# SUBMISSION REVIEW FORM

## DHCS MCOD CONTRACT OVERSIGHT BRANCH

**REVIEWER:** **DATE RECEIVED FROM PLAN:**

**UNIT:**

**RETURN TO:** **DHCS REVIEW DUE DATE:**

---

**PLAN NAME:**

**COUNTY(S):**

**SUBMISSION ITEM:** Policy and Procedure (P&P) regarding All Plan Letter (APL) 25-008: Hospice Services and Medi-Cal Managed Care

---

☐ APPROVED AS SUBMITTED

☐ ADDITIONAL INFORMATION REQUESTED #__ (LIST BELOW) SUBMIT TO DHCS BY:

☐ DENIED #____ (LIST BELOW) SUBMIT TO DHCS BY:

REVIEWER: DATE:
*(Signature)*

UNIT CHIEF: DATE:
*(Signature)*

---

Your submission will be reviewed based on the following criteria. Please review to ensure that your submission meets review requirements:

**Note:** The criteria presented here is to provide assistance for review but is not exhaustive. Submissions will be reviewed considering relevant contract sections, codes, regulations, APLs, and other related documents and standards.

**Citations:** APL 25-008: Hospice Services and Medi-Cal Managed Care

Policies and Procedures (P&Ps) for Managed Care Plans (MCPs) will demonstrate guidance regarding contractual, regulatory, and statutory requirements applicable to MCPs with respect to their responsibilities to provide Medically Necessary hospice services to their MCP Members.

**Review Findings:**

1. Does the P&P state that under existing Contract requirements and state law, MCPs are required to provide hospice services upon Member election to start and receive such care services? Hospice coverage is provided in benefit periods: Two 90-day periods, beginning on the date of hospice election; followed by unlimited 60-day periods. A benefit period starts the day the Member receives hospice care and ends when the 90-day or 60-day period ends.
(Reference: APL 25-008, page 1)

☐ Yes ☐ No
Citation:

2. Does the P&P state that Members who qualify for and elect to receive hospice care services remain enrolled in an MCP while receiving such services?
(Reference: APL 25-008, page 1)

☐ Yes ☐ No
Citation:

3. Does the P&P state that to avoid problems caused by late referrals, MCP P&Ps should clarify and detail how Members may access hospice care services in a timely manner, preferably within 24 hours of the request from in-Network hospice Providers?
(Reference: APL 25-008, pages 1-2)

☐ Yes ☐ No
Citation:

4. Does the P&P state MCPs may restrict coverage to in-Network Providers, unless Medically Necessary services are not available in-Network, consistent with contractual requirements for covered Medi-Cal benefits?
(Reference: APL 25-008, page 2)

☐ Yes ☐ No
Citation:

5. Does the P&P state Members who elect hospice care are entitled to curative treatment for conditions unrelated to their terminal illness?
(Reference: APL 25-008, page 2)

☐ Yes ☐ No
Citation:

6. Does the P&P state that for out-of-Network hospice Providers, the MCP should seek an agreement, such as a single case agreement or a letter of agreement, to cover hospice care services, and that agreements with the out-of-Network hospice Provider require the Provider to submit necessary documentation for the MCP to ensure that hospice services are provided in accordance with coverage policy, including Medical Necessity?
(Reference: APL 25-008, page 2)

☐ Yes ☐ No
Citation:

7. Does the P&P state that while Prior Authorization for hospice services is restricted, based on the level of care, MCPs are required to review documentation to avoid Fraud, Waste, and Abuse?
(Reference: APL 25-008, page 2)

☐ Yes ☐ No
Citation:

8. Does the P&P state that to avoid possible delays in hospice care services while the MCP processes requests from out-of-Network hospice Providers, MCP P&Ps should clarify and detail how Members may access hospice care services in a timely manner after the MCP confirms qualifications and/or agreement with the out-of-Network hospice Provider, or transfer to an in-Network hospice Provider?
(Reference: APL 25-008, page 2)

☐ Yes ☐ No
Citation:

9. Does the P&P state that for out-of-Network hospice Providers, MCPs must ensure the hospice Provider has Medicare certification, is licensed by the California Department of Public Health (CDPH), and has a National Provider Identifier prior to payments of claims?
(Reference: APL 25-008, page 2)

☐ Yes ☐ No
Citation:

10. Does the P&P state that requirements for the initiation of outpatient hospice services include a certification by the attending physician and/or the hospice medical director that a Member has a terminal illness with a life expectancy of six months or less, and the Member's election of hospice services in lieu of curative care for the terminal illness?
(Reference: APL 25-008, page 2)

☐ Yes ☐ No
Citation:

11. Does the P&P state that election of hospice care occurs when the Member or Authorized Representative voluntarily files an election statement with the hospice Provider, and that the hospice Provider is responsible for the coordination of hospice services and must submit the appropriate Department of Health Care Services' (DHCS) election form (Medi-Cal Hospice Program Election Notice) to the Member's respective MCP within five calendar days of certification and election of hospice care?
(Reference: APL 25-008, pages 2-3)

☐ Yes ☐ No
Citation:

12. Does the P&P state that in instances where the hospice Provider does not timely submit the election form to the MCP, the MCP is not obligated to cover and pay for the days of hospice care from the hospice admission date to the date the election form is submitted to, and accepted by the MCP, and that these non-covered days are a hospice Provider's liability, and the hospice Provider cannot bill the Member for them?
(Reference: APL 25-008, page 3)

☐ Yes ☐ No

Citation:

13. Does the P&P state DHCS and MCPs may conduct medical and site reviews, such as prepayment review, and/or request additional information as part of its claims processing and Utilization Management functions regarding a Member's certification and election, including supporting documentation?
(Reference: APL 25-008, page 3)

☐ Yes ☐ No
Citation:

14. Does the P&P state that a hospice Provider must obtain written certification of terminal illness for each hospice benefit period? For the initial 90-day benefit period, the hospice Provider must obtain written certification statements from the medical director of the hospice, the physician designee (as defined in 42 CFR 418.3), or the physician member of the hospice interdisciplinary group; as well as the Member's attending physician (generally the Member's Primary Care Physician and/or referring physician), if the Member has an attending physician. For subsequent benefit periods, the certification must be done by the medical director of the hospice, the physician designee, or the physician member of the hospice interdisciplinary group.
(Reference: APL 25-008, pages 3-4)

☐ Yes ☐ No
Citation:

15. Does the P&P state that "terminally ill" means that an individual has a medical prognosis that their life expectancy is six months or less if the illness runs its normal course and that federal law requires that the physician certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course?
(Reference: APL 25-008, page 4)

☐ Yes ☐ No
Citation:

16. Does the P&P state MCPs must not deny hospice care to Members certified as terminally ill?
(Reference: APL 25-008, page 4)

☐ Yes ☐ No
Citation:

17. Does the P&P state guidance provided by the Centers for Medicare & Medicaid Services (CMS) for reference by hospice Providers and MCPs in determining terminal status is not wholly restrictive and/or inclusive for MCP Members to receive hospice care services? And that the guidelines are a tool and are not exclusive to determining eligibility for hospice care and do not replace a physician's professional judgement, as some Members may not meet these guidelines, yet still have a life expectancy of six months or less?
(Reference: APL 25-008, page 4)

☐ Yes ☐ No

Citation:

18. Does the P&P state only general inpatient care is subject to Prior Authorization regardless of whether the services are to be rendered by an in-Network or out-of-Network Provider, and that the five listed documents must be submitted to the MCP for Prior Authorization of general inpatient care? Also, MCPs must not require Prior Authorization for routine home care, continuous home care and respite care, or hospice physician services?
(Reference: APL 25-008, page 4)

☐ Yes ☐ No
Citation:

19. Does the P&P state hospices must notify the MCP of general inpatient care placements that occur after normal business hours on the next business day?
(Reference: APL 25-008, pages 4-5)

☐ Yes ☐ No
Citation:

20. Does the P&P state an MCP may require documentation of medical justification for continuous home care and/or respite home care following the provision of general inpatient and continuous care, and that if the documentation does not support the continuous home care or respite home care levels of care, or if the documentation included is inadequate, reimbursement may be reduced to the rate for routine home care? Also, the hospice Provider may submit an appeal for reconsideration of payment by including additional documentation of the medical necessity for the increased level of care?
(Reference: APL 25-008, page 5)

☐ Yes ☐ No
Citation:

21. Does the P&P state payment and/or hospice care services coverage may be denied if it is determined, based on documentation, that the hospice care services are not medically necessary or the Member is not terminally ill, with liability placed on the hospice Provider?
(Reference: APL 25-008, page 5)

☐ Yes ☐ No
Citation:

22. Does the P&P state MCP procedures must facilitate Member election of hospice care services by engaging in practices that avoid unnecessary delays and complications, as well as placing appropriate safeguards to validate Member elections and to prevent Fraud, Waste, and Abuse as outlined in the APL?
(Reference: APL 25-008, page 5)

☐ Yes ☐ No
Citation:

23. Does the P&P state the Member's election of hospice care services must include the five listed elements on the appropriate DHCS hospice election form?
(Reference: APL 25-008, pages 5-6)

☐ Yes ☐ No
Citation:

24. Does the P&P state a Member may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods?
(Reference: APL 25-008, page 6)

☐ Yes ☐ No
Citation:

25. Does the P&P state that upon Member election of hospice services, MCPs must ensure provision of, and payment for, the 12 listed hospice care services as provided by a hospice Provider, and that MCPs may require that the Member use an in-Network hospice Provider, unless Medically Necessary services are not available in-Network?
(Reference: APL 25-008, pages 6-7)

☐ Yes ☐ No
Citation:

26. Does the P&P further state physician services include: (1) general supervisory services of the hospice medical director; and (2) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician of the hospice interdisciplinary team? Also, physician services not described above must be billed to the MCP separately and include services of the Member's attending physician or consulting physician(s) if they are not an employee of the hospice or providing services under arrangements with the hospice? Additionally, physician visits by a hospice-employed physician, medical director, or consultant are billable separately to the MCP? Does the P&P note that palliative items or services in the context of Medi-Cal hospice benefits are defined separately from the services referenced in Medi-Cal Palliative Care, as defined in APL 18-020, or subsequent APLs?
(Reference: APL 25-008, page 7)

☐ Yes ☐ No
Citation:

27. Does the P&P state a Member's voluntary election may be revoked or modified at any time during a benefit period, and that to revoke the election of hospice care, the Member or Authorized Representative must file a signed statement with the hospice Provider revoking the individual election for the remainder of that benefit period, including the effective date of the revocation? Also, the hospice Provider must submit the MCP Member's signed hospice revocation statement to the Member's respective MCP within five calendar days, and the revocation effective date may not be retroactive?
(Reference: APL 25-008, page 7)

☐ Yes ☐ No
Citation:

28. Does the P&P state that at any time after revocation, or a discharge by the hospice for cause, a Member may execute a new election, if they meet hospice coverage eligibility requirements, and that if the Member is still eligible, and makes a hospice election, and is readmitted to the same or different hospice Provider, the 90/90/unlimited 60-day benefit periods of care restart?
(Reference: APL 25-008, page 7)

☐ Yes ☐ No
Citation:

29. Does the P&P state that if the Member re-elects hospice care, the hospice Provider must submit a new hospice election form to the Member's respective MCP?
(Reference: APL 25-008, page 8)

☐ Yes ☐ No
Citation:

30. Does the P&P state a Member or Authorized Representative may change the designation of a hospice Provider once in each benefit period from the original hospice Provider with which the election was made, and that this change of the designated hospice Provider is not a revocation of the hospice benefit?
(Reference: APL 25-008, page 8)

☐ Yes ☐ No
Citation:

31. Does the P&P include the four listed special considerations in hospice election MCPs are required or expected to adhere to?
(Reference: APL 25-008, pages 8-9)

☐ Yes ☐ No
Citation:

32. Does the P&P include the face-to-face encounter requirements and criteria (and may include a reference to the Medi-Cal provider manual)?
(Reference: APL 25-008, page 9)

☐ Yes ☐ No
Citation:

33. Does the P&P state MCPs must instruct staff, Subcontractors, Downstream Subcontractors, Network Providers, other programs, and out-of-Network Providers of the importance of timely recognition of a Member's eligibility for hospice care services and their election of hospice care services, and that once a Member has elected hospice care services, MCP Network Providers and

case management staff must work closely with hospice Providers to facilitate the transfer of services for the Member from those directed toward cure and/or prolongation of life, to those directed toward palliation? Also, ongoing Care Coordination must be provided to ensure that services necessary to diagnose, treat, and follow-up on conditions unrelated to the terminal illness continue to be provided, or are initiated as necessary?
(Reference: APL 25-008, page 9)

☐ Yes ☐ No
Citation:

34. Does the P&P state under the Early and Periodic Screening, Diagnostic, and Treatment benefit, children receiving hospice care services for a terminal illness and life expectancy of six months or less may receive additional services than are available for adults? That in addition to hospice care services, children and families may benefit from receiving palliative care services? Children are eligible for hospice care under the same criteria as adults (a physician certifies the Member as having a life expectancy of six months or less), although children under 21 years of age also may elect to receive concurrent curative treatment of the hospice related diagnosis and concurrent palliative care (P&P may note reference to Medi-Cal provider manual)?
(Reference: APL 25-008, pages 9-10)

☐ Yes ☐ No
Citation:

35. Does the P&P state hospice and palliative care is available for California Children's Services (CCS) eligible children (P&P may reference CCS Numbered Letter (NL): 12-1119 and NL: 06- 1011), and that MCPs should contact their respective CCS county office with questions regarding palliative/hospice services for eligible children? Also, MCPs must work with CCS to facilitate Continuity of Care, including maintaining established patient-provider relationships, to the greatest extent possible? Further, hospice care, if elected, for children with terminal illnesses requires close consultation and coordination between the MCP, the local CCS program (when applicable), and/or other caregivers? Additionally, hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition? And MCPs participating in the CCS Whole Child Model (WCM) Program as a WCM MCP must adhere to program service coverage responsibilities, policies, and requirements, as outlined in APL 24-015, and any subsequent APLs?
(Reference: APL 25-008, page 10)

☐ Yes ☐ No
Citation:

36. Does the P&P state that Under section 2302 of the Patient Protection and Affordable Care Act, effective March 23, 2010, Medicaid children who have elected to receive hospice services, or for whom hospice services have been elected, may continue to receive services to treat their terminal illness?
(Reference: APL 25-008, pages 10-11)

☐ Yes ☐ No
Citation:

37. Does the P&P state that due to the highly specialized services provided by hospices, federal law mandates that the hospice designate an interdisciplinary group(s) to plan, provide, and/or supervise the care and services offered by the hospice Provider? Also, a written plan of care must be established by the attending physician, the medical director or physician designee, and the interdisciplinary group prior to providing care, and that the plan of care is then reviewed and updated at intervals specified in the plan of care by the attending physician, the medical director or physician designee, and the interdisciplinary group of the hospice? And MCPs must assure coordination of care between MCP and hospice Providers, and allow for the hospice interdisciplinary team to professionally manage the care of the Member as outlined in law?
(Reference: APL 25-008, page 11)

☐ Yes ☐ No
Citation:

38. Does the P&P state Medi-Cal program payments for hospice services are based upon the level of care provided so that hospice Providers may group services into the listed revenue codes as outlined in the Medi-Cal Provider Manual? And that the Medicaid hospice rates for hospices' four levels of care are calculated based on the annual hospice rates established under Medicare, and that these rates are authorized by federal law, which also provides for an annual increase in payment rates for hospice care services? And MCPs must update their rates annually to coincide with changes to the Medicare rates?
(Reference: APL 25-008, page 11)

☐ Yes ☐ No
Citation:

39. Does the P&P state MCPs may pay more, but not less than, the Medicare rate for hospice services, and that the Medicaid hospice payment rates for each federal fiscal year are printed in the Federal Register? Does the P&P include the seven listed revenue codes and their corresponding level of care?
(Reference: APL 25-008, pages 11-12)

☐ Yes ☐ No
Citation:

40. Does the P&P state a hospice day billed at the routine home care level in the first 60 days of a hospice election is paid at the high routine home care rate? That a hospice day billed at the routine home care level on day 61 or later of the hospice election is paid at the low routine home care rate? And for a hospice Member that is discharged and readmitted to hospice services within 60 days of the discharge, the hospice days will continue to follow the Member at the routine home care rates outlined above (i.e. the first 60 days paid at the high routine home care rate and day 61 or later paid at the low routine home care rate)? Also, if the hospice Member is discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the Member's 60-day window, paid at the routine home care high rate upon the new admission? Additionally, routine home care days that occur during the last seven days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment?
(Reference: APL 25-008, page 12)

☐ Yes ☐ No

Citation:

41. Does the P&P state MCPs must pay inpatient rates (general or respite) for the date of admission and all subsequent inpatient days, except the day on which a Member is discharged? And for the day of discharge, MCPs must pay the appropriate home care rate (routine or continuous) unless the Member dies as an inpatient? And that if the Member dies while an inpatient, the MCP must pay the inpatient rate (general or respite) for the discharge day?
(Reference: APL 25-008, page 12)

☐ Yes ☐ No
Citation:

42. Does the P&P state that pursuant to the MCP Contract, hospice services are Covered Services and are not categorized as Long-Term Care (LTC) services regardless of the Member's expected or actual length of stay in a nursing facility (NF) while also receiving hospice care?
(Reference: APL 25-008, page 12)

☐ Yes ☐ No
Citation:

43. Does the P&P state MCPs cannot require authorization for room and board for Members receiving hospice services and residing in a skilled nursing facility (SNF)/NF or intermediate care facility (ICF) as described in federal law?
(Reference: APL 25-008, page 12)

☐ Yes ☐ No
Citation:

44. Does the P&P state a Member who is a resident of a SNF or ICF may elect hospice care, and that payment from the MCP will be provided to the hospice for hospice care services (at the appropriate level of care)?
(Reference: APL 25-008, page 13)

☐ Yes ☐ No
Citation:

45. Does the P&P state the hospice Provider must reimburse the facility for the room and board at the rate negotiated between the hospice Provider and facility? That payment for the room and board component must be equal to at least 95 percent of the reimbursement the NF/SNF would have been reimbursed by Medi-Cal or the MCP, less the Member's share of cost, if applicable? That payments by a hospice Provider to a nursing home for room and board must not exceed what would have been received directly from Medi-Cal or the MCP if the Member had not been enrolled in hospice?
(Reference: APL 25-008, page 13)

☐ Yes ☐ No
Citation:

46. Does the P&P state LTC Members who elect the Medi-Cal hospice benefit are not disenrolled from the MCP, and that hospices will bill the MCPs using the six listed revenue (and facility type) codes?
(Reference: APL 25-008, page 13)

☐ Yes ☐ No
Citation:

47. Does the P&P state that for all Members with both Medicare and Medi-Cal coverage (dual eligibles), MCPs must ensure that Medicare remains the primary payor for the hospice care services, and MCPs must cover cost sharing for contracted services?
(Reference: APL 25-008, page 13)

☐ Yes ☐ No
Citation:

48. Does the P&P state that for dually eligible SNF residents, in accordance with Medicare policy (may reference Medicare Benefit Policy Manual, Chapter 9 section 20.3) payment for room and board must be made directly to the hospice Provider? That the room and board charge billed to the MCP as the hospice benefit under Medicare does not cover room and board? And that following payment from Medicare, the hospice Provider then bills the MCP for the Medicare co-payment amount; however, the total reimbursed amount cannot exceed the Medicare rate? And for Medicare Members entitled to only Medicare Part B, benefits will be billed directly to the MCP? And no Medicare denial will be required?
(Reference: APL 25-008, page 13)

☐ Yes ☐ No
Citation

49. Does the P&P state MCPs cannot require authorization for the hospice Provider to bill the MCP for the room and board covered by Medi-Cal while the patient is receiving hospice services under Medicare? Additionally, MCPs cannot require a copy of an Explanation of Benefits, Remittance Advice, or denial letter from Medicare to accompany room and board claims?
(Reference: APL 25-008, pages 13-14)

☐ Yes ☐ No
Citation:

50. Does the P&P state the hospice Provider must submit the DHCS election form to both DHCS and the Member's respective MCP (if enrolled in an MCP) for dual eligibles when a Member elects the Medicare hospice benefit?
(Reference: APL 25-008, page 14)

☐ Yes ☐ No
Citation:

51. Does the P&P state the MCP will then pay the room and board payment to the hospice Provider according to the rate as previously outlined, and the hospice must be responsible for paying the nursing home? That the eligibility for the Medi-Cal nursing home room and board payment continues to be determined by the nursing home and the MCP, and that the nursing home continues to remain responsible to collect the LTC share of cost, if applicable?
(Reference: APL 25-008, page 14)

☐ Yes ☐ No
Citation:

52. Does the P&P state that if hospice services, including room and board services, are covered by a recipient's Other Health Coverage insurance, MCPs must ensure hospice Providers bill the Other Health Coverage prior to billing Medi-Cal, and that a copy of the Explanation of Benefits, Remittance Advice, or denial letter must accompany each Medi-Cal claim for services?
(Reference: APL 25-008, page 14)

☐ Yes ☐ No
Citation:

53. Does the P&P state hospice Providers must use Revenue Code 0657 when billing for physician services for pain and symptom management related to a Member's terminal condition and provided by a physician employed by, or under arrangements made by, the hospice Provider, and that MCPs are required to reimburse Revenue Code 0657, which is limited to one visit-per-day, per-Member?
(Reference: APL 25-008, page 14)

☐ Yes ☐ No
Citation:

54. Does the P&P state that consulting/special physician services Revenue Code 0657 may be billed only for physician services to manage symptoms that cannot be remedied by the Member's attending physician because of one of the two listed circumstances?
(Reference: APL 25-008, page 14)

☐ Yes ☐ No
Citation:

55. Does the P&P state that the Medi-Cal Fee-For-Service (FFS) program does not permit Prior Authorization of hospice services, except for inpatient admissions, as outlined in state law; therefore, MCPs adhere to the same Utilization Review standards as required by federal law?
(Reference: APL 25-008, pages 14-15)

☐ Yes ☐ No
Citation:

56. Does the P&P state hospice Providers must submit the DHCS hospice election and addendum forms containing the necessary information and appropriate signatures to the Member's respective MCP, as previously outlined?

(Reference: APL 25-008, page 15)

☐ Yes ☐ No
Citation:

57. Does the P&P state that per Medicare policy (Medicare Benefit Policy Manual (Chapter 9) section 40.1.5), general inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot appropriately be provided in other settings? And that skilled nursing care may be needed by a Member whose home support has broken down, making it no longer appropriate to furnish needed care in the home setting? Also, general inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit? (P&P may include examples provided in APL)
(Reference: APL 25-008, page 15)

☐ Yes ☐ No
Citation:

58. Does the P&P include the five listed services not covered by a hospice Provider?
(Reference: APL 25-008, page 15)

☐ Yes ☐ No
Citation:

59. Does the P&P state MCPs are reminded to remain proactive and vigilant regarding program integrity requirements, especially those that address Fraud, Waste, and Abuse, as outlined in the MCP Contract and other policy guidance?
(Reference: APL 25-008, pages 15-16)

☐ Yes ☐ No
Citation:

60. Does the P&P state DHCS expects MCPs to apply appropriate compliance review protocols and procedures regarding claim processing and Utilization Management systems upon receipt of a hospice election form and/or hospice claim to identify a Member as receiving hospice, and that protocols and procedures also include informing the Member's PCP to notify them of the Member's election to hospice and adding any other system indicators to flag Members receiving hospice services?
(Reference: APL 25-008, page 16)

☐ Yes ☐ No
Citation:

61. Does the P&P state DHCS places an indicator in the Medi-Cal Eligibility Data System to designate Members in FFS receiving hospice services, and that as such, DHCS expects MCPs to initiate the same system changes when their Members have been designated as hospice with a "900" restricted services code as indicated in the eligibility files provided by DHCS to the MCPs?
(Reference: APL 25-008, page 16)

☐ Yes ☐ No
Citation:

62. Does the P&P state MCPs must examine documentation received from the hospice Provider to determine the qualification of the Member to receive hospice, and that if appropriate, MCPs should request additional documentation for such a determination, to confirm proper and appropriate claim payments and service authorizations are made, and not based on fraudulent submissions? (Reference: APL 25-008, page 16)

☐ Yes ☐ No
Citation:

63. Does the P&P acknowledge MCPs are still contractually obligated to report complete, accurate, reasonable, and timely submission of Encounter Data, and that DHCS requests, in particular, MCPs provide data for the referring Provider (attending physician), rendering Provider (hospice Provider), and the starting day of service data fields to assist DHCS in its program integrity activities? (Reference: APL 25-008, page 16)

☐ Yes ☐ No
Citation:

64. Does the P&P state that at any time, DHCS may inspect and audit MCP records, documents, and electronic systems to ensure compliance with service delivery and/or claim payments? (Reference: APL 25-008, page 16)

☐ Yes ☐ No
Citation: