KERN HEALTH SYSTEMS

## New Policy and Procedure

**KHS Policy & Procedure:** 3.96-P Long-Term Care Continuity of Care: Policy created to comply with DHCS APL 22-018.

| Reviewer | Date | Signature |
|---|---|---|
| Emily Duran<br>Chief Executive Officer | 8/24/23 | |
| Martha Tasinga<br>Chief Medical Officer | 08-16-23 | |
| Alan Avery<br>Chief Operating Officer | 5/8/2023 | Alan Avery |
| Deborah Murr<br>Chief Compliance and Fraud Prevention Officer | 6/13/2023 | Deborah L Murr, CCO |
| Michelle Curioso<br>Director of Population Health Management | 5/7/2023 | Michelle Curioso |
| Loni Hill-Pirtle<br>Director of Enhanced Care Management | 05/10/2023 | Loni Hill-Pirtle |
| Robin Dow-Morales<br>Director of Claims | 05/08/2023 | Robin Dow-Morales |
| Nate Scott<br>Director of Member Services | 5/10/2023 | Nate Scott |
| Misty Dominguez<br>Director of Utilization Management | 07/28/2023 | Misty Dominguez |

(CEO decision(s))
Board approval required: Yes ___ No ____ QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

KERN HEALTH SYSTEMS

| KERN HEALTH SYSTEMS<br><br>POLICY AND PROCEDURES | | | | | |
|---|---|---|---|---|---|
| SUBJECT: Long-Term Care Continuity of Care | | | | POLICY #: 3.96-P | |
| DEPARTMENT: Utilization Management | | | | | |
| Effective Date:<br>1/1/2023 | Review/Revised Date:<br>12/27/2022 | DMHC | X | PAC | |
| | | DHCS | X | QI/UM COMMITTEE | |
| | | BOD | | FINANCE COMMITTEE | |

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Compliance and Fraud Prevention Officer

_____ Date _____
Director of Population Health Management

_____ Date _____
Director of Enhanced Care Management

_____ Date _____
Director of Claims

_____ Date _____
Director of Member Services

_____ Date _____
Utilization Management Medical Director/ Utilization Management Director

**CalAIM LTC TRANSITION**

All Medi-Cal only and dual eligible beneficiaries in Medi-Cal FFS residing in a SNF on January 1, 2023, will be enrolled in a Medi-Cal MCP effective either January 1, 2023, or February 1, 2023. Beneficiaries who enter a SNF and would otherwise have been disenrolled from the Medi-Cal MCP will remain enrolled in managed care ongoing. This also includes Medi-Cal beneficiaries with other health coverage, including private coverage and Share of Cost (SOC) Medi-Cal beneficiaries in LTC aid codes.

**PURPOSE:**

To define and establish a mechanism for Kern Health Systems (KHS) to provide continuity of care for members transitioning into managed care assigned to KHS and are admitted and residing in a LTC nursing facility, in accordance with APL-22-018, Title 22 California Code of Regulations (CCR) 72520 and 51535 and 51535.1, Welfare and institutions Code Section 14186.3 (b)(4)(C)(c)(2)(4) 14186(b)(8), 9390.5. Department of Health Care Services Medi-Cal Long Term Care Provider Manual. Please refer to Kern Health System's Long Term Care Program.

**POLICY:**

KHS shall authorize utilization of nursing facility, subacute facility, intermediate acre facility services for its eligible members when medically necessary.

KHS Plan shall maintain the standards for determining levels of care and authorization of services for both Medicare and Medi-Cal services that are consistent with policies established by the Federal Centers for Medicare and Medicaid Services and consistent with the criteria for authorization of Medi-Cal services specified in Section 51003 of Title 22 of the California Code of Regulations, which includes utilization of the Manual of Criteria for Medi-Cal Authorization.

KHS shall maintain continuity of care (COC) for beneficiaries by recognizing prior treatment authorization made by the department for not less than twelve (12) months following enrollment of a beneficiary into KHS.

A beneficiary who is a resident of a long-term care nursing facility (LTC) prior to enrollment in the KHS, will not be required to change to another LTC facility ongoing if the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the facility agree to Medi-Cal rates. Members entering managed care residing in a SNF after June 30, 2023, will not receive automatic CoC and must request CoC. This follows the standard process outlined in APL 18-008 and APL 22-018.

**DEFINITIONS:**

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| **Skilled Nursing Facility (SNF)** | A special facility or part of a hospital that provides medically necessary services provided by nurses, therapists, and/or physicians.<br><br>A SNF is a licensed facility with the staff and equipment to provide nursing care and/or rehabilitative services at different levels as needed. The levels of care can vary, but usually include Subacute Care, Skilled Care and Long-Term Care. |
| **Long Term Care (LTC)** | Long-Term Care, also known as extended care or custodial care, and is recommended for patients who require longer stays when their care needs are no longer able to be met at a lower level of care. Patients with a chronic disease or debilitating medical condition such as Alzheimer's, heart disease, or stroke may require ongoing long-term care to improve their quality of life. This type of care provides patients with 24-hour care designed to support individual medical needs and may include a combination of a customized diet, restorative exercise, and assistance with daily activities.<br><br>Long Term Care is: The member has been reviewed, assessed, and determined that discharge potential is not possible, and placement is assumed for care in a facility for longer than the month of admission plus one month. |
| **Inclusive Items** | Inclusive items are all supplies, drugs, equipment, and services necessary to provide a designated level of care. These items are included in the LTC rate unless listed as separately reimbursable in California Code of Regulations (CCR), Title 22. All incontinence supplies are included in the facility rate and are not separately reimbursable for LTC patients, except for Intermediate Care Facility for the Developmentally Disabled-Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled-Habilitative (ICF/DD-H). |
| **Personal Hygiene Items** | The rates for Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) services include the cost for various personal hygiene items which facilities are required to furnish pursuant to federal law. Personal hygiene items include items such as denture cleaners, denture adhesives, dental floss, oral cleansing swabs, hair combs and brushes, lotions, shaving soap/cream, toothbrushes and toothpaste and tissue wipes for personal use. LTC providers cannot purchase items of personal hygiene with client funds. |
| **Exclusive Items** | Exclusive items are supplies, drugs, equipment or services not included in the per diem rate and are separately reimbursable subject to the utilization review controls and limitations of the Medi-Cal program outlined in LTC Part 2 Manual for Rates: Facility Reimbursement – Miscellaneous Inclusive and Exclusive Items. |

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| **Nonparticipating Provider** | Nonparticipating provider means a provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract. |
| **Provider** | Provider shall have the same meaning as set forth in California Code, Health and Safety Code - HSC § 1345 |
| **Provider Group** | Provider group means a medical group, independent practice association, or any other similar organization. |

**PROCEDURE:**

1. Facility Continuity of Care (COC)- attempts to maintain continuity of care will be facilitated in recognizing any treatment authorizations made by DHCS for nursing facility services that were in effect when the beneficiary enrolled into KHS. KHS will put forth best efforts to identify members' requiring 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. The COC requirement is established under W&I Code §14186.3(c)(3). COC for Medi-Cal is for a period up to 12 months.
    B. For Nursing Facilities with residents who are assigned to KHS, existing approved DHCS TARs will be honored for the initial authorization and used to create a KHS authorization, which is valid for six-month period (increments) from the date of enrollment up to 12 months.
    C. Members will be allowed to stay in the same SNF under continuity of care if all the following applies:
        1. The facility is enrolled and licensed by CDPH,
        2. The facility is enrolled as a provider in Medi-Cal,
        3. The SNF and KHS agree to payment rates that meet state statutory requirements, and,
        4. The facility meets the DHCS and KHS applicable professional standards and has no disqualifying quality-of-care issues.
    D. 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,
    E. Members newly enrolling in KHS and are residing in a SNF after June 30, 2023, will not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 18-008. Members residing in a SNF will be notified by KHS of their right to request COC.
    F. For any COC not granted members will be provided a written notice of action of an adverse benefit determination in accordance with APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates.

2. Provider COC, members may continue seeing their out-of-network Medi-Cal providers for up to 12 months and in accordance with HSC § 1373.96 as follows:

A. The completion of covered services shall be provided by a terminated provider to a member who, at the time of the contract's termination, was receiving services from that provider or the completion of covered services shall apply for a newly covered member requesting COC from a non-participating provider when meeting the following applicable conditions as described in HSC § 1373.96.
B. applicable medical conditions as described in HSC § 1373.96.
    1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
    2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the member and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered member.
    3. A pregnancy. Pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
    4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new member.
    5. The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered member.
    6. Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member.

Provider COC, members may continue seeing their out-of-network Medi-Cal providers for up to 12 months when:

3. At the request of the member, authorized representative, or provider, provide for the completion of covered services by a terminated provider or by a nonparticipating provider with the following considerations:

A. KHS will require the terminated provider or a nonparticipating provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider before termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.
    1. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.

B. Unless otherwise agreed upon by the terminated provider or a nonparticipating or by the individual provider and the provider group and KHS the services rendered shall be compensated at rates and methods of payment similar to those used by the KHS or provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider.
    1. Neither KHS nor the provider group is required to continue the services of a terminated provider if the provider does not accept the payment rates provided for as described above.

4. If KHS has delegated the responsibility of complying with HSC § 1373.96 provisions of COC to a provider group KHS shall ensure that the requirements are met through delegation oversight.

5. COC requirements do not apply for completion of covered services by a provider whose contract with the KHS or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professions Code, or fraud or other criminal activity.

6. KHS is not required to cover services or provide benefits that are not otherwise covered under the terms and conditions of the KHS and DHCS plan contract.

7. Dual eligible members may continue seeing their existing Medicare providers, those Medicare providers do not change and do not have to be in the Medi-Cal MCP provider network.

8. KHS will be responsible for all other approved TARs for services in a SNF exclusive of the SNF per diem rate for a period of 90 days after enrollment into KHS.

9. KHS will reassess the member and authorize and connect the member to medically necessary services with consideration of maintaining provider service relationships willing to accept Medi-Cal rates and meets DHCS and KHS quality standards and credentialing requirements.

10. KHS shall pay providers, including institutional providers, in accordance with the prompt payment provisions including the ability to accept and pay electronic claims.

11. When KHS has authorized services in a facility and there is change in the beneficiary's condition under which the facility determines that the facility may no longer meet the needs the beneficiary, the beneficiary's health has improved sufficiently so the resident no longer needs the services provided by

the facility, or the health or safety of individuals in the facility is endangered by the beneficiary, KHS shall arrange and coordinate a discharge of the beneficiary and continue to pay the facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

12. For prior authorization requests for Members who are transitioning from an acute care hospital KHS will handle them as an expedited, requiring a response time no greater than 72 hours, including weekends. This process is supported in the KHS Discharge Planning Policy.
    A. KHS shall process TAR request using the timeframes consistent with its policies and procedures, pursuant to the requirements in Health and Safety Code, Section 1367.01.

13. For further information regarding COC refer to P&P 3.39 Titled "*Continuity of Care by Terminated Providers*", and P&P 3.40 Titled *" Continuity of Care for New Members".*

**REFERENCE:**

**Revised 2022-12:** Policy created to comply with APL 22-018. DHCS approval issued 1/19/2023.

1. APL-22-018,
2. Title 22 California Code of Regulations (CCR) 72520 and 51535 and 51535.1,
3. Welfare and institutions Code Section 14186.3 (b)(4)(C)(c)(2)(4) 14186(b)(8), 9390.5.
4. Department of Health Care Services Medi-Cal Long Term Care Provider Manual.
5. APL 18-008, and APL 22-018, and APL 21-011
6. CA. HSC § 1373.96
7. HSC § 1345
8. P&P 3.39 Titled "*Continuity of Care by Terminated Providers*",
9. P&P 3.40 Titled *"Continuity of Care for New Members".*