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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: June 18, 2014

DUAL PLAN LETTER 14-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN CAL MEDICONNECT

SUBJECT: REQUIREMENTS FOR NURSING FACILITY SERVICES

PURPOSE:
The purpose of this Duals Plan Letter (DPL) is to clarify the responsibilities of Medicare-Medicaid Plans (MMPs) to provide coverage of nursing facility services as required under the Coordinated Care Initiative (CCI) for MMP beneficiaries in CCI counties.

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).

The Duals Demonstration Project, referred to herein as Cal MediConnect, is one component of the CCI. MMPs complete an extensive Cal MediConnect readiness review process, including, but not limited to, MMP development of policies and procedures (P&Ps) on the following topics:

- Nursing facility care coordination in compliance with CCI standards;
- Authorization and reauthorization of nursing facility placement; and
- MMP oversight of delegated entities to ensure compliance with Cal MediConnect requirements.

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

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PLAN POLICIES AND PROCEDURES:
MMPs shall submit to DHCS the applicable P&Ps for nursing facility services within 45 calendar days from the date that this DPL is issued. DHCS will review the P&Ps for compliance with the guidelines provided in this DPL. The MMP's P&Ps should address in detail contractual requirements, applicable DHCS guidance letter requirements, and SB 1008, SB 1036, and SB 94 legal requirements on the following topics:

1. Prompt payment and electronic claims payment for Medicare and Medi-Cal services;
2. Medi-Cal and Medicare reimbursement;
3. Leave of absence and bed holds;
4. Medicare coinsurance and deductibles;
5. Medi-Cal share of cost (SOC);
6. Continuity of care;
7. Change in a beneficiary's condition and discharge;
8. Authorization processes for Medi-Cal and Medicare services including nursing facility provider authorization request processes; and
9. DHCS approval process for MMP delegation and MMP delegate oversight and monitoring.

PROVIDER CONTRACTS:
MMP contracts with providers shall comply with all Cal MediConnect requirements.

PROMPT PAYMENT AND ELECTRONIC CLAIMS:
MMPs shall pay providers, including institutional providers, in accordance with the prompt payment provisions contained in each MMP'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) that applies to nursing facility services provided through MMPs in CCI counties.

For nursing facility services provided through MMPs in CCI counties, MMPs 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 MMP have agreed in writing to a faster alternate payment schedule. The date of receipt shall be the date the MMP 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. MMPs shall also pay all claims submitted by contracting nursing facility services providers in accordance with Health and Safety Code (H&S) §§1371–1371.36 if:

1) The timeline provided by these sections is less than the timeline provided above; and,
2) The contracting provider and MMP have not agreed in writing to a faster alternate payment schedule.

An MMP shall be subject to any remedies, including interest payments, provided for in these sections if the MMP fails to meet the standards specified in these sections.

For nursing facility services provided through MMPs in CCI counties, if the submitting provider requests electronic processing, the MMP 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 MMPs in CCI counties, MMPs 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.

REIMBURSEMENT FOR MEDICARE NURSING FACILITY SERVICES:
W&I Code § 14132.276 (b) and (c) states that in Cal MediConnect, Medicare nursing facility services are to be paid at rates that are no less than the recognized rates under Medicare. In addition, W&I Code § 14132.275 (o)(2) states that the intent of the Legislature for Cal MediConnect is that savings under Cal MediConnect are to be achieved through shifts in utilization, and not through reduced reimbursement rates to providers. MMPs may enter into alternative payment arrangements with nursing facilities and are not restricted to only Medicare FFS equivalent rates when they choose to do so.

LEAVE OF ABSENCE AND BEDHOLDS:
Pursuant to W&I Code § 14186.1 (c)(4), for nursing facility services provided through MMPs in CCI counties, MMPs shall include as a covered benefit any leave of absence or bedhold that a nursing facility provides in accordance with the requirements of Title 22 California Code of Regulations (CCR), § 72520 or California's Medicaid State Plan.

Medi-Cal requirements for bedhold and leave of absence are detailed in Title 22 CCR §§ 51535 and 51535.1.

MEDICARE COINSURANCE AND DEDUCTIBLES:
Pursuant to DHCS All Plan Letter (APL) 13-003, Medi-Cal managed care covered benefits include coverage of nursing facility Medicare coinsurance and deductibles. An

MMP may not require a beneficiary to pay coinsurance or deductibles for nursing facility services. DHCS APL 13-003 is available at the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-003.pdf.

MEDI-CAL SHARE OF COST:

MMPs shall process claims submitted by nursing facilities consistent with Medi-Cal guidelines for SOC, as outlined in the Medi-Cal Long-Term Care (LTC) Provider Manual (see internet link below) and the SOC Frequently Asked Questions (FAQs) for Cal MediConnect and Managed Long-Term Services and Supports. To request a current copy of the SOC FAQs, please contact your MMP contract manager.

When a Medi-Cal beneficiary has an LTC aid code and an SOC, a nursing facility will subtract the SOC that is paid or obligated to be paid from the claim amount. The MMP shall pay the balance.

In addition, as required by the *Johnson v. Rank* settlement agreement, if a beneficiary spends part of the SOC on “non-covered” 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 MMP 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, non-covered, 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 non-covered 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 MMP) 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 MMP) because the service is not considered medically necessary.

DHCS guidelines regarding *Johnson v. Rank* requirements are available in the Medi-Cal LTC Provider Manual at the following link: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/shareltc_l00.doc.

CONTINUITY OF CARE:
For information regarding continuity of care requirements that are applicable to Cal MediConnect, please see DHCS DPL 13-005 at the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-005.pdf.

Pursuant to the Cal MediConnect contract §§ 2.8.4.1.1.2. and 2.8.4.1.2.2., for services provided under the Cal MediConnect continuity of care requirements, MMPs shall pay out-of-network providers at rates not less than the current Medicare fee schedule for Medicare nursing facility services and not less than the applicable Medi-Cal FFS rate for Medi-Cal nursing facility services.

CHANGE IN A BENEFICIARY'S CONDITION AND DISCHARGE:
W&I Code § 14186.3 (c)(4) applies to nursing facility services provided through MMPs 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 MMP 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 MMP 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 MMP may also arrange and coordinate the discharge of a beneficiary if the MMP determines that one, or more, of the three circumstances noted above are present, or if the facility does not meet the MMP's network standards because of documented quality of care concerns.

AUTHORIZATION OF MEDICARE AND MEDI-CAL SERVICES:
W&I Code 14186.3 (c)(2) applies to nursing facility services provided through MMPs in CCI counties. Pursuant to this section, MMPs shall authorize utilization of nursing facility services for their beneficiaries when medically necessary. The MMP shall maintain standards for determining levels of care and authorizing services for both

Medicare and Medi-Cal services that are consistent with policies established by the federal Centers for Medicare and Medicaid Services and with the criteria for authorizing Medi-Cal services specified in Title 22 CCR § 51003.

DELEGATION OVERSIGHT:
MMPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including APLs and DPLs. DHCS's readiness review process includes a review of each MMP's delegation oversight.

MMPs must receive prior approval from DHCS for each delegate.

MONITORING:
DHCS will closely monitor beneficiary access to Medicare and Medi-Cal nursing facility services and quality outcomes. DHCS will review and provide ongoing monitoring of MMP P&Ps. DHCS will enforce appropriate prime plan oversight of delegate compliance with the prime plan's P&Ps. DHCS monitors compliance through the activities of the Cal MediConnect Contract Management Team, the Independent Duals Office of the Ombudsman, and other activities. DHCS also monitors quality through regular MMP submission of DHCS-specified health care service quality data.

If you have any questions regarding this DPL, please contact Sarah Brooks, Chief, Program Monitoring and Medical Policy Branch at sarah.brooks@dhcs.ca.gov.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Acting Deputy Director
Health Care Delivery Systems