DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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Model Contract Language

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Medi-Cal managed care plans (MCPs) are required to incorporate these standard model contract terms and conditions, in addition to their own terms *and the Network Provider Agreement requirements in APL19-001*[1,2], in their contracts with ICF/DD Homes. If the MCP's contract substantially deviates from these terms and conditions, MCPs are required to submit to DHCS for review and approval.

As used in this document, the subsequent terms are defined as follows:

1. "Per Diem Services"
    a. For ICF/DD Home-Nursing, the services described in 22 Code of California Regulations (CCR) sections 76345 through 76355;
    b. For IFC/DD-Habilitative, the services described in 22 CCR sections 76853 through 76906; and
    c. For ICF/DD Facility, the services described in 22 CCR sections 76301 through 76413 and 22 CCR section 51165.
2. "MCP" means a Managed Care Plan that contracts with the Department of Health Care Services to provide Medi-Cal services to Members.
3. "Facility" and "Home" are interchangeable terms for an Intermediate Care Facility/Developmentally Disabled (ICF/DD) Facility and can include the following types:
    a. ICF/DD-Habilitative as defined in Health and Safety Code (H&S) section 1250(e);
    b. ICF/DD-Nursing as defined in H&S section 1250(h); and
    c. ICF/DD as defined in H&S section 1250(g). This does not include ICF/DD-Continuous Nursing Care Program.
4. "Member" means a Medi-Cal recipient who is enrolled with the MCP.
5. "Contract" means the written agreement between a Home and the MCP.

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[1] *APL 19-001 can be found at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-001.pdf*

[2] *APL 19-001 Attachment A can be found at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-001AttachmentA.pdf*

6. "Network Provider" means a Provider that subcontracts with Contractor for the delivery of Medi-Cal Covered Services, including a Home that provides Per Diem Services defined above. The Two-Plan Non-CCI Boilerplate provides more in-depth definitions of provider types.[3]
7. "Excluded Covered Services" means services that a Home may provide which is not included in the Per Diem rate.
8. "Claim" means:
    a. A bill for services,
    b. A line item of service, or
    c. All services for one Member within a bill.[4]
9. "Clean Claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
10. "Regional Center" means one of 21 community-based centers that coordinate services, provide comprehensive assessments, determine eligibility for services, is responsible for the development and oversight of a Member's Individual Program Plan (IPP), and offer ongoing case management services for individuals with developmental disabilities.

ICF/DD Per Diem Rates and Directed Payment

- For all counties where coverage of ICF/DD Home services are newly transitioning from the FFS delivery system to the Medi-Cal managed care delivery system on January 1, 2024, the MCP must pay the Home for authorized Per Diem Services in accordance with All Plan Letter (APL) 23-023 and Welfare and Institutions Code (W&I) section 14184.201(c)(2). MCP will adopt and pay the California Department of Health Care Services' (DHCS') published per diem rates in accordance with the Medi-Cal Provider Manual.

  Model contract language:

  - MCP must pay the Homes for authorized Per Diem Services in accordance with APL 23-023. MCP will adopt and pay DHCS' published per diem rates. Excluded Covered Services are not subject to the per diem rates and are negotiated between the MCP and Home. If, as the

[3] See the Two-Plan Non-CCI Boilerplate, page 220, at: https://www.dhcs.ca.gov/provgovpart/Documents/2-Plan-Non-CCI-Boilerplate-Final-Rule-Amendment.pdf.
[4] See 42 Code of Federal Regulations (CFR) § 447.45(b) at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-A/section-447.45.

result of retroactive adjustments to the Medi-Cal FFS per diem rates by DHCS, additional amounts are owed in accordance with the terms of APL 23-023 to the Home, *then the MCP will make such adjustments as soon as practicable, but no later than 30 calendar days after the receipt of the claim by the health care service plan*[5,6]. An ICF/DD Home accepts the applicable prevailing per diem rates as published by DHCS, as payment in full in accordance with the Medi-Cal Provider Manual.

- For all counties where ICF/DD Home services were already covered in the Medi-Cal managed care delivery system prior to January 1, 2024, the MCP must pay the Home for authorized Per Diem Services in accordance with APL 23-023 and Welfare and Institutions Code (W&I) section 14184.201(c)(2). MCP will pay no less than the California Department of Health Care Services' (DHCS') published per diem rates in accordance with the Medi-Cal Provider Manual.

  Model contract language:

  - MCP must pay the Homes for authorized Per Diem Services in accordance with APL 23-023. MCP will adopt and pay no less than DHCS' published per diem rates. Excluded Covered Services are not subject to the per diem rates and are negotiated between the MCP and Home. If, as the result of retroactive adjustments to the Medi-Cal FFS per diem rates by DHCS, additional amounts are owed in accordance with the terms of APL 23-023 to Home, then MCP will make such adjustments *then the MCP will make such adjustments as soon as practicable, but no later than 30 calendar days after the receipt of the claim by the health care service plan*. The Home accepts the applicable prevailing per diem rates as published by DHCS, as payment in full in accordance with the Medi-Cal Provider Manual.

Prompt Payment and Claims

- ICF/DD Homes are not eligible for Medicare reimbursement and often do not have the same financial reserves or diverse payer mix as other types of providers and rely on prompt payment from Medi-Cal FFS and MCPs. DHCS requires MCPs to identify and implement practices for expedient remittance processing, including but not limited to processing and paying Clean Claims at the frequency they are received up to the maximum 30 *calendar* days; prioritizing Homes' Claim types as high priority; standardizing authorization processes with other MCPs;

[5] *Per Health and Safety Code (H&S) 1371(a)(1)*
[6] *See also 28 CCR 1300.71(g) and APL 23-020*

and providing open door forums to provide education and training on Clean Claims processes.

- While these are the minimum requirements, **nothing precludes the MCP from advancing payments to ICF/DD Homes and reconciling to the paid amounts based on what the providers have appropriately billed,** particularly at the start of the transition so that ICD/DD Homes can get accustomed to the MCPs' claims payment processes and MCPs can ensure timely payment and cash flow to ICF/DD Homes.

  Model contract language:

  - MCPs must pay the Homes for Per Diem Services provided to Members when Claims are submitted in accordance with this Contract, MCP policies, and when MCP authorized the Member's admission or continued residency. In accordance with the DHCS Contract, MCPs are required to pay at least 90% of Clean Claims within 30 calendar days of receipt, and 99% of all Clean Claims within 90 *calendar* days. MCPs are highly encouraged to pay claims and invoices at the same frequency in which they are received, whether electronic or paper claims.

  - MCPs must provide outreach, education, and support to Homes to understand how to submit Clean Claims and to meet Clean Claims requirements.

  - MCPs must identify an individual or set of individuals to serve as a Long-Term Services and Supports (LTSS) liaison for the ICF/DD Home. The LTSS liaison must provide support to the ICF/DD Home both in a Provider representative role and to support care transitions, as needed.

Electronic Claims Payments

- APL-23-023 requires MCPs to provide a process for Network Providers, including ICF/DD Homes, 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 provide clear instructions on electronic Claims processing systems to reduce errors and associated payment delays. MCPs must also provide a clear explanation of the Claims appeals process.

Model contract language:

- MCPs must provide education and training for their Network Providers on their billing/Claims processes including appeals processes. MCPs must make this available to their Home providers.

- The Home must submit Claims for Per Diem Services in accordance with MCP Policies. Claims may be submitted electronically to the MCP. If the Home chooses to electronically submit Claims, the Home must complete a process agreed upon by the Home and the MCP. If the Home chooses to receive payment electronically, the Home must complete an Electronic Fund Transfer ("EFT") Authorization Form.

- In the event the Home is unable to submit Claims to the MCP electronically, the Home must submit an UB-04 invoice form to the MCP with a minimum set of data elements as defined by DHCS and as referenced in the Billing and Invoicing Guide necessary for the MCP to convert the invoice to an encounter for submission to DHCS.

Leave of Absence and Bed Holds

- Clear communication about payment and payment timelines for leave of absences and bed holds helps to support the Homes' compliance with these requirements and supports smooth transitions for Members. Leave of absence (LOA) and bed hold policies are often new to MCPs taking on the LTC ICF/DD Home benefit. A promising practice is to have MCP authorization policies for bed holds and leave of absences stated in the Home/MCP contract. The MCP and Home should communicate often about how to timely and accurately request authorizations or documentation needed for reimbursement when prior authorization is not needed. The MCP must also ensure that internal plan staff, including provider relations staff and Claims and billing staff, have specific knowledge regarding the leave of absence and bed hold ICF/DD-specific benefit.

- Under the LOA and bed hold policies, MCPs must allow the Member to return to the same ICF/DD Home where the Member previously resided if it is the Member's preference, which are detailed in 22 CCR sections 51535 and 51535.1. *The Home shall hold a bed vacant during the entire hold period – a maximum of seven calendar days for each bed hold period*[7] *– but is not required to hold the bed if notified in writing by the attending physician that the patient require more than seven calendar days of hospitalization.*[8]

[7] *Per 22 CCR 51535.1(c)(2)*
[8] *Per 22 CCR 51535.1(b)*

- MCPs must ensure the ICF/DD Home notifies the Member or the Member's authorized representative in writing of the right to exercise the bed hold provision. If a Member does not wish to return to the same ICF/DD Home following a LOA or approved bed hold period, the MCP must provide care coordination and transition support, including working with the assigned Regional Center, in order to assist the Member to identify another ICF/DD Home within the MCP's Network that can serve the Member.

  Model contract language:

  - The MCP must include as a covered benefit any leave of absence (LOA) that a Home provides in accordance with the requirements of 22 CCR section 51535. The MCP must approve up to 73 LOA days per calendar year. *A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.*[9]

  - The MCP must also include as a covered benefit any bed hold. MCPs must cover the stay when Members transfer from an ICF/DD Home to any acute care hospital setting, a post-acute care setting such as a skilled nursing facility (SNF), or rehabilitation facility, and then require a return to an ICF/DD Home when that member was admitted by an attending physician[10] in accordance with the requirements of 22 CCR section 51535.1. The Home must maintain a bed hold for 7 days per incident (hospitalization) while receiving payment from the MCP.

Service Authorizations

- MCPs new to covering ICF/DD Home benefits may not be experienced with the associated authorization criteria and are required to build existing requirements into their utilization management policies and procedures. A promising practice is to include in the Home/MCP contract references to the guiding statutes and regulations, including the Individual Program Plan (IPP) process used by the

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[9] *The Leave of Absence (LOA), Bed Hold, and Room and Board section of the Medi-Cal Provider Manual Provider Manual (Part 2: Long Term Care) requires physician prescription for overnight LOAs in summer camps. See the Medi-Cal Provider Manual at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/FE5E3E2C-BD09-4A1A-8C42-036F13C17CFD/leave.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO*

[10] Bed holds require that a physician has ordered acute hospitalization. See the Medi-Cal Provider Manual at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/FE5E3E2C-BD09-4A1A-8C42-036F13C17CFD/leave.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

Regional Centers to offer residential living options. Consistent and continuous communication ensures both parties are operating from the same rule book.

- As MCPs are developing their utilization management policies and procedures, they must consider how a person-centered approach should consider input and evidence of need and traditional concepts of "medical necessity" for the ICF/DD level of care from Members, their responsible family members/guardians, authorized representatives, and interdisciplinary team members. The MCP plan of care must include evidence of care needs from interdisciplinary team members, treating physicians, home caregivers, and/or family members.

  Model contract language:

  - MCPs must be responsible for all determinations of approval or denial of a Member's admission to and/or continued residency in the Home using Form HS 231 *and DHCS 6013A* In making this determination, the MCP must utilize the determination and recommendation from the coordinating Regional Center and attending physician. As part of such review the MCP must certify the medical necessity of institutional care as defined in Title 22 of the Code of California Regulations: (1) ICF/DD-Nursing (22 CCR section 51343.2); (2) ICF/DD-Habilitative (22 CCR section 51343.1); and (3) ICF/DD (22 CCR section 51343), and as stated in the DHCS Long Term Care (LTC) Provider Manual and Manual of Criteria for Medi-Cal Authorization.

Service Authorization Timeline

- Transition to an appropriate level of care without delay is important for optimal Member outcomes and avoiding unnecessary healthcare costs.

- DHCS provides additional detail on how LTC authorization requests are handled in Medi-Cal FFS through the Medi-Cal Provider Manual. *MCPs must also use the MCP ICF/DD Authorization Request form or the data fields on the form. The MCP ICF/DD Authorization Request form can be found in Attachment B of APL-23-023.*

  Model contract language:

  - Pursuant to 22 CCR sections 51334, 51343, and as applicable, 22 CCR sections 51343.1 and 51343.2, an initial MCP ICF/DD Authorization Request must be required for each ICF/DD Home admission. ICF/DD Homes will continue to submit the Certification for Special Treatment Program Services form HS 231 to the MCPs with any initial or reauthorization requests. MCPs must accept the Certification for Special

Treatment Program Service*s* form HS 231 and *DHCS 6013A* as evidence of the Regional Center's determination that the Member meets the ICF/DD Home level of care. *The Regional Center's determination of Medical Necessity stands for both initial authorizations and reauthorizations.*

- An initial Authorization may be granted for periods up to two years from the date of admission. The MCP reserves the right to initiate review of the need for the continued level of care and to reauthorize the services more frequently. An approved initial *authorization* is required prior to transfer of Members between Homes.

- A request for reauthorization must be received by the MCP on or before the first working day following the expiration of a current authorization. MCPs and Homes are required to follow the Medi-Cal Provider Manual and *the data fields of the MCP ICF/DD Authorization Request form.* Reauthorizations may be granted for up to *two years*.

- The MCP must inform the Home of its authorization protocols including:

  - Making the authorization request process and timeframes easily understandable and readily available; and

  - Developing clear, specific, and available MCP escalation contacts for Homes and/or Members to escalate concerns when there are delays in pending authorizations, including providing the LTSS Liaison contact.