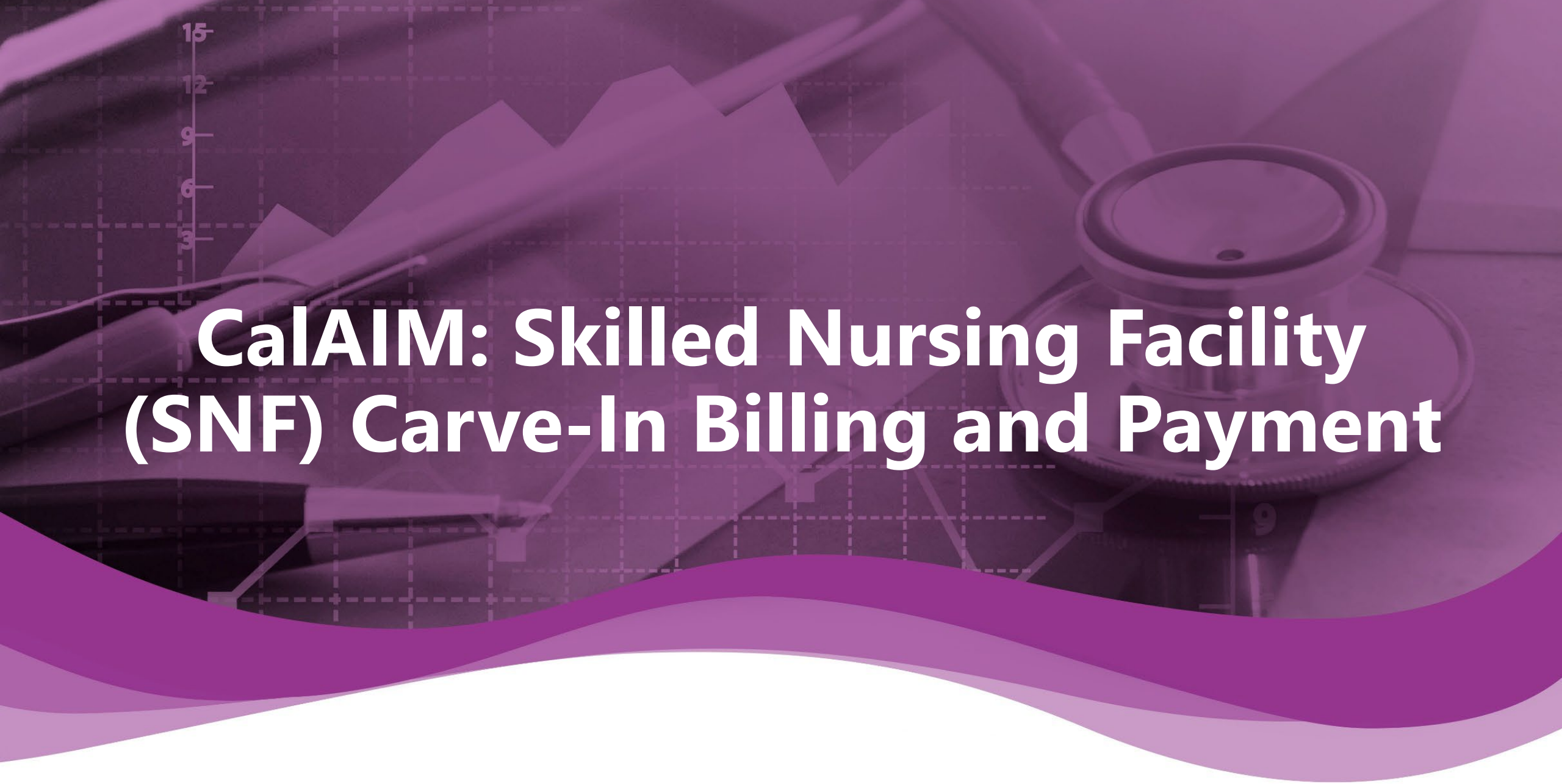


CalAIM: Skilled Nursing Facility (SNF) Carve-In Billing and Payment

DHCS

December 2, 2022

How to Add Your Organization to Your Zoom Name

- Click on the “Participants” icon at the bottom of the window.
- Hover over your name in the “Participants” list on the right side of the Zoom window.
- Select “Rename.”
- Enter your name and add your organization as you would like it to appear.
  - For example: Kristin Mendoza-Nguyen – Aurrera Health Group

Meeting Management

- This webinar is being recorded.
- Participants are in listen-only mode.
- Please use the “chat feature” to submit any questions you have for the presenters.
- This webinar will include various Q&A sessions. Please note that this webinar is focused on the SNF Carve-In and questions specific to the SNF Carve-In will be addressed during the Q&A sessions.

Agenda

Topics	Time
Welcome and Introductions	1:00 – 1:05 PM
CalAIM LTC Carve-In Transition Background and Overview and Q&A	1:05 – 1:15 PM
SNF Carve-In Directed Payment Policy & Payment Requirements Overview, and Q&A	1:15 – 1:40 PM
SNF Carve-In Promising Practices: Billing, MCP Presentation, and Q&A	1:40 – 1:58 PM
Next Steps & Closing	1:58 – 2:00 PM

California Advancing and Innovating Medi-Cal (CalAIM): Long-Term Care (LTC) Carve-In

CalAIM Long-Term Care Skilled Nursing Facility Carve-In Overview

- Effective January 1, 2023, Medi-Cal managed care plans (MCPs) in all counties will cover the LTC benefit for Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital
- All Medi-Cal beneficiaries residing in a LTC facility are mandatory to enroll in a MCP for their Medi-Cal covered services.

SNF Carve-In Goals

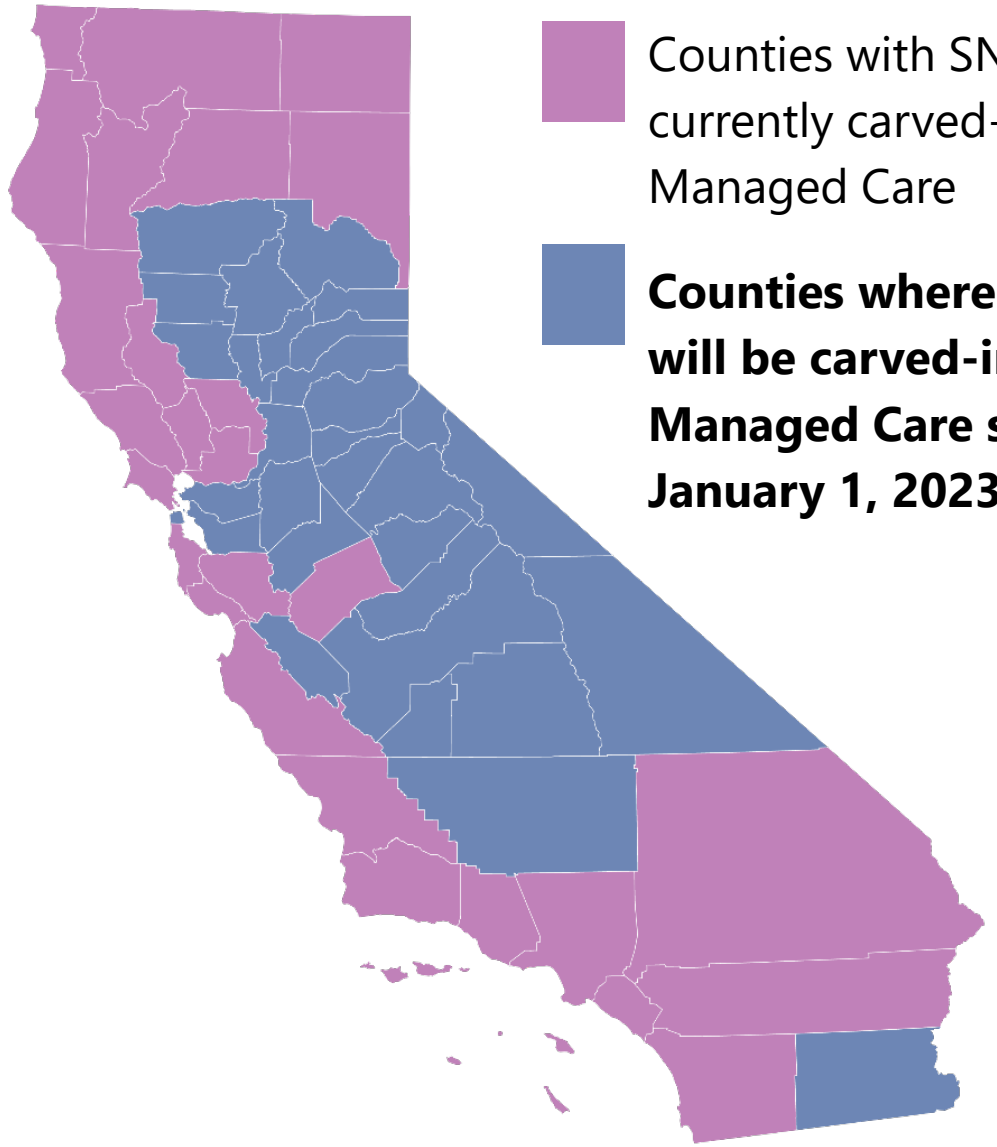
- Standardize SNF services coverage under managed care statewide.
- Advance a more consistent, seamless, and integrated system of managed care that reduces complexity and increases flexibility.
- Increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal beneficiaries in SNFs.

CalAIM LTC Carve-In: What is Changing?

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

Statewide Skilled Nursing Facility Carve-In

- Estimated ~28,000 members residing in SNFs will be carved into Medi-Cal managed care.
- Dual eligible members represent the majority residing in SNFs that will be transitioning to Medi-Cal managed care.



SNF Carve-In: Key Activities & Updates

- DHCS shared detailed member data with MCPs in November 2022, including utilization data and TAR information. MCPs and SNFs are required to coordinate with each other to share data to facilitate a seamless transition for members and help ensure day one coverage.
- Members and their authorized representatives (ARs) received the 60-day SNF LTC Carve-In member notice and Notice of Additional Information (NOAI) in early November, and 30-day member notices by December 1, 2022.
- Member Choice Packets were mailed at the end of November.
  - Choice Packets were only mailed to members not part of the Medi-Cal matching plan policy.
- Health Care Options member outbound call campaign starts in December.
- MCP and SNF outreach, communications, and contract negotiations are ongoing.

Questions?

SNF Carve-In Overview and Policy

SNF Carve-In
Directed Payment Policy & Payment Requirements Overview

SNF Carve-In: Directed Payment Policy

- MCPs must reimburse a Network Provider furnishing SNF services to a Member, and each Network Provider of SNF services **must accept**, the payment amount the Network Provider would be paid for those services in the FFS delivery system. [Welf. & Inst. Code § 14184.201(b)(2)]
- DHCS will operationalize this policy as a State directed payment subject to approval by the Centers for Medicare and Medicaid Services (CMS).
- MCPs CY 2023 rates will include funding levels based on the projected directed payment in 2023.

Directed Payment Policy: New Counties

- MCPs in counties where coverage of SNF services is ***newly transitioning*** from the FFS delivery system to the managed care delivery system, must reimburse Network Providers of SNF services for those services at **exactly the Medi-Cal FFS per-diem rates** applicable to that particular type of institutional LTC provider.

SNF Carve-In New Counties include:

- Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, and Yuba.

Directed Payment Policy: Existing Counties

- MCPs in counties where SNF services are *already* Medi-Cal managed care Covered Services must reimburse Network Providers of SNF services for those services at **no less than the Medi-Cal FFS per-diem rates** applicable to that particular type of institutional LTC provider.

SNF Medi-Cal Managed Care Existing Counties:

- Del Norte, Humboldt, Lake, Lassen, Los Angeles, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.

What is covered under the SNF Directed Payment Policy?

- This reimbursement requirement **only applies** to SNF services as defined in Title 22 CCR, Sections 51123(a), 51511(b), 51535, and 51535.1, as applicable, starting on the first day of a 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 51511(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 MCPs in accordance with the MCP's agreement with the Network Provider.

Per Diem Rate: Included SNF Services

- Rates for LTC facilities include all supplies, drugs, equipment and services necessary to provide a designated level of care. Other inclusive items include:
  - Room and board
  - Nursing and related care services
  - Personal hygiene items
  - Routine therapy services
- MCPs are obligated to pay for all SNF levels of care, including custodial care, skilled nursing facility care (NF-B), and intermediate care (NF-A).
- Additional Information: Medi-Cal Provider Manual: LTC Inclusive and Exclusive Services

Per Diem Rate: Inclusive Therapy Services

- What therapy services are covered under the per diem rate (i.e., inclusive services)?
  - Per the Medi-Cal Provider Manual, in many cases, therapy services needed to attain and/or maintain the highest practicable level of functioning can and should be performed as part of the Nursing Facility (NF) inclusive services rendered to the Medi-Cal resident in the NF.
    - e.g., Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
  - These "routine" therapy services would be subject to the directed payment policy outlined in APL 22-018.

Per Diem Rate: Exclusive Therapy Services

- When are therapy services no longer considered routine and can be covered outside the per diem rate (i.e., exclusive services)?
  - 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 practicable 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 rate.
- Further details regarding exclusive services not covered under the per diem rate are available at TAR Criteria for NF Authorization (Valdivia v. Coye)

Per Diem Rate: Exclusive SNF Services

- **Services outside the per-diem rate** are not subject to the Directed Payment policy and would follow the MCP and providers normal 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 as specified in CCR, Title 22, Section 51321(g)
  - Laboratory services and X-rays
  - Dental services
- Medi-Cal Provider Manual: LTC Inclusive and Exclusive Services and excluded items are outlined in 22 CCR, Sections 51123(b) and (c) and 51511(c) and (d),

Other Payment Requirements in APL 22-018

- 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 FFS per-diem rates
  - Coordinate benefits for members with Other Health Coverage
  - Pay the full deductible and coinsurance for dual eligible individuals
- DHCS guidance on the Workforce and Quality Incentive Program (WQIP) established under Assembly Bill 186 is forthcoming. Information is available here.
- Additional details of reimbursement requirements applicable to publicly owned distinct-part nursing facilities are forthcoming.

Pharmacy Coverage and Payment

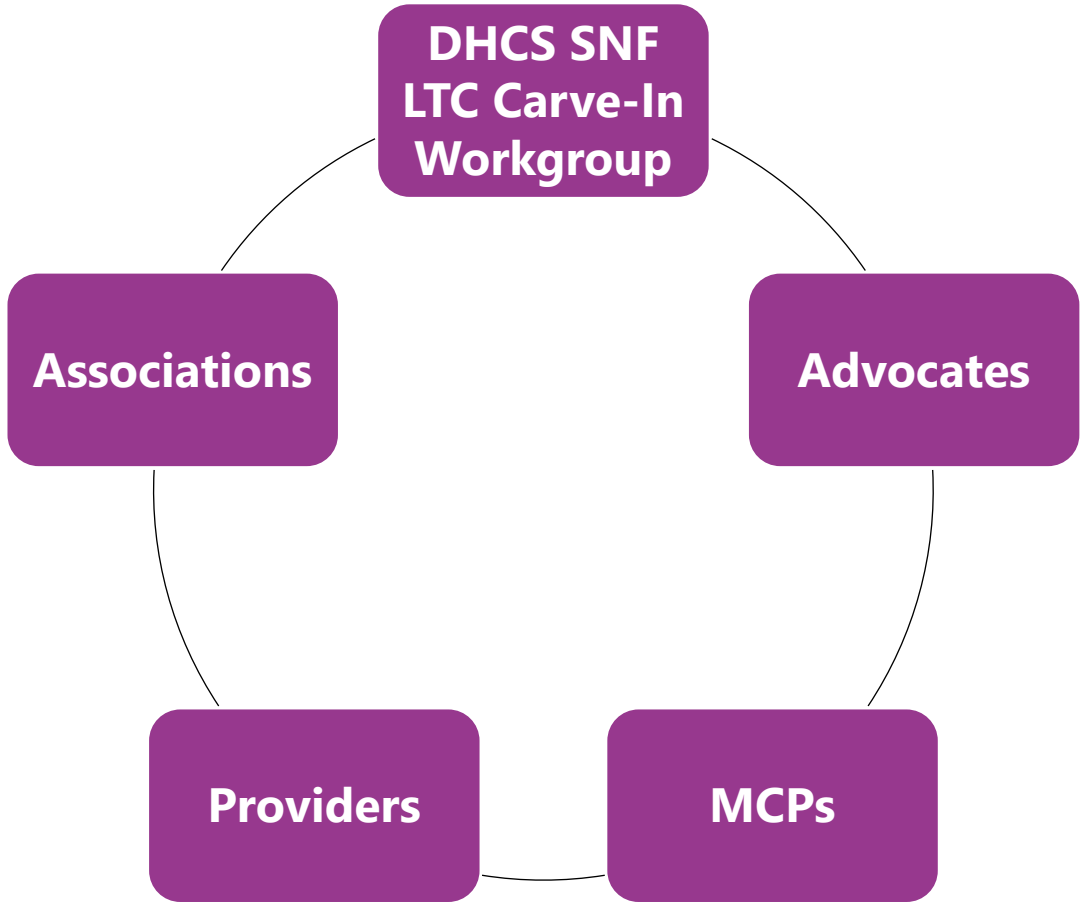
- The SNF Carve-In policy does not make any changes to the coverage policies for pharmacy benefit coverage nor make any changes to Medi-Cal Rx. The financial responsibility for outpatient prescription drugs is determined by the claim type of which they are billed.
  - If drugs are dispensed by a pharmacy and billing on a pharmacy claim, they are 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 medical or institutional claim, the MCP is responsible.
- If a prescribing provider at the SNF determines a patient or resident requires treatment that is administered on site with a stock medication at the SNF (e.g., not ordered or filled by an outpatient pharmacy), this would be part of a medical visit claim and would not be covered by Medi-Cal Rx and is the responsibility of the MCP.
- Additional information can be found at:
  - Medi-Cal Rx Website
  - Medi-Cal Rx FAQs.
  - LTC section of the Provider Manual

Questions?

Directed Payment Policy & Payment Requirements

Billing and Promising Practices

SNF LTC Carve-In Promising Practices



- Prioritizing stakeholder engagement to support MCP and provider readiness.
- Identifying challenges and best practices to better inform and prepare counties for the statewide CalAIM LTC Carve-In.
- Leveraging experience from counties where LTC is currently carved in to Medi-Cal managed care.

Prompt Claims and Payments

- Some SNFs reported challenges around being paid timely.
- LTC facilities, including SNFs, often do not have the financial reserves, or a diverse payer mix as other types of providers and rely on prompt payment from Medi-Cal FFS and MCPs.
- SNFs and MCPs should work closely to ensure SNFs are set up to receive payment via Electronic Funds Transfer (EFT) to receive payments timely, if EFT is requested by SNFs.
- APL 22-018 states MCPs must pay timely, in accordance with prompt payment standards within their Contract, including any additional amounts that are owed to a Network Provider of SNF services by virtue of retroactive adjustments to the Medi-Cal FFS per-diem rates by DHCS.

- **Promising Practice:** Shorter payment timeframes for clean claims can help support provider operations in SNFs.

Clean Claims

- MCPs have reported issues with facilities being able to submit clean claims in a timely manner.
- MCP and DHCS contracts specifies that the MCP shall pay 90 percent of all clean claims from Providers, within 30 calendar days of the date of receipt, and 99 percent of all clean claims from Providers' claims, within 90 calendar days of the date of receipt.
- MCPs and SNFs should work collaboratively to ensure an alignment in understanding claims requirements and the submission process. MCP LTSS Liaisons could potentially support and help resolve any claims challenges.

- **Promising Practice:** SNFs need outreach, education, and support from MCPs to understand how to submit clean claims and meet clean claims requirements.

Claim Forms Used to Bill Medi-Cal

Claim Form Used by (Provider Type)	Submit When Billing For:
CMS-1500 Claim: Allied Health, Medical Services Pharmacy, Vision Care	• Medical services and supplies • Vision Care services/eye appliances
Payment Request for Long Term Care (25-1): Long Term Care	Long term care services rendered in either a free-standing facility or distinct part of an acute inpatient facility
UB-04 Claim: Inpatient, Outpatient	Inpatient and outpatient services as follows: ▪ Inpatient services for acute hospital accommodations and ancillary charges ▪ Outpatient services for institutional facilities and for others, such as Rural Health Clinics (RHCs) and chronic dialysis services

Tips for Billing

- SNFs and LTC providers should validate billing codes with MCPs to ensure the appropriate codes are being utilized to ensure a clean claim.
- For Bed Holds, check regularly for recipients on leave at home, at an acute hospital, or transferred to another LTC facility.
- Verify that dates of service on the claim reflects only the dates for services rendered and verify that the dates of service on the claim match the approved dates within the TAR and/or authorization (e.g., if dates do not match a reauthorization may be required)
- Verify that the facility to which the recipient was transferred is billed correctly.
- For dual beneficiaries, bill Medicare or the OHC within one year of the month of service to meet Medi-Cal timeliness requirements. Submit claim to the California MMIS Fiscal Intermediary within 60 days of Medicare or OHC carrier's resolution. Use the OHC Explanation of Benefits date or Medicare Remittance Advice date to calculate timeliness.
- Confirm that the patient status code agrees with the accommodation code. For example, if the status code indicates leave days, the accommodation code must also indicate leave days.

Additional Tips and Resources for Billing

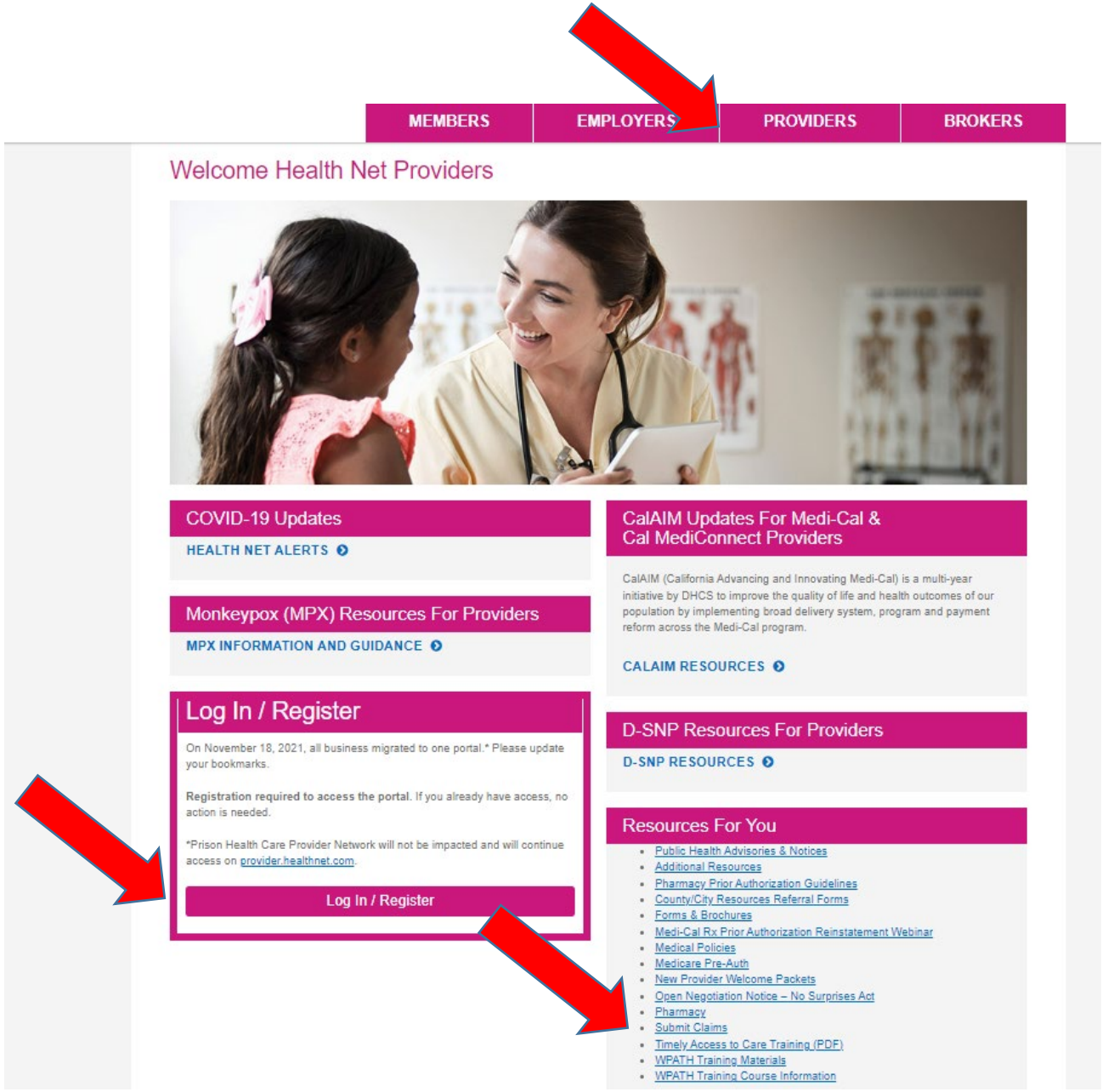
- Additional tips for billing and common billing errors
- LTC Claim Form and Code Conversion: https://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaa_ltc_home.aspx
- LTC Code and Claim Form Conversion FAQs: https://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaa_ltc_faq.aspx
  - LTC 25-1 to UB-04
  - Accommodation, Revenue, Value Codes Crosswalk
  - Patient Status Code and Discharge Code Crosswalk
- Balance Billing: https://www.dhcs.ca.gov/individuals/Pages/Balanced-Billing.aspx

MCP Presenter: David Tran
Senior Manager, Contracting and Network Development, Health Net

David Tran, Senior Manager, Contracting and Network Development, Health Net

- **What can SNFs expect when working with MCPs?**
  - Health Net has several teams dedicated to working with LTC Providers to address contracting, authorizations, claims and issue resolution. Health Net is here to partner with LTC Providers to ensure a smooth transition and work along side LTC Providers with any problems that may arise.
- **Highlights and promising practices as it relates to billing and payment**
  - The DHCS FAQs page contains valuable information related to billing: https://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaa_ltc_faq.aspx
- **How has Health Net supported SNFs and other LTC providers to in submitting clean claims and ensuring prompt/timely payments?**
  - Register for Health Net online Provider Portal Access. Portal contains numerous resources and communications related to claims billing and payment: https://www.healthnet.com/content/healthnet/en_us/providers.html
  - Set up EDI/EFT/ERA billing and payment for expedited billing and payment.

Health Net Provider Portal



Health Net Provider Communication Sample

PROVIDER*Update*

Health Net®

NEWS & ANNOUNCEMENTS | JUNE 29, 2018 | UPDATE 18-444 | 13 PAGES

Medical Paper Claims Submission Rejections and Resolutions

The preferred and most efficient way for fast turnaround and claims accuracy is to submit medical claims electronically to Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company (Health Net). However, when additional documentation or attachments are required, paper claims will be accepted. The following information applies to medical paper claims and does not apply to pharmacy paper claims. All paper claims sent to the Health Net Claims Department must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. Claims missing the necessary requirements are not considered clean claims and will be returned to providers with a written notice describing the reason for return. The following information will assist providers in submitting clean paper claims. The following topics are outlined and addressed in this provider update:

- Acceptable forms
- Claims rejection reasons and their resolutions
- Mandatory line items for claims submission
- Paper claims submission address change (reminder)
  - Using correct Health Net entity name
- Appendix A – CMS-1500 (02/12) form billing instructions
- Appendix B – CMS-1450 (UB-04) billing instructions

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- HMO/POS/HSP
- PPO
- EPO
- Medicare Advantage (HMO)
- Medi-Cal
  - Kern
  - Los Angeles
    - Molina
  - Riverside
  - Sacramento
  - San Bernardino
  - San Diego
  - San Joaquin
  - Stanislaus
  - Tulare

PROVIDER SERVICES
provider_services@healthnet.com

EnhancedCare PPO (IFP)
1-844-463-8188

Questions?

Promising Practices: Billing

Next Steps

SNF Carve-In Webinars

Topic	Audience	Date and Time
CalAIM LTC SNF Carve-In 101 for MCPs	MCPs	September 21, 2022, 10am –11am
CalAIM LTC Statewide Carve-In 101 for SNFs	SNFs	October 7, 2022, 1pm – 2pm
Promising Practices for Contracting	SNFs and MCPs	November 4, 2022, 1pm – 2pm
Billing and Payment	SNFs and MCPs	December 2, 2022, 1pm– 2pm
Care Transitions and Care Management	SNFs and MCPs	January 2023 – TBD
TBD	SNFs and MCPs	February 2023 – TBD

Materials from previous webinars and information on upcoming public webinars and registration details can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx

Resources and Contact Information

Questions? Please contact info@calduals.org

- SNF LTC Carve-In Frequently Asked Questions (FAQs) available under Key Documents here: https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx
- APL 22-018 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of members to Managed Care

Thank you!

Appendix A: CalAIM LTC SNF Carve-In Background

CalAIM: LTC Carve-In

Goal: Make coverage of institutional LTC consistent across all counties and members.

Starting on January 1, 2023:

- **Medi-Cal managed care plans (MCPs) in all counties will cover LTC benefit for following facility types:**
  - **Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital**
- **All Medi-Cal beneficiaries residing in a LTC facility are mandatory to enroll in a MCP for their Medi-Cal covered services.**

Starting on July 1, 2023:

- Medi-Cal managed care plans (MCPs) in all counties will cover LTC benefit for following facility types:
  - Intermediate Care Facility for Developmentally Disabled (ICF-DD);
    - ICF-DD/Habilitative;
    - ICF-DD/Nursing;
  - Subacute Facility; and
  - Pediatric Subacute Facility.

LTC In Managed Care Today: COHS and CCI Counties

- MCPs are contractually responsible for all medically necessary LTC services regardless of the length of stay in a facility.
  - County Organized Health Systems (COHS) counties currently have the full LTC benefit carved in.
  - Coordinated Care Initiative (CCI) counties have the LTC benefit for most facilities other than ICF/DD carved in.
- In COHS and CCI counties, MCP members requiring long-term stays at nursing facilities continue to stay enrolled in their Plan and do not transition to Fee-For-Service (FFS).
- Cal MediConnect plans and MCPs are required to coordinate care and transitions of care for beneficiaries.

LTC In Managed Care Today: COHS and CCI Counties

MCP (^ are COHS plans)	Counties (* are CCI counties)
CalOptima^	Orange*
CenCal Health^	Santa Barbara, San Luis Obispo
Central California Alliance for Health^	Santa Cruz, Monterey, Merced
Gold Coast Health Plan^	Ventura
Health Plan of San Mateo^	San Mateo*
Partnership Health Plan^	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo
LA Care Health Plan, Health Net	Los Angeles*
Inland Empire Health Plan, Molina Healthcare	Riverside*, San Bernardino*
Anthem Blue Cross Partnership Plan, Santa Clara Family Health Plan	Santa Clara*
Aetna Better Health, Blue Shield, Community Health Group Partnership Plan, Health Net, Kaiser Permanente, Molina Healthcare, United Healthcare	San Diego*

LTC Today in Non-COHS/Non-CCI

- MCPs are responsible for medically necessary LTC services for two months – the month of a person's admission to an LTC facility and the following month.
- After the second month, MCPs must disenroll the member into Medi-Cal Fee-For-Service (FFS).
  - Until the disenrollment is approved by DHCS, MCPs must provide all medically necessary covered services to the beneficiary.
  - MCPs are also required to coordinate the beneficiary's transfer to the Medi-Cal FFS program upon the effective date of disenrollment.

Non-COHS/Non-CCI Counties

MCP	Counties
Alameda Alliance for Health, Anthem Blue Cross Partnership Plan	Alameda
Anthem Blue Cross Partnership Plan, California Health & Wellness	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba
Anthem Blue Cross Partnership Plan, Contra Costa Health Plan	Contra Costa
Anthem Blue Cross Partnership Plan, CalViva Health	Fresno, Kings, Madera
California Health & Wellness, Molina Healthcare of California Partner Plan	Imperial
Health Net Community Solutions, Kern Family Health Care	Kern
Aetna Better Health of California, Anthem Blue Cross Partnership Plan, Health Net Community Solutions, Kaiser Permanente, Molina Healthcare of California Partner Plan	Sacramento
Anthem Blue Cross Partnership Plan	San Benito
Anthem Blue Cross Partnership Plan, San Francisco Health Plan	San Francisco
Health Net Community Solutions, Health Plan of San Joaquin	San Joaquin, Stanislaus
Anthem Blue Cross Partnership Plan, Health Net Community Solutions	Tulare

Appendix B: SNF Carve-In Policy Overview

SNF Carve-In APL Structure

- SNF APL Topics:
  - Benefits
  - Network Readiness
  - Leaves of Absence (LOA) or Bed Holds
  - Continuity of Care (CoC)
  - Treatment Authorizations
  - Facility Payment
  - Population Health Management (PHM)
  - Policies and Procedures

Continuity of Care (CoC): SNF Services

- MCPs must provide Continuity of Care (CoC) for all medically necessary LTC services at non-contracting LTC facilities for members residing in a SNF at the time of enrollment.
- To prevent disruptions in care, members must be allowed to stay in their current SNF residence, as long as:
  - The facility is licensed by the California Department of Public Health (CDPH);
  - The facility meets acceptable quality standards, including the MCP's professional standards; and
  - The facility and MCP must agree to work together.
- This continuity of care protection applies to all SNF residents transitioning on January 1, 2023 and lasts for 12 months.
  - After 12 months, members may request an additional 12 months of continuity of care.
- This continuity of care protection is **automatic**, meaning the beneficiary does not have to request to stay in their facility.
- If member is unable to access continuity of care as requested, the MCP must provide the member with a written notice of action of an adverse benefit determination and find alternative placement.

Continuity of Care (CoC): Providers and Other Services

Providers:

- Under CoC, members may continue seeing their out-of-network Medi-Cal providers for up to 12 months.
  - The member, authorized representative, or provider contacts the new MCP to make the request.
  - The member can validate that the member has seen the provider for least one non-emergency visit in the prior 12 months.
  - The provider meets the MCP's professional standards and has no disqualifying quality of care issues.
  - The provider is willing to work with the MCP (i.e., agree on payment and/or rates).
- Members entering managed care residing in a SNF after June 30, 2023 **will not** receive automatic CoC and must request CoC. This follows the standard process outlined in APL 18-008.

Other Services:

- Maintenance of current drug therapy, including non-formulary drugs, until the member is evaluated or re-evaluated by a Network Provider. MCPs may choose to cover drugs not covered by Medi-Cal Rx, inclusive of over-the-counter drugs and other therapies otherwise not covered.
- CoC provides continued access to: Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), Facility Services, Professional Services, Select Ancillary Services, and appropriate level of care coordination.

Authorizations

- **Treatment Authorizations Requests (TARs)**
  - MCPs must maintain continuity of care for members in a SNF facility by recognizing any treatment authorization requests for SNF facility services made by DHCS for the member enrolled into the MCP.
  - MCPs are responsible for all other approved TARs for services in a SNF exclusive of the SNF per diem rate for a period of 90 days after enrollment in the MCP, or until the MCP is able to reassess the member and authorize and connect the member to medically necessary services.
- **Service Authorizations**
  - Prior authorization requests for members who are transitioning from an acute care hospital must be considered expedited, requiring a response time no greater than 72 hours, including weekends.

Care Management and Care Coordination

- MCPs are required to provide care coordination to support members.
- Care coordination is scaled to member needs, but for those in LTC it would likely include:
  - Comprehensive assessment of the member's condition
  - Determination of available benefits and resources
  - Development and implementation of a Care Management Plan (CMP) with performance goals, monitoring and follow-up
- MCPs also must assess for and provide additional care coordination services if medically necessary:
  - Enhanced Care Management (ECM) and Community Supports
  - Complex Care Management
  - The SNF LTC Carve-In will not change the administration of the Medi-Cal benefits are carved out of managed care and will continue to be carved out after January 1, 2023

Appendix C: Crossover Claims and Balance Billing

Balance Billing

- Medicare is the primary payer for services to dual eligible beneficiaries.
- Dual eligible beneficiaries should **never** receive a bill for Medicare cost sharing. This is called improper billing (or balance billing) and is illegal under state and federal law.
- Balance billing is prohibited in both MA and Original Medicare.
- Beneficiaries will not pay a plan premium or pay for provider visits and other medical care when they receive services from a provider in their Medi-Medi Plan provider network. They may still have a copay for prescription drugs.

Current Crossover Claims Policy

- For beneficiaries that are in traditional Medicare and Medi-Cal plans, Part A Reimbursement should be as follows:

Days	Reimbursement
First 20 days	Medicare pays 100%
21st to 100th day	Medicare pays all, but the daily coinsurance. Medi-Cal plans responsible for the coinsurance.
Beyond 100 days	Medi-Cal plan responsibility

- Most claims for Medicare/Medi-Cal recipients must first be billed to the appropriate Medicare carrier or intermediary for processing of Medicare benefits, this includes Medicare Advantage plans, whose coverage of coinsurance and deductibles may differ based upon plan.

Balance Billing and Crossover Claims

- Billing dual eligible beneficiaries violates both federal law and California state law:
  - **2023 D-SNP SMAC:** D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Act, and 42 CFR section 422.504(g)(1)(iii).
- DHCS Beneficiary Balanced Billing Fact Sheet
- DHCS is currently updating guidance on crossover claims. Additional information will be forthcoming.

Appendix D: Public Health Emergency (PHE) Unwinding

Public Health Emergency (PHE) Unwinding

- **The COVID-19 PHE will end soon and millions of Medi-Cal beneficiaries may lose their coverage.**
- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a ***DHCS Coverage Ambassador!***
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available

DHCS PHE Unwind Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Launch immediately**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
    - » Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch 60 days prior to COVID-19 PHE termination.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.