

**California Duals Demonstration  
Long-Term Services and Supports Network Adequacy Standards  
November 21, 2012**

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 Health Plan readiness for the dual demonstration. CMS and the State are currently developing a joint Readiness Review Plan, which will assess whether the plan is compliant with the State/federal criteria for readiness, and able to deliver quality service and coordination. In addition, the State is developing policy guidance on Home- and Community-Based Services (HCBS) "In-Lieu of" Benefits, as outlined in Welfare and Institutions Code Section (WIC) 14186.1(c); that guidance will supplement the standards below.

The State will also require 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), Nursing Facilities, Subacute Care Facilities (NF/SCF), and, to the extent covered by the Health Plan, HCBS In-Lieu of Benefits.

**Provider Network and Contracting**

For IHSS, Health Plans shall meet the following:

1. Effective February 1, 2013, an executed 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. The provisions of the MOU shall be consistent with state law, including the provisions of WIC 14186.35. In particular, the MOU shall maintain the role of county social service (or health service) agencies and Public Authorities in IHSS 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 Statewide Public Authority, acting as employer of record, and providing access to trained IHSS providers and backup providers.
  - f. Pursuing overpayment recovery.
  - g. Performing quality assurance activities.
  - h. Sharing confidential data as necessary.
  - i. Appointing an advisory committee.
  - j. 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. Evidence of Health Plan policies that 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. Policies and procedures to receive consent from IHSS recipients or their authorized representatives to include IHSS providers in care planning or coordination.
  4. Policies and procedures to 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. Policies and procedures for an expedited referral, when appropriate, to county social services agencies for a member who is at risk for out-of-home placement, and may qualify for IHSS services.
  6. Policies and procedures to 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, or it has been determined that the recipient is unable to function as the employer of the provider due to dementia, cognitive impairment, or is unable to retain a provider due to geographic isolation and distance, authorized hours.

For CBAS, Health Plans shall meet the following:

1. Policies and procedures to evaluate and document, on an annual basis, the amount of time that elapses between when a member is referred for CBAS services, and when those services are received.

2. Policies and procedures to ensure that Health Plan members' total one-way transportation time between home and the CBAS centers does not exceed 60 minutes each way, to ensure compliance with WIC 14550(h).
3. Policies and procedures to arrange, and show availability of providers for, unbundled services for Health Plan 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' cultural and linguistic needs.
4. When establishing eligibility for CBAS services, the Health Plan follows all regulatory timelines for intake, assessment, and authorization of services. Policies and procedures to ensure compliance with designated time-frames for completing determinations of members' eligibility for CBAS center services, upon referrals by members themselves, family members, CBAS Centers, physicians and other Health Plan staff and providers, health care and social services providers, or other community-based organizations.
5. Documentation of having contracted with all CBAS centers within the Health Plan's covered zip code areas and in adjacent zip codes accessible to members.
6. Policies and procedures that Health Plans are able to provide linguistically and culturally competent CBAS services when such services are available in the county.
7. Documentation of having established policies and procedures to collaborate with CBAS centers to conduct annual reviews of their contract arrangements, licensing and credentialing status, and areas of collaboration and improvement.

For MSSP, Health Plans shall meet the following:

1. Effective May 1, 2013, Health Plans will provide evidence of having executed contracts 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.
2. Documentation that Health Plans have developed and will conduct a benefit orientation and training program specific to MSSP for staff or contractors to act as care managers for members. The Health Plan also provides documentation that they have trained personnel of MSSP organizations to the Health Plan's covered benefits and policies and procedures to access services and coordinate care.

Such training shall include the components of medical and social services care planning for members needing LTSS, 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 the Health Plan's policy and procedures for referring members to MSSP for assessment and eligibility determination.

3. Documentation that the Health Plan has worked with their contracted MSSP organizations to develop a care coordination and management model that supports appropriate referral of Health Plan members to the MSSP for assessment, eligibility determination, and services.
4. Policies and procedures for establishing, convening, and considering the recommendations of MSSP organizations, Health Plan members and other stakeholders in the implementation of the MSSP contract.
5. Plans shall provide documentation of having developed policies and procedures governing how the Health Plan will make referrals to MSSP and defining the respective care management roles and duties of the Health Plan's Interdisciplinary Care Team (ICT) and MSSP care managers.
6. Health Plans shall provide documentation of having developed policies and procedures governing MSSP assessment and eligibility determination as part of the Health Plan's care coordination.
7. Health Plans shall have contracts with MSSP sites/organizations to provide Plan members who are MSSP waiver participants, MSSP case management services, and if needed, receive MSSP waiver services (supplemental personal care, respite, ramp, nutrition services maintenance type, etc.);
8. Documentation that the Health Plan has incorporated the use of MSSP services and other LTSS into their policies and procedures:
  - Use of MSSP waiver resources for plan members:
  - At the discretion of Health Plans and MSSP sites, policies and procedures on using MSSP sites to manage additional services outside of the scope of the MSSP waiver.
  - Incorporation of features or elements of the MSSP care management approach.
  - Plans shall have policies and procedures to refer MSSP eligible plan members to the MSSP sites, if there is availability.

For NF/SCF, Health Plans shall meet the following:

1. Policies and procedures for authorization of NF/SCF for members. Such policies and procedures shall cover criteria and authorization/reauthorization for placement in contracted facilities. These policies and procedures should include,

but not be limited to utilizing current Medicare criteria for Medicare skilled nursing facility placement or Medicaid criteria for Medi-Cal skilled nursing facility placement.

2. Policies and procedures to ensure members have opportunities to transition from nursing facility to community settings, as specified in the Care Coordination Standards.
3. Evidence of orientation and training programs for registered nurses, other clinical personnel, and appropriate Health Plan staff, directly employed or contracted, to conduct utilization management and community care transition for plan members. This training shall include, but not be limited to incorporating the core concepts of the Olmstead Decision, i.e. serving members in the least restrictive settings as appropriate, as well as criteria for safe transitions, transition planning, and care plans after transitioning.
4. Policies and procedures to provide Health Plan members post transition care coordination, as specified in the Care Coordination Standards.
5. In contracting with NF/SCFs pursuant to these standards, Health Plans shall contract with licensed and certified nursing facilities that provide all levels of care. Health Plans must contract with a sufficient number of facilities located in the Health Plans' covered zip code areas and, to the extent necessary, in adjacent zip code areas accessible to Health Plans members. 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. (WIC 14186.3(c))
6. Health Plans shall have policies and procedures to facilitate nursing facility compliance with state and federal requirements regarding readmission to a nursing facility after hospitalization in an acute care hospital.
7. When contracting with NF/SCFs, the executed contract must include evidence of the following:
  - A comprehensive policy on occurrence reporting, including, but not limited to sentinel events and quality issues.
  - Provisions on how the Health Plan will address change of ownership, loss of licensure, or any expected or unexpected closure of a contracted NF/SCF.
  - Policies and procedures that address the management of the nursing facility benefit.
  - Provider training curriculum for newly contracted NF/SCF providers.
  - Staff curriculum for training on how to manage the benefit including:
    - Sign in sheets for the staff training on how to manage the benefit.
    - Care coordination for members in nursing facilities.
    - Required notices for members in nursing facilities.
    - How to provide notices to members in nursing facilities.

- Relevant state and federal standards on the benefit.
- Relevant state and federal standards on consumer rights and protections.
- Sentinel events-quality reporting
- How to pay claims
- Encounter data submissions

For all LTSS:

Health Plans shall have a process to train care coordination staff on LTSS, eligibility for LTSS, and the benefits to members of these services.

### **Financial Information/Claims Processing**

For IHSS, the details of claims processing and funding sources and mechanisms will be detailed in a contract between DHCS, CDSS, and Health Plans.

For MSSP, Health Plans shall meet the following:

Provide assurance that, through December 31, 2014, they shall allocate to their contracted MSSP organization(s) the same level of funding as those organizations otherwise would have been allocated under their MSSP contract with the California Department of Aging (CDA).

For CBAS and NF/SCF, Health Plans shall meet the following:

1. Documentation that they have incorporated mechanisms into their claims processing systems to pay contracted CBAS centers and NF/SCFs in a timely fashion; consistent with regulatory timeframes established for all other contracted Health Plan providers.
2. Policies and procedures for resolving, within a defined time frame, any disputed claims for CBAS or NF/SCF reimbursement and to avoid disruption in care to Health Plan members.
3. Policies, procedures, and mechanisms for reporting individual encounter, claims, and quality data to DHCS for their members' utilization of facilities and services, and admissions to hospitals from facilities.
4. Documentation of the readiness of electronic claims processing systems to pay claims submitted by contracted providers in accordance with current law and regulations.

## **Management Information System**

For IHSS, Health Plans shall meet the following:

Effective February 1, 2013, evidence of data sharing agreements with counties and county Public Authorities.

For MSSP, Health Plans shall meet the following:

1. Evidence of 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. Evidence of having executed data sharing agreements (to include sharing of clinical data, utilization of plan benefits and MSSP waiver services) with their contracted MSSP organization(s).
3. Evidence of 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 IHSS, Health Plans shall meet the following:

Policies and procedures defining 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))

For CBAS, Health Plans shall meet the following:

1. Demonstrate that their Quality Assurance and Improvement Plans will include targeted, focused protocols for CBAS centers.
2. Policies and procedures detailing how their contracted CBAS centers will adhere to Plan-established quality assurance provisions and any other applicable State and federal standards and requirements. Health Plans will seek technical assistance from the State as is necessary.
3. Demonstrate, at a minimum, contracts with all CBAS centers that meet State licensure requirements for adult day health care centers and Medi-Cal certification requirements for CBAS providers, without any encumbering sanctions or citations.

4. Policies and procedures for sharing the findings, and coordination of any subsequent follow up, from Health Plan/CBAS center quality assurance activities with CDA and the California Department of Public Health (CDPH).

For MSSP, Health Plans shall meet the following:

1. Policies and procedures detailing how their contracted MSSP organization(s) will adhere to quality assurance provisions and any other applicable State and federal standards and requirements.
2. Policies and procedures documenting how Health Plans will report the findings and coordination of any subsequent follow up, from MSSP quality assurance activities with CDA and DHCS.

For NF/SCF, Health Plans shall meet the following:

1. Evidence of quality standards for NF/SCF services provided to members, and policies and procedures for health plans to monitor quality and the process to address any deficiencies identified by Health Plans.
2. Evidence that Quality Assurance and Improvement Plans include quality improvement activities for contracted facilities. These Plans should include monitoring for the effectiveness of care transitions.

### **Provider Relations**

Health Plans shall meet the following:

1. Policies and procedures for securing authorization from members or their legal representative to include IHSS provider in the Interdisciplinary Care Team for that member.
2. Documentation of having assigned and trained staff specifically to address and process complaints and grievances from contracted CBAS centers, MSSP sites, and NF/SCF on issues including, but not limited to, claims, payments, coordination with the Health Plan, referrals of Health Plan members, and concerns about Health Plan members' service needs.
3. Develop and conduct orientation and training programs to familiarize contracted facilities with Health Plans' operations, members' rights, plan-specific policies and procedures, claims submission and payment, reporting requirements, and conflict resolution process.

## **Member Grievance System**

For IHSS, Health Plans shall meet the following:

Policies and procedures for informing recipients 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.

For CBAS, MSSP, and NF/SCF, Health Plans shall meet the following:

Policies and procedures describing 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. Health Plans must also show documentation that these policies and procedures were developed in collaboration with their contracted CBAS centers, MSSP sites, and NF/SCF. Additionally, the policies shall include a process for referral of complaints to state licensing representatives.

## **Member Services**

For IHSS, CBAS, MSSP and NF/SCF, Health Plans shall meet the following:

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

## **Health Insurance Portability and Accountability Act (HIPAA)**

For IHSS, CBAS, MSSP and NF/SCF, Health Plans shall meet the following:

1. Policies and procedures to ensure compliance with the Health Insurance Portability and Accountability Act of 1996.
2. For IHSS, policies and procedures consistent with HIPAA to allow IHSS providers to speak on behalf of member, if so authorized.