all high-risk Members***[25]*, including assigning a single point of contact, referred to as a care manager, to assist Members throughout their transition and ensure all required services are complete. MCPs and their assigned care managers must ensure Member transitions to and from a SNF are timely and do not delay or interrupt any medically necessary services or care, and that all required transitional care*

[24] AB 186 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB186.
[25] *Members receiving long term services and supports (LTSS), including SNF services, are one of the groups considered to be "high risk".*

*activities are completed. By January 1, 2024, MCPs must ensure all TCS are completed for **all** Members.*

Care management *beyond transitions* consists of two programs: (1) Complex Care Management (CCM) and (2) Enhanced Care Management (ECM). *If a Member is enrolled in either CCM or ECM, TCS must be provided by the Member's assigned care manager.* MCPs must *also* continue to provide all elements of BPHM to Members enrolled in care management programs.

CCM is a service for managed care Members who need extra support to avoid adverse outcomes but who are not in the highest risk group. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs with a goal of regaining optimum health or improved functional capability, in the right setting and in a cost-effective manner.

ECM is a whole-person, interdisciplinary approach to comprehensive care management for managed care Members who meet the Populations of Focus criteria. It is intended to address the clinical and non-clinical needs of high-cost, high-need Members through systematic coordination of services and it is community-based, interdisciplinary, high-touch, and person-centered. One of the ECM Populations of Focus is specifically intended for nursing facility residents transitioning to the community. For these Members, the ECM Lead Care Manager must identify all resources to address all needs of the Member to ensure they will be able to transition and reside continuously in the community *and provide longitudinal support beyond the transition*.

MCPs are strongly encouraged to offer Community Supports services to Members who meet any of the ECM Populations of Focus, as well as other Members receiving CCM or BPHM, depending on their needs. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address social determinants of health, which are factors in people's lives that influence their health. All MCPs are encouraged to offer as many as possible of the Community Supports approved by DHCS.

For more information about PHM, please refer to the DHCS PHM website[26]; the PHM Policy Guide[27]; APL 22-024, or any superseding APL; and the Amended 2023 MCP Contract. For more information about ECM or Community Supports, *please refer to the*

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[26] The DHCS PHM webpage is located at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx
[27] The PHM Program Guide is available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf

DHCS ECM & Community Supports *website*[28]*; APL 21-012, or any superseding APL; APL 21-017*, or any superseding APL; the Finalized ECM and Community Supports MCP Contract Template[29]; the ECM Policy Guide[30]; and the Community Supports Policy Guide.[31]

VIII. MCP Quality Monitoring

MCPs are responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for long term care services provided. MCPs must have a system in place to collect quality assurance and improvement findings from CDPH to include but not limited to survey deficiency results, site visit findings, and complaint findings. The MCP's comprehensive QAPI program must incorporate the following:

- *Contracted SNFs' QAPI programs, which should include five key elements identified by CMS.*[32]
- *Claims data for SNF residents, including but not limited to emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions as well as DHCS supplied WQIP data via a template provided by DHCS on a quarterly basis.*
- *Mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan.*
- *Efforts supporting Member community integration*
- *DHCS and CDPH efforts to prevent detect, and remediate identified critical incidents*

IX. Monitoring and Reporting

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[28] *The ECM & Community Supports webpage is located at: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.*
[29] The finalized ECM and Community Supports MCP Contract Template is available at https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-Template-Provisions.pdf.
[30] The ECM Policy Guide is available at https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide-Updated-May-2022-v2.pdf.
[31] The Community Supports Policy Guide is available at: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf.
[32] *QAPI five key elements: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/qapifiveelements.pdf*

MCPs are required to report on LTC measures within the Managed Care Accountability Set (MCAS) of performance measures.[33] MCPs are required to calculate the rates for each MCAS LTC measure for each SNF within their network for each reporting unit. MCPs will be held to quality and enforcement standards in APL 19-017 and APL 22-015, respectively, or any superseding APLs.

MCPs are also require to annually submit QAPI program reports with outcome and trending data as specified by DHCS.

***X*. Policies and Procedures**

Within 60 days of the release of this APL, MCPs must update and submit their Policies and Procedures (P&Ps) to include all requirements in this APL to their Managed Care Operations Division (MCOD) Contract Manager. In addition, MCPs must submit any P&Ps required in any DHCS deliverables lists for LTC to their MCOD Contract Manager. MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[34] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[33] *Measurement Year 2023/Reporting Year 2024 MCAS*
[34] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.