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SPEAKERS

Kristin Mendoza-Nguyen
Dana Durham
Beau Bouchard
David Tran

Kristin Mendoza-Nguyen:

Good afternoon everybody and happy Friday. Going to give a couple minutes just so the waiting room folks join in. Welcome to today's webinar. This is the CalAIM: SNF Carve-In Billing and Payments. This is the third webinar in this series and we're very delighted to have you all today. We have some great presenters for today's webinar. We have Dana Durham, Chief of the Managed Care Quality and Monitoring Division at DHCS, Beau Bouchard, Assistant Division Chief of Capitated Rates Development Division, and David Tran, Senior Manager of Contracting and Network Development from Health Net as a guest speaker. The PowerPoint slides in today's meeting materials will be available on the website. The team will put it in the chat. All materials from previous carve-in webinars are also on that website. So, please do take a look at those, I know we got some questions about the previous materials.

Kristin Mendoza-Nguyen:

DHCS has also published a frequently asked questions or an FAQ document on the webpage as well, so the link will be there for you guys to reference. Next slide please. So for today, we do request you all to add your organization to your Zoom name. It helps with tracking questions. So, if you click the three little dots on your name, you can click rename and you can add the organization name so we can track them. Next slide. Just a couple of meeting management items for today. This webinar is being recorded. All participants are going to be in listen only mode. We'll be using the chat feature for all of the Q&A sessions for today's webinar. And then lastly, there's going to be three different Q&A sessions throughout this presentation. I know there's been lots of questions in previous webinars, so we just wanted to leverage the time and highlight the topic specific for today, which is Billing and Payments. And with that, I will turn it over to Dana to start us off.

Dana Durham:

Thank you so much. Well as said previously, we're really happy to have you here today. Do want to note, we have done the welcome and introductions. So past that point, we'll be going over the Long-Term Care Carve-In Transition, give you some background and overview overall and do a little bit of questions and answers. Then we'll talk to you about the directed payment policy and payment requirements. And then we'll talk about promising practices, as well as have some guests from our managed care plans, which we're excited about that, and then we'll do next steps and closing. But with that, there is a lot on this agenda, so let's go to the next slide. And this is just really an introduction to what we're doing overall. So, just want to note that as we look at an overview of the Carve-In and managed care plans as the delivery system, that's where we'll start. Next slide please.

Dana Durham:

So, as we look at the [Skilled] Nursing Facility Carve-In as an overview, as many of you know or probably most of you know because you're in the webinar, effective January 1st, 2023, managed care plans in all counties will cover the long-term care benefit for skilled nursing facilities. All Medi-Cal beneficiaries residing in a long-term care facility

are mandatory to enroll in a managed care plan for the Medi-Cal covered services. And the reason we're doing this really is to standardize the coverage of skilled nursing facilities statewide. So it really is more consistent, seamless, and integrated as a system of managed care that really reduces for our beneficiaries the complexity, and increases flexibility. So if you're going from one area of the state to another, the expectations don't change and you don't have to learn anything else. It also increases the ability to do comprehensive care coordination, care management, and introduces a broad array of services for Medi-Cal beneficiaries in skilled nursing facilities. Next slide please.

So, just to talk a little bit about what's changing, all Medi-Cal only and dual eligible beneficiaries in fee-for-service residing in a SNF on January 1st will be enrolled in a Medi-Cal managed care plan. And that'll either happen effective January 1st or February 1st of the upcoming year, which is just around the corner, so it's happening really soon. So, beneficiaries who enter a skilled nursing facility and otherwise would've been disenrolled from managed care, will remain in managed care ongoing. And this will include most Medi-Cal beneficiaries including those who have Medi-Cal only, dual eligible beneficiaries, so those eligible for both Medicare and Medi-Cal, and Medi-Cal beneficiaries with other health coverage, and that can include private insurance. And also those who have a Share of Cost in long-term care aid codes. Next slide please.

Dana Durham:

And so, this is going to impact approximately 28,000 members residing in a skilled nursing facility, they'll be carved into managed care. And the map that you have really shows where managed care is already carved in and that is in [purple]. And then counties where skilled nursing facility services will be carved into managed care is in the blue. And so, dual eligible members represent the majority of those residing in skilled nursing facilities that will be transitioning. So, as you look at this map, you'll see that a large portion of our state is already having beneficiaries carved into managed care, but this is completing it where it's consistent across the state. Next slide please. So, a little bit of the key activities that have happened or are happening really are that detailed member data was shared with managed care plans beginning in November and that includes utilization data and Treatment Authorization information. And managed care plans and skilled nursing facilities are working to coordinate with each other to share data to really facilitate that seamless transition for members and help ensure coverage.

Dana Durham:

Members and their Authorized Representatives received a 60-day skilled nursing facility long-term care carve-in notice and Notice of Additional Information in early November as well as 30-day member notices were received by December 1st. Members were also allowed to have choice, and those Choice Packets were mailed at the end of November. Choice Packets that were mailed only to members not part of the Medi-Cal matching plan policy. So, that is when a plan had a facility in their network. That was our priority. Health Care Options member outbound call campaign that starts this month. So they'll be calling beneficiaries to make sure that they know options and can make choices. And finally the managed care plans and the skilled nursing facilities are engaged in outreach, communications and finalizing – it says contract negotiation, but I think we're

more at the point of finalizing where we are with those negotiations. And at this point, we'll go through questions and answers.

Kristin Mendoza-Nguyen:

Great. Thank you, Dana. We did get a couple of questions through the registration form so I'm going to just kick off with one or two of those. So, the first question is "What will happen to all the other plans that currently hold LTC lives in the counties that were CCI?"

Dana Durham:

If you're in a CCI county, there really isn't a change in what's happening with individuals. Skilled nursing facilities have already been carved in and they will continue to operate as they've been operating.

Kristin Mendoza-Nguyen:

Okay, great. And then "What happens if a SNF is not in the network of a plan auto assigned to a resident?"

Dana Durham:

Well, the goal was to make sure that there is matching and so that was the first thing we did, was match skilled nursing facilities to individual plans and their networks. There always is the ability of an individual to choose a plan and that's either through those Choice Packets I talked about and/or through... a member can always call up and change the plan if they want to. So that could happen. And the individual could change plans if there's a plan that they would prefer to be in. So, if that is a mismatch and you're aware of it, you should work with the individual to make sure they're in a plan that works with your skilled nursing facilities.

Dana Durham:

However, that's the first part of the answer, but the second part of the answer is if the skilled nursing facility is not contracted with the plan, then they will be able to have continuity of care with the skilled nursing facility that they are in. And plans are actively working on making sure that individuals do not have to move. So, I hope that I answered the question but feel free to follow-up if you have something else with that.

Kristin Mendoza-Nguyen:

Okay, great. And there's a question I've also received before and in the chat, it's a similar question is, "Will the facility or the primary clinic physician provider be responsible for SNF authorization from MCP?"

Dana Durham:

So, the authorization will mirror what happens in fee-for-service now. Either can request that authorization. So, the facility can request or the physician can request that authorization and you would want to work with the managed care plan, make sure you

knew their processes, so that you could be consistent with them. But if there's some misunderstandings or something, they will follow up with you and make sure that you're on the same page.

Kristin Mendoza-Nguyen:

Okay. "Are there limits for the number of times a member can change plans?" from Tina in the chat.

Dana Durham:

It is on a monthly basis so you can't change in the middle of a month, but with that, you can change at other points on a monthly basis.

Kristin Mendoza-Nguyen:

Okay. So this is from Theresa, "We are a large SNF with a rehab unit. If a patient converts from short-term rehab to long-term care custodial and they're from a different county – we are in San Francisco – it can take 60 days to process an inner county transfer. Will the MCP from the other county pay our facility while the ICT is in process?"

Dana Durham:

So, I'm going to answer on a general basis because honestly, that is a little bit specific. Everyone in managed care has a residence that is of record and so they're enrolled into a managed care plan through their county of record and that county of record processes that request and that county of record is responsible until someone changes county. So, even though you're not necessarily in the same county as the individual is authorized through, that managed care plan that they're with would be responsible for working with you. And if the individual transferred to a different county, say the county you're in, then the managed care plan would switch at that point. But it is about the residence through which the individual is enrolled.

Kristin Mendoza-Nguyen:

Okay. In the chat from Shannon, "Will DHCS be providing more information on how to identify the LTC SNF numbers newly carved in the utilization data?" She's referencing the APCD files.

Dana Durham:

So that's more of a technical question and if you're a managed care plan and you have questions about that, you should really talk with the group that you're getting those files from. I don't think we have anyone on the call who can answer that question, but we certainly will take it back and see what we can do to identify someone who can answer that question.

Kristin Mendoza-Nguyen:

Okay. And then last question, "How is transportation managed, only those contracted with managed care plans?"

Dana Durham:

Yes, the transportation is managed through the managed care plan and they're responsible for contracting with and making sure the individuals have appropriate transportation.

Kristin Mendoza-Nguyen:

Okay, great. So that was…

Dana Durham:

Sorry. As far as appropriate transportation, appropriate method, so if you need a certain type of transportation, that will be managed through the managed care plan and their process is to ask them.

Kristin Mendoza-Nguyen:

Okay, great. Thank you, Dana. So, that closes out our first Q&A for right now, so I will go ahead and transition over to the next portion which is our directed payment policy and payment requirements overview. So, I will turn it over to Beau for the presentation.

Beau Bouchard:

Thanks, Kristin. Yeah, so I'll be going over the carve-in directed payment policy and payment requirements overview, mainly outlined in our APL 22-018 and just wanting to make sure and call out the importance of these requirements and some of the nuances between different counties. Next slide please. So, the directed payment policy is that managed care plans must reimburse a network provider furnishing SNF services to a member and that each network provider of SNF services must accept the payment amount the network provider would be paid for those services in the fee-for-service delivery system, and you can see the Welfare and Institution Code listed there. And that DHCS will operationalize the policy as a state directed payment subject to approval by CMS. And that the managed care plans 2023 rates that they'll be receiving here shortly, will be including funding levels based on the projected directed payment in 2023. Next slide please.

Beau Bouchard:

So some of those nuances I just talked about. So for new transitioning counties where this carve-in is going to be new starting 1/1/23, managed care plans in counties where coverage of SNF services is newly transitioning from the fee-for-service delivery system to the managed care delivery system, must reimburse network providers of SNF services for those services at exactly the Medi-Cal Fee-For-Service per-diem rate, applicable to that particular type of institutional long-term care provider. And so below, there is a list of the counties that are considered new or transitioning. Go ahead and next slide please. So for existing counties who are not transitioning due to this Carve-In, the managed care plans in those counties where the SNF services are already a Medi-Cal covered service, they must reimburse the network providers of SNF services for those services at no less than the Medi-Cal Fee-For-Service per-diem rates applicable to the particular type of institutional long-term care provider.

Beau Bouchard:

We have a list of counties here, but these would be our COHs and CCI counties. All right, next slide. Excuse me. So what is covered under the SNF directed payment policy? The reimbursement requirement only applies to SNF services as defined in the Title 22 CCR, section 51123(a), 51511(b), 51535 and 51535.1 as applicable. And it does imply or is required at the first day of the member's stay. It does not apply to any other services provided to a member receiving SNF services such as, but not limited to, services outlined in 22 CCR sections 51123(b) and (c) and 5511(c) and (d), services provided by an out-of-network provider of SNF services or services that are not provided by a network provider of SNF services. Such non-qualifying services are not subject to the terms of the CMS approved state directed payment and are payable by managed care plans in accordance with the MCP's agreement with the network provider.

Beau Bouchard:

And then just making a quick note here as well for some of the SNF services that apply or do not apply, these services are also outlined in the Medi-Cal Handbook. I'm not as familiar with it, but I just wanted to call that out that it does call out the services that are a part of the per-diem and then the services that are excluded from the per-diem for reference. And so that'll transition us to the next slide for the per-diem rate. So the included SNF services within the per-diem rate are the rates for the long-term care facilities, which include all supplies, drugs, equipment and services necessary to provide a designated level of care. Other inclusive items include the room and board, nursing and related care services, personal hygiene items, and then the routine therapy services. The managed care plans are obligated to pay for all SNF levels of care including custodial, skilled nursing facility care, and intermediate care. And so there's a link in the slide deck at the bottom for additional information on the Medi-Cal Provider Manual for the inclusive and exclusive services. Next slide.

Beau Bouchard:

For the per-diem rate, inclusive therapy services. So, what therapy services are covered under the per-diem rate? So in other words, inclusive services. The per-diem Medi-Cal Provider Manual, in many cases, therapy services needed to attain and or maintain the highest practical level of functioning can and should be performed as part of the nursing facility inclusive services rendered to the Medi-Cal resident in the nursing facility. For example, keeping recipients active and out of bed for reasonable periods of time except when contradicted by a physician's order. These routine therapy services would be subject to the directed payment policy outlined in 22- and I believe it should... 22-008, sorry. Next slide.

Beau Bouchard:

The exclusive therapy services. When are therapy services no longer considered routine and can be covered outside the per-diem rate? A physician must determine if a patient requires intensive therapy beyond the normal course typically provided to SNF residents to attain or maintain the highest practicability, occupational, mental and

psychosocial functioning in accordance with their individualized plan of care. MCPs and SNFs can negotiate payment for such services outside of the directed payment. Further details regarding exclusive services not covered under the per-diem are available at the link here for the TAR Criteria For Authorization. Next slide.

Beau Bouchard:

So, exclusive SNF services. So services outside the per-diem rate are not subject to the directed payment policy and would follow the normal managed care plan and provider negotiation process. These exclusive items are separately reimbursable and subject to the utilization review controls and limitations of the Medi-Cal program. Exclusive items not included in the per-diem rate include supplies, drugs, equipment or services such as durable medical equipment, laboratory services and x-rays, and dental services. And there's a link here for that Medi-Cal Provider Manual with the inclusive/exclusive services. And then some of the services that are excluded are outlined in that 22 CCR that we referenced in one of the previous slides. Next slide.

Beau Bouchard:

Other payment requirements in 22-018, and I think it was a slide or two where it said 008, so just acknowledging a typo there. MCPs are required to provide a process for SNFs to submit electronic claims and receive payments electronically if requested. Ensure network providers of SNF services receive required reimbursement regardless of subcontractor arrangements. Pay timely in accordance with prompt payment standards within their contract, including any additional amounts that are owed by virtue of retroactive adjustments to SNF Fee-For-Service per-diem rates. Coordinate benefits for members with other healthcare coverage. Pay the full deductible and coinsurance for dual eligible individuals. And then just a couple of notes here with DHCS guidance for the new workforce – or the transitioning Workforce Quality Incentive Program established under AB 186, will be forthcoming and there's a link here for some additional information on the program. And then there's also going to be some additional details of reimbursement requirements that are applicable to publicly owned distinct part nursing facilities. That will be forthcoming separately as well. Next slide.

Beau Bouchard:

So, Pharmacy Coverage and Payment. The SNF Carve-In policy does not make any changes to the coverage policies for pharmacy benefit coverage nor make any changes to Medi-Cal Rx. The financial responsibility for outpatient prescription drugs is determined by the claim type of which they're billed. If drugs are dispensed by a pharmacy and billing on a pharmacy claim, they're carved out of the managed care benefit and covered by Medi-Cal Rx. If the drugs are provided by the SNF and billed on a Medi-Cal or institutional claim, the managed care plan is responsible for those. If the prescribing provider at the SNF determines a patient or resident requires treatment that is administered onsite with a stock medication at the SNF or not ordered or filled by an outpatient pharmacy, this would be part of a Medi-Cal visit claim and would not be covered by Medi-Cal Rx and is the responsibility of the managed care plan. And there's a couple links here as well with some additional information on Medi-Cal Rx. So that brings us to the question section.

Kristin Mendoza-Nguyen:

Great. Thank you, Beau. All right, so the number of questions come in, I'll kick us off. “Will the annual rates be updated online more quickly than it has been in the past?”

Beau Bouchard:

And that, I'll defer. I know we have some Fee-For-Service Rates Development folks on the line, so I will let them answer that question.

Christie Hansen:

Thank you, Beau. This is Christie Hansen with Fee-For-Service. That's a question I'll have to take back in writing to my team and provide a response in writing.

Kristin Mendoza-Nguyen:

Okay. Thank you, Christie. From Paul, "For new counties, are you saying we must reimburse at Medi-Cal fee-for-service rate or at least? What if we have a new contract with the provider for a higher rate?"

Beau Bouchard:

Yeah, so any transitioning county, so any new county that's carved-in, for anything that's any of the SNF services that are covered under the per-diem rate today, the plan is required, and the provider must accept the Fee-For-Service rate, not as a floor but as both the floor and a ceiling. So it's the exact Fee-For-Service per-diem rate for those SNF services that would be covered under the per-diem rate.

Kristin Mendoza-Nguyen:

And then from Janine at Blue Shield, "Will any of the new SNF appeal rates be posted on the website?"

Beau Bouchard:

That's going to be a Fee-For-Service question as well.

Christie Hansen:

Christie Hansen again. I'll take that back to my team and provide a response in writing.

Kristin Mendoza-Nguyen:

Question from Beth, "Please confirm if Medi-Cal fees for patients receiving skilled services will be included in WQIP calculation?"

Beau Bouchard:

So, I don't know if I have anyone on to speak specifically to the WQIP program. I know there's other forums and other meetings that we’re having with the different providers and managed care plans on this program. So Beth, I would say to go ahead and send

those questions in to the WQIP team or I can also take that back and flag it for them to follow up.

–Kristin Mendoza-Nguyen:

From Debbie, “Our facility currently bills Medi-Cal weekly. Will we be able to do this with the MCPs?” We’ll have to take that one back I think... Oh, go ahead, Beau.

Beau Bouchard:

No, I was going to say it sounds like we’re going to take it back. That’s not in my area and I don’t know if we have any folks on the line that can speak to it.

David Tran:

This is David Tran from Health Net of California and for Health Net of California: yes.

–Kristin Mendoza-Nguyen:

Okay. Thank you, David. There’s been a couple questions on routine therapy. Beau, do you mind kind of expanding on that a bit? There’s been a couple folks asking for clarification on those.

Beau Bouchard:

Yeah. Again, this is something I think we’d have to take back. I don’t know if our Fee-For-Service folks can speak to it, but the definition of this services are not something that the Capitated Rate section oversees, so happy to take it back and discuss internally.

Christie Hansen:

Yeah. Thank you, Beau. Fee-For-Service will take it back and we can also connect with Benefits if need be.

–Kristin Mendoza-Nguyen:

Okay. Question from Barbara, “To confirm, if a resident’s level of care is custodial, the MCPs are required to reimburse at the AB 1629 rates. However, if the level of care becomes skilled, then the MCP and SNF will and can negotiate a higher reimbursement if such language is not already set in your contracts.” Bit more of a clarification question.

Beau Bouchard:

I don’t know if I can confirm that specific example, but I can just go back again to state that if the services fall within the per-diem rate, you would be required to pay the Fee-For-Service per-diem rate for those services. If the services fall outside of the per-diem rate, the plans and providers are free to negotiate as they do today.

–Kristin Mendoza-Nguyen:

Okay. I don’t see-

Beau Bouchard:

Sorry, for the newly transitioning counties, just to clarify.

–Kristin Mendoza-Nguyen:

I don't see too many other payment questions, so I'm going to scroll up to the... I know we received some others from earlier. So this might be something where' either Dana or potentially Bambi, if you want to weigh in on. "What are the reasons a resident is not eligible to enroll into managed care plan?"

Dana Durham:

I think we're going to have to take that one back. I'm not as familiar with the enrollment requirements, so I think we'd take that one back and look at it. There aren't many, I'll start by saying that. It is that most individuals who are in skilled nursing facilities are enrolling in [MCP]s, but we certainly can get more information on that question.

Kristin Mendoza-Nguyen:

Okay. "Will SNFs follow the current DHCS discharge appeals process that is managed by DHCS?"

Dana Durham:

The appeal process does remain the same for managed care plans. So, if someone has a grievance or appeal, they first go through their managed care plan and then there are processes after that that are... such as state fair hearing and possibly an independent medical review. It's not exactly the same as Fee-For-Service, but it is the appeals process for the managed care plan.

Kristin Mendoza-Nguyen:

And then an earlier question from Jessica that we ran out of time for, "Many of my residents are being matched to Anthem Medi-Cal. We prefer San Francisco Health Plan and did some online elections for that, but received notifications that the members aren't eligible for that election currently, but it will be saved for future elections?"

Dana Durham:

Can you read that one again, Kristin? I'm sorry, my mind didn't capture it.

Kristin Mendoza-Nguyen:

No worries. "Many of my residents are being matched to Anthem Medi-Cal. We prefer San Francisco Health Plan and did some online elections but received notification that the members aren't eligible for that election currently, but it will be saved for future elections?"

Dana Durham:

Since we're doing sharing of data, those who've been matched are at a point where they can't change right now, but they can change as soon as the transition is complete.

Now it looks like Anastasia has something to add to this, so totally would love to hear that.

Anastasia Dodson:

I just saw the note from Janine. There is that Medi-Cal matching plan policy. So, if someone is enrolled in a Medicare Advantage plan and that Medicare Advantage plan has a corresponding Medi-Cal plan in that county, then we have a process in certain counties where we automatically enroll that individual into the Medi-Cal plan that matches their Medicare plan. It's not in all counties, but it is in the large Southern California counties and then San Francisco Bay Area – 12 counties. Thank you, Janine. So, hard to tell if that's the individual scenario that's happening but it could be.

Kristin Mendoza-Nguyen:

Great. Thank you.

Dana Durham:

And if you have questions about specifics, we probably can follow up on those but you'd need to follow up differently and we'd need permission to share information with you from specific individuals.

Kristin Mendoza-Nguyen:

Earlier question, "We have not received any letters for residents. Are we expecting actual letters soon?" So it might be about member notices.

Dana Durham:

Yeah. And our specialists who work in that area aren't on the call, so I'll let you know that the residents receive the notices. The facilities wouldn't receive the notices in the same way, but the residents are the ones that receive notices at their address that is on record, so just want to make that clear.

Kristin Mendoza-Nguyen:

Okay. Question from Sarah, "Will all MCPs be required to approve authorizations even if the request is outside of 30 days? Specifically referring to beneficiaries who are retro approved, will all MCPs be required to approve an auth if LTSS is confirmed to be required?"

Dana Durham:

I'm not sure I totally understand that. I think we talked a little bit about that if someone is residing in a facility, that they would continue to stay in that facility. As of January 1st, that authorization process moves to the managed care plan that the individual is in instead of being something that would go through the department. But if someone is existing in a facility, the goal is to not move them. And so, would appreciate if that answered the question or in the chat, please let us know if you have additional questions regarding that.

Kristin Mendoza-Nguyen:

“Will the claims go through the DHCS CMC website or be billed directly to the plan?”

Dana Durham:

They're billed to the plan.

Kristin Mendoza-Nguyen:

“If the enrollment date is 2/1/2023, will the MCL system reflect pending MCP enrollment January 1st, 2023?”

Dana Durham:

I don't think we have our experts who can talk about the enrollment process on the phone today, so we'll have to take that one back.

Kristin Mendoza-Nguyen:

Okay. Let's see. There's more questions on choice forms, but we don't have those folk. Any other questions? I don't see any other questions coming in. We do have a couple more minutes, but I think we have another Q&A session at the very end so we'll just go ahead and transition to the Billing and Promising Practices portion. So Dana, I will turn it back to you.

Dana Durham:

Great. Thank you so much. So we're going to talk about promising practices. So these are things that we've found over time to be things that really do show up to be really good ways of interacting between the skilled nursing facility and the managed care plan. And we're lucky enough that we have managed care plans who are going to specifically talk about this in a minute, but if you'll go to the next slide. So, some of the things that really help move the relationship forward are really prioritizing that engagement that really supports the managed care plan and the skilled nursing facility and making sure that there's quite a bit of conversation going on on both sides and that they're talking to each other. That helps identify challenges and really helps us know best practices that really have helped us inform where things can really be improved as we take the CCI Carve-In and make that more applicable to the larger and the additional individuals who will be transitioning.

Dana Durham:

And so what we've done is leverage experience from counties where long-term care is currently carved in to managed care, to inform some ways that really that transition can be improved in ways that plans and SNFs should focus. Next slide, please. So some of those promising practices are around prompt claims and payments. One of the things that really has helped with some of the plans and SNFs and areas is making sure there are shorter payment timeframes for clean claims and that really helps the provider operations in the skilled nursing facilities. And that's kind of in response to some skilled nursing facilities have reported challenges around being paid timely. And that's because

that really impacts some of the skilled nursing facilities because sometimes, they don't have the financial reserves or a diverse payer mix that might impact their ability to continue and so they rely on prompt payments from Fee-For-Service and plans.

Dana Durham:

So, the suggestion and what we found to be the promising practice is the working closely with the skilled nursing facilities and managed care plans to set up a way to receive electronic fund transfers, to receive timely payment if that electronic fund transfer is requested. And the APL that we have out, 22-018, states that manage care plans must pay timely in accordance with prompt payment standards within their contract, including any additional amounts that are owed to a network provider of a skilled nursing facility, by virtue of retroactive adjustments to the Medi-Cal Fee-For-Service per-diem rate. So next slide, please. Clean Claims. What is a clean claim? Well, that's good to know and one of the things that managed care plans have reported is sometimes, the claim can't be paid because it's not what's called a clean claim. And a clean claim would mean it contains all of the information that is needed to pay.

Dana Durham:

And the managed care plan and DHCS contract specifies that the managed care plan shall pay 90% of all clean claims from providers within 30 days of the date of receipt and 99% of all clean claims within 90 days of the receipt. So one of the best practices really is to have the managed care plan and the skilled nursing facility work together to ensure that they understand what a clean claim is, what's required and how's it submitted. And the managed care plan Long-Term [Services and Supports] Liaison could potentially support in helping resolve any claims challenges that exist. So, we've really found that work together with the skilled nursing facility and the managed care plan to understand what a clean claim is and how to make sure that any claim has all those requirements met. Next slide, please.

Dana Durham:

So the Claim Forms used to bill Medi-Cal are specified here. Those are the ones that have been used long term. Now the managed care plan may have a different form that they want you to use. These are the ones that had typically been submitted when billing Fee-For-Service Medi-Cal. But the managed care plan is familiar with all these forms and you should work with your managed care plan to understand what form is required and what kind of information they need to be able to pay on a clean claim. Next slide, please. So, some tips for billing is that you should work to validate billing codes with the managed care plan. So don't let something hit you reactively. Be proactive in working with your managed care plan to know those codes that should be utilized to ensure a clean claim.

Dana Durham:

If you have a bed hold, check regularly for recipients on leave at home, at an acute care hospital and transferred to another facility. So make sure that you know what's happening with those you've got a bed hold for. Verify that the dates of service on claim

reflect only the dates of services rendered and verify that the dates of service on the claim match the approved dates within the prior authorization for managed care plans. Verify that the facility to which the recipient was transferred is billed correctly. For dual beneficiaries, bill Medicare or the other health coverage within one year of the month of service to meet timeliness requirements and submit claims to California MMIS physical intermediary within 60 days if it's a Fee-For-Service claim, or you need some help in really understanding what the other health coverage carrier is doing or you need to resolve that.

Dana Durham:

And confirm that the patient status code agrees with the accommodation code and an example of that really is, if the status code indicates leave days, the accommodation code should also indicate leave days. Next slide, please. And we're going to provide you the slide deck and just know that there's some additional tips and resources for billing and they let you know what's out there and make sure that you're aware of billing practices. Next slide please. And with that, I know we've got lots of questions in the chat, but I really am excited about David Tran coming and talking to us from Health Net and talking to us about billing practices overall. So I'll turn it over to him and we'll have him present for us. David?

David Tran:

Thank you, Dana and DHCS for inviting us to present at this webinar. I want to briefly start off by just giving a quick overview of Health Net, specifically for the Medi-Cal population here in California. We have been partnered with the state to serve the Medi-Cal population, I want to say for almost 40, 45 years roughly. Currently for the Health Net market, we are in nine current markets for the Medi-Cal population. Our sister company, California Health & Wellness has 19 counties that they currently operate in and for CalViva Health, who we are a county partner with, there are three counties that we cover. We're currently in two CCI counties for Los Angeles as well as San Diego, covering in total of over two million Medi-Cal members in the state of California.

David Tran:

One of the big questions that we were asked is what can SNFs expect when working with managed healthcare plans? I assume that many of the participants on this call are familiar with our company as well as my team who have done numerous outreaches to the SNF community over the last 15 years or so, trying to build out our network. We have several dedicated teams working with long-term care providers to address a multitude of different issues, from contracting, to authorization, to claims to issue resolution. I just want to say that Health Net is here really to partner with the SNF community to make sure that we are working together as partners to ensure a smooth transition and work alongside the SNF community to ensure that any and all problems that arise are going to be addressed by Health Net.

David Tran:

Dana had previously presented in the previous slide some very good resource links on the DHCS website to FAQs, billing information, crossover, and I just want to emphasize that when my company has reviewed a lot of those links, a lot of good information is available on those links. As many of the facilities on here in the CCI counties who have worked with us before, those resources were not available when LTC was first launched. And DHCS has done a wonderful job in building out all of those resource materials that helps not only the providers, but as well as health plans follow a guide on how billing should be done. I've attached it in the slide, you guys can see it, the FAQ link, I think it's a very good resource. Within that link, there are numerous links that the SNF communities should be aware of.

David Tran:

One of the other big questions that everybody seems to be questioning and I'm looking at the chats now, everybody is talking about billing. Health Net recommends that all of the facilities do go onto our Health Net provider portal website to register for an account. The portal contains numerous resources and communications related to long-term care, to billing, to medical policies. It's a great resource that everyone should do in addition to our web portal, not just registering so that you can bill claims electronically, which I do want to mention that Health Net does accept EDI claims whether you are registered or not. You just need to make sure that you provide your clearinghouses with the correct payer number.

David Tran:

But once you do register for our website... and can we jump to the next slide real quick, Dana? I just wanted to screen print what our web portal looks like there. The arrow on the left does show you where you can log in or register. There's a tab on top for the provider section of our web portal and I just wanted an arrow to the left of some of the major resources that we have on there and submitting claims is one of them. Within that link, there is a plethora of information on how you can submit a claim, whether you're registered or not, how you can register for EDI claims. Registered providers also get the benefit of EFTs, ERAs, eligibility status, claims status, claims acknowledgement. So it is a really good resource to register for Health Net's website on the Provider Portal and submit your claims through that system, set up your EFTs and ERAs because that is one of the big drivers that seems to be a hot topic on this webinar is payment; claims payment, appropriate payment, timely payment.

David Tran:

I know a few questions came directly to me on whether or not Health Net allows for weekly billing of claims. We do. We do allow for weekly billing of claims. Some providers do it weekly, biweekly, some do it monthly. Health Net will accept the claims as clean claims that come in and we will promptly try to pay all of those claims. Can we go to the next slide? This is just a quick sample of some of the communications that we do send out to our SNF community or... I mean we send it out to all of our parties, but one of the major issues that have come up over the last couple years is a lot of providers have asked us why their claims were denied. We list all of our provider updates onto the

Provider Portal post login, it has really great information specifically around addressing claims, rejections, denials, PIN status and I just wanted to show this Provider Update.

David Tran:

We couldn't do every single page because it's very long, but it does break down every single field on a Claim Form that should be filled out for specific provider types, specific claim forms, what fields do not need to be filled out. And it also addresses the various denial codes or PIN codes that you may receive and how to go about addressing those as well. I think that was the last slide that I had. I just wanted to thank everyone on here for the opportunity. Again, Health Net is here to partner with all of the SNF communities. Many of the providers that are on this call or clients that are on this call have worked with our teams before. We will be available to continue working with you. We do suggest that if you have any issues, don't hesitate. As Dana said earlier, reach out to us directly, let us know that you're experiencing some weird problem, whether it's authorizations or claims or just questions on how things should be billed or how care should be provided.

David Tran:

If you have any questions regarding your specific contracts with Health Net, I also suggest that you would reach out to our Contracting Team as well. Check the DHCS FAQ website, check your contracts. I think that is a big part of a lot of the errors that we see is that certain providers will think that Health Net bills – or Health Net's requirement for coding and billing is exactly the same as L.A. Care, or Molina, or Anthem. Contracts are very specific. Our systems are set up to process and pay specific coding as defined in the contract. That's how we make sure that our systems are configured in a way that process the claim the quickest, the cleanest, and properly as possible. So again, please do check your contracts. There is information in there on what code should be billed for which service.

Kristin Mendoza-Nguyen:

Great. Thank you, David. And we did have a couple questions for you that came in from folks about the Portal. “Are non-contracted Health Net providers able to register for the Health Net online Provider Portal access?”

David Tran:

So the online Provider Portal access, there is general areas that can be accessed for people who are not or for clients that are not contracted. But to get the most out of the website, you should pursue a contract directly with Health Net.

Kristin Mendoza-Nguyen:

Okay. And then: “Can providers check claim status in the Health Net Provider Portal and when will they be able to do that?”

David Tran:

So the Health Net Provider Portal does have claims access on there. You would need to log into the member's eligibility... sorry. If you have a claim number, you can check it that way. If you do not, you can pull claim specific to a member using their Member ID Number or CIN number. We prefer for Health Net specifically, that for Medi-Cal patients that you bill and you utilize their CIN number because that will drive everything specifically to their Medi-Cal benefits and claims.

Kristin Mendoza-Nguyen:

Okay. More general questions, it might be both for David and for Dana or other folks, from Marlene earlier, "How about retro billing for Fee-For-Service with dates of service prior to 1/1/2023? How do we bill those claims?"

Dana Durham:

Yeah, if a person is not in a care plan, then the facility should bill Fee-For-Service. So let's say that the service date is October and the individual has not transitioned yet, no matter what date that is submitted on, it still would go through Fee-For-Service. And if it's after an individual is enrolled in a managed care plan, that billing would go through the managed care plan. So for instance, you have a bill that covers December and January. One part of that bill, you'd need to split it into two, and follow the appropriate requirements. The December would go to Fee-For-Service and the January would go to the managed care plan. I think I got what you were asking, Kristin, but just want to make sure.

Kristin Mendoza-Nguyen:

Okay. And then an earlier question, "I'm wondering if a resident needs skilled or custodial care on or after the custodial date, but the nursing home doesn't have a network contract with the MCP. Does that mean that the resident must be admitted to a network provider instead of remaining in a nursing home?"

Dana Durham:

So, I think I understand this question and I think it depends on the length of the Treatment Authorization that is in place and how long the individual is there. So, if an individual has a Treatment Authorization from the state that would be honored until it expires and/or if... it also has to be the appropriate level of care. So, at any point, if someone gets to the point where they can transition to a lower level of care and that lower level of care is available, then the managed care plan is to put the individual in the correct level of care. But David, maybe you can add on to that a little bit?

David Tran:

Yeah, from a managed care perspective, for Health Net specifically, if a member is assigned to a facility or is... sorry, is admitted to a facility and enrolled with Health Net, Health Net will always pay at minimum the Medi-Cal Fee-For-Service rate in lieu of a contract. If the facility has a specific contract with Health Net then obviously we will follow that contracted rate, as long as either A, there is a Health Net authorization or there is an open TAR from the state that we will honor.

Kristin Mendoza-Nguyen:

Okay, great. And then one question-

Dana Durham:

Just to say, that practice is pretty much the same across plans. I mean there may be some different processes, but if someone is in a skilled nursing facility, there is in the APL, the ability to stay with that skilled nursing facility for 12 months as appropriate.

David Tran:

And Kristin, I don't know if you tracked who that was, but if you're not contracted with Health Net, please reach out to me. Health Net wants to contract with every SNF in the state for every county that we are licensed in.

Kristin Mendoza-Nguyen:

Okay. All right, last question. This was an earlier one and I think one we received in the past, but we haven't yet had the opportunity to answer, "Is hospice room and board in a SNF included in the Carve-In for the new counties?"

Dana Durham:

That's a good question. We're going to need to take that one back because I don't know all the nuances of it and I don't want to answer it incorrectly and things are a little nuanced with hospice. It would be-

David Tran:

So-

Dana Durham:

Go ahead, David.

David Tran:

So Dana, I would want DHCS to validate, but I believe that there are hospice billing rules that indicate the hospice provider should bill for those services, including the room and board with the special revenue code and I think there's a patient status code. The payment is issued directly to the hospice provider who is required by law to do a pass-through and compensate the skilled nursing facility for that bed directly.

Dana Durham:

Thank you and really appreciate you knowing that. I just couldn't remember the exact language. We will confirm through the exact language, so I appreciate the question as well and thank you so much for answering, David.

Kristin Mendoza-Nguyen:

Great, and we'll go to the next slide and then, Dana, if you want to just close us out for today?

Dana Durham:

Sure. Hasn't switched... okay, Next Steps. Go ahead to the next too, please. So, we do have the Care Transitions and Care Management webinar that will be coming up in January. So as this transition happens, we want to talk a little bit more about some of the care transitions and care management that will be happening and so we're scheduling that for January. That date hasn't been determined yet. And then we are reserving a time for another webinar in February. We just will make sure that that is timely and that the subject is appropriate, which is why you see a to-be-determined because we want to understand what some of the hurdles are and that we make sure that we specifically address those hurdles. And next slide, please.

Dana Durham:

We do want to make sure that you have resources and contact information and there are Frequently Asked Questions as well as our APL. And most of all, we really thank you for attending today and being part of this conversation. Next slide, please. That is it. There is an Appendix that is available that follows, but just thank you for being here and hope you have a great day as we're one minute over, so we will see you later.