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

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DATE: May 22, 2015

ALL PLAN LETTER 15-013

TO: MEDI-CAL MANAGED CARE HEALTH PLANS OPERATING IN COORDINATED CARE INITIATIVE COUNTIES

SUBJECT: REQUIREMENTS FOR MEDI-CAL MANAGED CARE HEALTH PLANS AND QUALIFIED AGENCY CONTRACT

PURPOSE:
This All Plan Letter (APL) provides direction for Medi-Cal managed care health plans (MCPs) operating in Coordinated Care Initiative (CCI) counties, Qualified Agencies, and counties regarding the provision of In-Home Supportive Services (IHSS) via contracts between Qualified Agencies and MCPs pursuant to Welfare and Institutions Code (WIC) Section (§)12302.6 (Contract Mode). This APL outlines the contract approval process and requirements for MCPs and Qualified Agencies.

BACKGROUND:
WIC §12302.6 sets forth requirements for the provision of IHSS through the Contract Mode and also specifies that such contracts must be approved by the California Department of Social Services (CDSS). Specific requirements regarding certification, re-certification, and other requirements, regarding the Contract Mode are provided in All County Letter (ACL) No. 14-02, ACL No. 14-03, and ACL No. 15-15.[1]

MCP AND QUALIFIED AGENCY CONTRACT APPROVAL AND REQUIREMENTS:

A. MCP and Qualified Agency Contract Approval
Pursuant to WIC §12302.6(k) any contract entered into between an MCP and a Qualified Agency must be reviewed and approved by CDSS. The contract must meet certain requirements to be approved by CDSS. MCPs are required to submit draft contracts between MCPs and a Qualified Agency to CDSS for review and approval at least 60 calendar days prior to execution. After approval and execution by the parties, CDSS must receive an executed copy of the contract.

B. MCP AND QUALIFIED AGENCY CONTRACT REQUIREMENTS
In order to be approved by CDSS, contracts must include clauses that require the Qualified Agency to comply with statutory and regulatory requirements and meet certain

[1] ACLs No. 14-02, No. 14-03, and No. 15-15 can be found at the following link: http://www.dss.cahwnet.gov/lettersnotices/PG3680.htm

programmatic policies. As discussed in further detail below, these requirements include the following:

1. The contract must include provisions requiring that any contract between an MCP and a Qualified Agency must provide for a minimum amount of Service Utilization, which must be approved and monitored by CDSS pursuant to WIC §12302.6(k). Service Utilization is the percentage of hours which the Qualified Agency actually provides in relation to the overall amount of authorized hours that were referred to the Qualified Agency. The minimum amount of service utilization provided by a Qualified Agency must be no less than 75 percent of the total authorized IHSS hours referred to the Qualified Agency.

   In no case can the number of IHSS recipients referred for services under Contract Mode exceed five percent of the IHSS caseload in the county where services are provided, regardless of the number of MCPs or Qualified Agencies doing business in the county. The five percent limitation on caseload applies to all IHSS recipients currently authorized to receive services that are referred to Contract Mode in a county rather than five percent per MCP and/or Qualified Agency. Each county must notify the MCP of the IHSS county caseload each month to ensure the five percent limitation is being met. These numbers may fluctuate monthly.

   At a minimum, these procedures must require Qualified Agencies to submit a monthly Contract Mode Service Report (State of California [SOC] 2277, see form and instructions attached) to all other Qualified Agencies doing business in the county, if applicable, all MCPs doing business in the county, the county, and CDSS beginning by the fifth of each month, and no later than the 10th of each month to ensure timely payment to the county.

   CDSS will review the Contract Mode Service Report monthly to ensure compliance with the five percent case load limitation. If CDSS determines that the caseload limitation is close to or being exceeded, it will notify the Qualified Agency(ies), the county, and the Department of Health Care Services (DHCS).

2. Service hours provided to an IHSS recipient via Contract Mode must be deducted from a recipient's current authorized service hours on an hour-to-hour basis. Pursuant to WIC §12302.6(i), Qualified Agencies are required to coordinate with the applicable county and CDSS to ensure hours are accurately captured and not duplicated per IHSS program requirements. Qualified Agencies providing services in Contract Mode must complete a monthly Service Report (SOC 2277) and must submit the Service Report to the applicable county, MCP, and CDSS on the fifth day of each month, and no later than the 10th of each month, on the hours for the previous month. The Qualified Agency must also upload an electronic file summarizing the service hours it has provided to the Case Management Information Payrolling System (CMIPS) II Contractor, Hewlett

Packard (HP), via a Secure File Transfer (SFT) by the fifth day of each month, and no later than the 10th of each month. The CMIPS II Contractor (HP) must then update all services provided by the Qualified Agency in CMIPS II. The CMIPS II system will then notify the county that the information is ready for review. The county must then review the data to ensure hours are accurately captured, appropriately deducted from the authorized hours and not duplicated per IHSS program requirements.

3. The contract must ensure that all wages and benefits for contract providers for their provision of IHSS must not be less than the individual provider rate that is negotiated by the Statewide Authority for the county where services are provided (WIC §12302.6(j)). CDSS will monitor and track wages and benefits to ensure compliance.

4. Procedures must be in place so that the Qualified Agency may provide back-up services to the recipient when his or her individual provider is unavailable due to vacation, illness, or other extraordinary circumstances that leave the recipient in immediate and temporary need of an IHSS provider. A Qualified Agency may also provide back-up services to such a recipient if he or she is in the process of hiring or replacing a provider.

5. A provision that requires that a Qualified Agency to not disclose any confidential information which is restricted or prohibited by any provision of law, including, but not limited to: WIC §10850; Title 22, California Code of Regulations, §51009; the Health Insurance Portability and Accountability Act of 1996, and the California Information Practices Act, California Civil Code §1798.3 et seq.

6. A provision stating that if a Qualified Agency becomes decertified by CDSS for non-compliance, the contract between that Qualified Agency and the MCP becomes null and void.
7. The MCP must notify CDSS within 60 calendar days if the contract is suspended, amended or terminated for any reason.
8. MCPs must notify CDSS of any rate change request at least 60 days in advance of the effective date of the new rate. CDSS will review and provide the MCPs with the final decision. If the new rate is approved, CDSS will inform DHCS of the change for tracking purposes. State approval is required before the new rate can be utilized.

C. Recipient Referrals

Once an agency has been certified by CDSS as a Qualified Agency, and has entered into an approved contract with an MCP, the Qualified Agency may only receive IHSS recipient referrals from county IHSS social workers, MCPs and/or Care Coordination Teams (CCTs)/Interdisciplinary Care Teams (ICTs) established pursuant to WIC

§14186 et seq. An individual must be authorized to receive IHSS services prior to being referred to the Qualified Agency. For more information on CCTs/ICTs, please refer to ACL No. 14-25[2] and APL 14-010.[3]

Pursuant to WIC §12302.6(g), when a recipient has been referred to a Qualified Agency by an MCP, the Qualified Agency may provide services to the IHSS recipient in the following circumstances:

1. It has been determined that upon referral by a county IHSS social worker or in collaboration with the MCP that the IHSS recipient is unable to function as the employer of the provider due to dementia, cognitive impairment, or other similar issues which indicate that the recipient's needs would be better served by a Qualified Agency;

2. The IHSS recipient has been identified to need services under the Contract Mode by the CCT; or

3. The IHSS recipient is unable to retain a provider due to geographical isolation, distance, and/or authorized hours that cannot be worked by other providers.

All recipients that meet the above criteria may be referred to a Qualified Agency. However, the MCP may refer the recipient back to the county if the Qualified Agency is unable to meet the recipient's needs or if the county has already met the five percent caseload maximum specified in WIC §12302.6(k) under Contract Mode. Additionally, when a recipient who is severely impaired, as described in WIC §12303.4(b), has been referred to a Qualified Agency by a county IHSS social worker, MCP, or CCT, the Qualified Agency may provide back-up services to the recipient when his or her individual provider is unavailable due to vacation, illness, or other extraordinary circumstances that leave the recipient in immediate and temporary need of an IHSS provider. A Qualified Agency may also provide back-up services to such a recipient if he or she is in the process of hiring or replacing a provider.

D. Billing Process

An agency certified as a Qualified Agency will contract and work with the MCPs in order to service IHSS referred recipients. The following procedures require coordination between the county, MCPs, Qualified Agencies and CDSS to ensure timely payments are made. The procedures are as follows:

1. The Qualified Agency will send an electronic file to the MCP and the CMIPS II Contractor (HP) that will then update CMIPS II for all Contract Mode IHSS

[2] ACL 14-25 can be found at the following link: http://www.dss.cahwnet.gov/lettersnotices/PG3408.htm
[3] APL 14-010 can be found at the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-010.pdf

services provided in the previous month, beginning on the fifth of each month and no later than the 10th of each month.

2. The MCP will receive the file from the Qualified Agency and forward it to the county on the 11th (or the first business day following) of each month. The MCP will reimburse the Qualified Agency for any CCI referred IHSS recipients who received services in the prior month.

3. The county will receive the file from the MCP. The CMIPS II system will generate a report that the county reviews to resolve any payroll record discrepancies before approving the billing information to be input on the SOC 432 and sent to CDSS by the 17th of every month.

4. After CDSS reviews and accepts the SOC 432 invoice, the invoice will be submitted to the CDSS Accounting Unit.

5. The CDSS Accounting Unit prepares the State Controller's Office (SCO) Warrant Schedule and sends to it to the SCO.

6. The SCO has 10 days to cut a warrant to the county.

7. Once the county receives the warrant from the SCO, the county will reimburse the MCP.

As a workaround for the payment process until CMIPS II has the capability to streamline the payment process, MCPs will pay the Qualified Agency and invoice the county. The county will then seek reimbursement from CDSS. Once reimbursed by CDSS, the county will pay the MCPs. Please see the attached CCI Managed Care/Qualified Agency Billing Process Flow Chart.

If you have any questions regarding this APL, please contact Ruben Romero, Chief of the Systems and Administrative Branch, CDSS at (916) 653-3850 or Ruben.Romero@dss.ca.gov.

Sincerely,

Original Signed by Sarah C. Brooks

Sarah Brooks, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services

Attachments (3)

CONTRACT MODE SERVICE REPORT

Agency:		County:		Month:		Year:	

	Consumer Name	Case Number	Zip Code	DPSS Auth. Hours	Total Served	Total Unserved
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Number of Referrals For Contract Mode Received in the Month From the County, Care Coordination Team, or Medi-Cal managed care health plan (MCP)/Medicare-Medicaid Plan (MMP)

Total Referrals For the Month:			Name of MCP/MMP	Total From Each MCP/MMP
From:	County:			
	Care Coordination Team:			
	MCP/MMP:			
Total # of Recipients who Received Services During the Month:				

Instructions for the Contract Mode Service Report

The attached Form SOC 2277 is a hard copy version of the Contract Mode Service Report. An electronic version of the report will be sent to Qualified Agencies to use for monthly completion and submittal. To request the electronic version please contact Rolonda Moen, Contract Mode and Certification Unit at 916-651-5332 or rolonda.moen@dss.ca.gov.

1. Enter the name of the Qualified Agency completing the report in cell F1.

2. Enter the name of the County in which the Agency is providing service(s) in cell C2.

3. Enter the year in which the Agency provided the service(s) in cell E2.

4. Enter the month in which the Agency provided the service(s) in cell G2.

5. Enter the Consumer Name, Case Number, Zip Code, DPSS Authorized Hours, Total Hours Served, and Total Hours Unserved in cells B4, C4, D4, E4, F4, and G4. Complete this information for all consumers served by the Agency in the reporting month.

6. Enter the total number of referrals for Contract Mode received for the reporting month in cell K4.

7. Enter the total number of referrals received from the County in cell K7, the Care Coordination Team in cell K8, and the MCP/MMP in cell K9.

8. Enter the name(s) of the MCP/MMP in cells I12, I13, I14, I15, and I16 (as needed). Enter the total number of referrals from each MCP/MMP in cells N12, N13, N14, N15, and N16 (as needed).

9. Enter the total number of recipients who received services from the Agency during the reporting month in cell I22.

10. The Agency shall submit completed Service Report to the applicable county, MCP/MMP, and CDSS by the 5th day of each month, however no later than the 10th day of each month. The Service Report shall be submitted to CDSS electronically to rolonda.moen@dss.ca.gov.

CCI Managed Care/Qualified Agency Billing Process