

**California Duals Demonstration
Long-Term Services and Supports Network Adequacy and Readiness Standards
January 22, 2013**

These Standards, in conjunction with the companion Care Coordination Standards, are part of the requirements that the Centers for Medicare/Medicaid (CMS) and the California Department of Health Care Services (DHCS) will use to assess Demonstration Health Plan readiness. CMS and the State are currently developing a joint Readiness Review Tool, which will assess whether the Health Plan is compliant with the State/federal criteria for readiness, and able to deliver quality service and coordination.

The State will also require participating Health Plans to meet these standards for their non-Demonstration Medi-Cal managed care for Long-Term Services and Supports (LTSS). LTSS includes:

- In-Home Supportive Services (IHSS);
- Community-Based Adult Services (CBAS);
- Multipurpose Senior Service Programs (MSSP); and
- Nursing Facilities, Sub-Acute Care Facilities (NF/SCF).

Provider Network and Contracting

For IHSS, Health Plans shall develop policies and procedures to:

1. Develop and execute Memorandum of Understanding (MOU) with county agencies that reflects an agreement between the Health Plan and county agency regarding roles and responsibilities for the first year of the Demonstration and Medi-Cal LTSS. Subsequent MOUs for future years will be jointly developed with the Health Plan and stakeholders. The provisions of the MOU shall be consistent with state law, including the provisions of WIC 14186.35. The MOU shall be completed four months prior to the effective date of the Demonstration.

An MOU shall maintain the role of county social service (or health service) agencies and a separate MOU will explain the ongoing role of the Public Authority in IHSS, as appropriate, for:

- a. Assessing, approving, and authorizing each current and new member's initial and continuing need for services.
- b. Enrolling providers, conducting provider orientation, and retaining enrollment documentation.
- c. Conducting criminal background checks on all potential providers.

- d. Providing assistance to IHSS recipients in finding eligible providers through an established provider registry.
 - e. Until the function transfers to the California In-Home Support Services Authority (the Statewide Public Authority), acting as employer of record, and providing access to trained IHSS providers and backup providers.
 - f. Performing quality assurance activities.
 - g. Sharing confidential data as necessary.
 - h. Appointing an advisory committee.
 - i. Continuing to perform other functions as necessary, as defined by statute and California Department of Social Services (CDSS) regulation, for the administration of the IHSS program.
2. Maintain the consumer-directed model for IHSS, which allows the member to self direct his or her care by being able to hire, fire, and manage his or her IHSS provider. (WIC 14186.35(a)(2))
 3. Determine whether the recipients' desires to have their IHSS providers involved in care planning or coordination, and if so, obtain express consent from the recipient or his or her authorized representative."
 4. Provide information and referral of members who have complaints, grievances, or appeals related to IHSS, to the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS. (WIC 14186.35(c))
 5. Support a member who is at risk for out-of-home placement in obtaining IHSS services.
 6. Ensure compliance with WIC 12302.6, regarding agencies, approved by CDSS, that provide IHSS personal care, attendant care or chore services in the home for emergency back-up services, as necessary.
 7. Report documentation that Health Plans have developed and will conduct a benefit orientation and training program specific to IHSS for staff or contractors. The Health Plan also provides documentation that it has trained personnel of IHSS organizations regarding the Health Plan's covered benefits and policies and procedures to access services and coordinate care.

For CBAS, Health Plans shall develop policies and procedures by no later than August 2014 to:

1. Arrange and show availability of providers of HCBS for members whose level of care needs correspond to CBAS benefit eligibility requirements, when CBAS centers are unavailable, inaccessible, limited in capacity, or cannot meet members' cognitive, cultural and linguistic needs.
2. Contract with all willing licensed and certified CBAS centers within the Health Plan's covered zip code areas and in adjacent zip codes accessible to members and for addressing loss of licensing or certification or closure of a contracted CBAS center.
3. Every effort should be made to ensure that Members receive CBAS services that are linguistically, culturally, and cognitively competent, when available.
4. Collaborate with CBAS centers to discuss at least annually on areas of collaboration and improvement.
5. Govern how the Health Plan will: 1) make referrals to CBAS (consistent with the waiver Special Terms and Conditions), 2) communicate generally with CBAS centers, 3) share the member's health information, and 4) coordinate care between the Health Plan and the CBAS center.
6. Work in collaboration with CBAS organizations and contracted providers to develop protocols for coordinating the Member's Interdisciplinary Care Team (ICT) with the CBAS Multi-Disciplinary Teams, and delineating roles and responsibilities among the entities.
7. Support any member who is at risk for out-of-home placement in obtaining CBAS services, when appropriate as determined by the Health Plan.

For MSSP, Health Plans¹ shall develop policies and procedures to:

1. Execute agreements with all MSSP organizations in the Health Plan's covered zip code areas for providing MSSP waiver services to eligible members, or have demonstrated that they have negotiated, in good faith, to attempt to secure executed contracts, in anticipation of plan readiness review, in order to have MSSP serve as a provider to the health plan.
2. Work with their contracted MSSP organizations to develop a care coordination and management model that supports appropriate referral of Health Plan members to the MSSP organization for assessment, eligibility determination, and services.

¹ Note, CalOptima is already an MSSP site. These rules will apply to CalOptima's interaction will all other MSSP sites.

3. Establish, convene, and consider the recommendations of MSSP organizations, Health Plan members and other stakeholders in the implementation of the MSSP contract.
4. Govern how the Health Plan will make referrals to MSSP and define the respective care management roles and duties of the Health Plan's ICT and MSSP care managers.
5. Govern MSSP assessment and eligibility determination as part of the Health Plan's care coordination process.
6. Contract with MSSP sites/organizations to provide Health Plan members who are MSSP waiver participants, MSSP case management services, and as needed, receive MSSP waiver services (such as supplemental personal care, respite, ramp, nutrition services, maintenance type, etc.).
7. Demonstrate the Health Plan has incorporated the use of MSSP services and other LTSS into its policies and procedures regarding:
 - Use of MSSP waiver resources for plan members.
 - Use MSSP sites to manage additional services outside of the scope of the MSSP waiver, at the discretion of Health Plans and MSSP sites.
 - Incorporation of features or elements of the MSSP care management approach.
8. Refer plan members, who have medical necessity, for coordinated care/case management to MSSP sites to receive needed services if there is sufficient and available capacity at the site. If there is no capacity, plans must provide some level of MSSP-like services through a network of providers selected by the health plan.

For NF/SCF, Health Plans shall develop policy and procedures to:

1. Govern authorization of NF/SCF services for members. Such policies and procedures shall cover criteria and authorization/reauthorization for placement in contracted facilities. These policies and procedures should be based on Medicare criteria for Medicare NF/SCF placement or Medicaid criteria for Medical nursing facility placement.
2. Offer and explain facility options to the member.
3. Ensure members have opportunities to transition from NF/SCF to community settings, as specified in the Care Coordination Standards.
4. Provide Health Plan members post-transition care coordination, as specified in the Care Coordination Standards.

5. Contract with licensed and certified nursing facilities. Health Plans must contract with a sufficient number of facilities located in the Health Plans' covered zip code areas. If NF/SCF facilities within the covered zip code areas cannot meet the member's medical needs, the Health Plan must contract with the nearest NF/SCF outside of the covered service area. Health Plans are responsible for all covered services even if their members are placed on short or long-term basis in NFs outside of their target service areas or contracted network. (WIC 14186.3(c))

Reimburse NF/SCFs for Medi-Cal bed holds and leave of absences consistent with federal and state requirements (California Code of Regulations, Title 22 Section 72520)

6. A comprehensive policy on occurrence reporting, including, but not limited to unusual occurrences and quality issues impacting its members.
7. Provisions on how the Health Plan will accommodate the transfer of members residing in a contracted NF/SCF facility who experiences a loss of licensure, or any expected or unexpected closure.
8. Provisions on how the Health Plan will provide training to NF/SCF staff on working with the Health Plan.

For all LTSS, Health Plans shall develop policies and procedures to train:

1. All health plan staff involved in care coordination:
 - the person-centered planning processes;
 - linguistic, cultural, and cognitive competence;
 - core concepts of the Olmstead Decision, i.e. serving members in the least restrictive settings as appropriate;
 - accessibility and accommodations; independent living;
 - wellness principles;
 - criteria for safe transitions, transition planning, care plans after transitioning; and,
 - along with other required training as specified by DHCS—both initially and on an annual basis.
2. Specially designated care coordination staff in dementia care management including but not limited to:
 - understanding dementia;
 - its symptoms and progression;
 - understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and,
 - community resources for patients and caregivers.

3. Specially designated care coordination staff in MSSP including but not limited to:
 - an overview of the characteristics and needs of MSSP's target population;
 - MSSP's eligibility criteria;
 - assessment and reassessment processes, services, and service authorization process; and,
 - refer members to MSSP for assessment and eligibility determination.
4. All Health Plan staff generally on the addition of LTSS and social services to Health Plan operations. For all trainings, Health Plans shall meet specifications set by DHCS, document completion of training, and have specific policies to address non completion.

For all LTSS referrals, Health Plans will comply with current contractual standards for all covered services.

Financial Information/Claims Processing

For MSSP, Health Plans shall develop the following policy and procedures to:

1. Allocate, for nineteen months following the start date of the demonstration, funding for the capitation for MSSP slots as established in the three-way contracts with DHCS and CMS that will be the same level of funding (as estimated by DHCS) as those organizations otherwise would have been allocated under their MSSP contract with the California Department of Aging (CDA). (SB 1008)

For CBAS, MSSP, and NF/SCF, Health Plans shall develop the following policy and procedures to:

1. Ensure claims processing systems pay MSSP, contracted CBAS centers and NF/SCFs in a timely fashion; consistent with regulatory timeframes established for all other contracted Health Plan providers. Documentation of system readiness must be provided prior to enrollment beginning.
2. Resolve any disputed claims for CBAS, MSSP, or NF/SCF reimbursement consistent with any other contracted health plan providers and to avoid disruption in care to Health Plan members.
3. Report individual encounter, claims, and quality data to DHCS for their members' utilization of facilities and services, and admissions to hospitals from facilities.
4. Ensure readiness of electronic claims processing systems to pay claims submitted by contracted providers in accordance with current law and regulations under Medi-Cal and Medicare law and regulation, as evidenced by testing of claims submissions and successful payment; instructions and training for

contracted providers on the accurate submission process, including the use of required claim forms; required fields; availability of electronic fund transfer, and a Plan contact for resolving claims submission problems or errors. (Payments by the plan will be made using Medi-Cal standards for Medi-Cal benefits and Medicare standards for Medicare benefits.) This shall include any system design change to ensure the timely processing of authorizations. Specific documentation of this must be provided to DHCS prior to any enrollment.

Management Information System

For MSSP, Health Plans shall develop policy and procedures for the following:

1. Data sharing agreements, through MOU or contract, with CDA and DHCS for exchanging confidential and other information about Health Plan members who are enrolled in MSSP.
2. Data sharing agreements (to include sharing of clinical data, utilization of plan benefits and MSSP waiver services) with their contracted MSSP organization(s), consistent with state and federal privacy rules.
3. Policies, procedures, and systems to identify Health Plan members who should be evaluated for MSSP eligibility and a protocol and mechanism for transmitting data and sharing care plans and other information relevant to these Health Plan members' care between the Health Plan and the contracted MSSP organization(s).

Quality Improvement System

For LTSS, Health Plans shall develop policy and procedures to:

1. Detail how their contracted CBAS centers will adhere to Health Plan-established quality assurance provisions, to be developed in collaboration with CBAS leaders, and consistent with state quality and ICT metrics as specified in the demonstration. Health Plans will seek technical assistance from the State as is necessary.
2. Define how it will adhere to quality assurance provisions and other standards and requirements as specified by CDSS, as well as any other state or federal requirements. (WIC 14186.35(a)(7))

Provider Relations

Health Plans shall develop policies and procedures to:

1. Secure authorization from members or their legal representative to include IHSS provider of their choosing in the Interdisciplinary Care Team for that member, as deemed appropriate by the Health Plan.
2. Have assigned and trained staff specifically to address and expeditiously process grievances, appeals, and complaints from contracted LTSS providers (CBAS centers, MSSP sites, and NF/SCFs) on all relevant areas of concern under the demonstration, including payment.
3. Develop and conduct initial and periodic orientation and training programs to familiarize contracted LTSS providers with Health Plans' operations, methods for provider communications, members' rights, plan-specific policies and procedures, claims submission and payment, coordination of benefits for the various types of beneficiaries reporting requirements, and conflict resolution process including how frequently such training will be conducted.

Member Grievance System

For IHSS, Health Plans shall develop policies and procedures to:

1. Inform beneficiaries that they will continue to be able to utilize the State Fair Hearing process with the County Social Service Agencies for issues of appeals to authorized IHSS hours.
2. Update contact lists for LTSS providers on a quarterly basis.

For CBAS, MSSP, and NF/SCF, Health Plans shall develop policies and procedures to:

1. Describe how Health Plan members' grievances regarding eligibility determinations, assessments, and care delivered by the Plan's contracted CBAS centers, MSSP sites, or NF/SCF should be submitted and will be adjudicated.

Member Services

For all LTSS, Health Plans shall develop policies and procedures to:

1. Train Health Plan staff to answer any service related questions or direct members to appropriate agency.
2. Ensure that all Health Plan members and/or authorized representatives are fully aware and informed of their rights, and that those rights are not violated.

3. Create and maintain a list of available LTSS providers; the list will be update no less than quarterly.
4. Demonstrate how authorizations and Individual Plans of Care will be transferred from one plan to another plan when a member disenrolls from one plan and enrolls in another to ensure no interruption in services to the member and no interruption in reimbursement to the provider responsible for the transferring member's care.

Health Insurance Portability and Accountability Act (HIPAA)

For IHSS, CBAS, MSSP and NF/SCF, Health Plans shall develop the following policy and procedures to:

1. Ensure compliance with the Health Insurance Portability and Accountability Act of 1996.

For IHSS, Health Plans shall develop the following policy and procedures to:

1. Ensure consistency with HIPAA to allow IHSS providers to speak on behalf of member, if the member has so authorized.