CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (DHCS)
CLINICAL ASSURANCE DIVISION (CAD)
PUBLIC HOSPITAL PROJECT
Technical Workgroup Teleconference
September 13, 2021 Teleconference Minutes

Teleconference Attendees on Behalf of the Department:

	Name	Organization
1.	Dr. Van Natta	DHCS CAD
2.	Paul Miller	DHCS CAD
3.	Jillian Hart	DHCS CAD
4.	Dr. Steven Kmucha	DHCS CAD
5.	Tyra Taylor	DHCS CAD
6.	Cynthia Hicks	DHCS CAD
7.	Richard Luu	DHCS CAD
8.	Janelle Jones	DHCS CAD
9.	Lauren Palmer	DHCS CAD
10.	Monique Doduc	DHCS CAD
11.	Laura Watkins	DHCS CAD
12.	Cherease Baker	DHCS CAD
13.	Angela Carlos	DHCS CAD
14.	Stephan Fukasawa	DHCS A&I
15.	Lynzee Belen	DHCS A&I
16.	Ahmad Asir	DHCS OLS

Handouts

Each participant was e-mailed an agenda. In addition, a link to the Designated Public Hospitals (DPH) website for minutes from previous meetings was also provided.

Agenda Item I: Introductions

Agenda Item II: Report Card for 2019 Data

Discussion: In mid-2020, DHCS provided individual report cards of 2018 paid claims data. Due to the pandemic and postponed reviews, 2019 report cards are delayed due to paid claims reviews still in progress.

If requested via the Public Hospital Project inbox at PublicHospitalProject@dhcs.ca.gov, DHCS can prepare a preliminary partial 2019 report card however, due to multiple variables, a comprehensive blind report of provider compliance is unavailable at this time. If any concerns arise, DHCS will contact the facility directly.

Agenda Item III: Request for Process of Subacute Billing

Discussion: DHCS would like to confirm that the process for subacute billing is identical as any acute day. Designated Public Hospitals are allowed to bill as acute level of care until placement can be found for a beneficiary awaiting placement into a subacute facility. Please note that daily Utilization Review documentation (IQ/MCG) is not needed while awaiting placement however an initial secondary review approving subacute status must be present as well as progress notes. No further secondary reviews are required if the beneficiary remains at the subacute level of care prior to transfer.

Agenda Item IV: COVID Reminder

Discussion: COVID flexibilities will continue until the end of the Public Health Emergency. As a reminder, these flexibilities include the following:

1) Acute Administrative Days – flexibility for delay in beneficiary placement due to actual diagnosis of COVID with a positive test. No call lists are required.

2) Acute Inpatient Intensive Rehabilitations (AIIR) – flexibility for the required 15 hours of therapy provided (i.e. available staff/therapists etc.) due to limitations caused by the pandemic. These limitations must have documentation describing COVID impact.

3) Availability of Oxygen & Restricted Aid Codes – flexibility for typical physiologic oxygen requirement (i.e. saturations etc.) and allow patients with restricted aid codes to be safely discharged with supplemental oxygen. Beneficiaries need to have Medi-Cal eligibility: full scope, restricted scope or V2 code and providers must submit documentation both describing COVID impact, as well as their consideration for the beneficiary's need for the supplemental oxygen.

4) Allowance of no daily IQ/MCG when staff is impacted due to COVID surge. DHCS recommends the continued submission of daily Utilization Review documentation (IQ/MCG), however choosing the notation of COVID impact can replace this requirement.

These flexibilities will remain in place until further notice.

Follow Up: Per provider request, DHCS will communicate with California Association of Public Hospitals and create written documentation for flexibilities stated above.

Agenda Item V: Fee for Service Transplants

Discussion: Beginning January 1, 2022, organ transplant services that were previously carved out of Managed Care plans and billed through fee for service, will return to Managed Care plans. Please note – it is anticipated that some Fee for Service transplants will continue as a beneficiary could be in fee for service with no managed care eligibility.

Agenda Item VI: Managed Care Plans and Changes During Stay

Discussion: There has been ambiguity with who is responsible for coverage (Medi-Cal Fee for Service or Managed Care plans) when a beneficiary was initially enrolled in Medi-Cal fee for service, but moves to Managed Care in the middle of a stay.

Scenario: Beneficiary was admitted as Medi-Cal fee for service on April 20th but then placed into a Managed Care plan as of May 1st.
Question: Does Managed Care only cover days May 1st forward or does it cover the days in April as well?

Answer – The provider should bill April 20th – April 30th as Fee for Service and then the managed care plan for any dates of service after May 1st related to the same admission. Designated Public Hospital are allowed to interim bill to accommodate this scenario.

Scenario: In May, a beneficiary had disenrolled from fee for service Medi-Cal and became retro-eligible for a managed care plan on May 27th.
Question: What is the time frame to where a DPH have to notice the eligibility change in order to do a retro back to May 1st?

Answer – Enrollment into the managed care plan is effective the first of each month and does not have mid-month enrollment. Please see the answer above for interim billing.

Scenario: Beneficiary was enrolled in an out-of-network managed care plan (DRG payment methodology). Therefore, this managed care plan is per discharge and not per day.
Question: Who would be responsible for which portion of the stay? Managed Care plan vs. fee for service Medi-Cal.

This question is outside the scope of the Clinical Assurance Division and should be negotiated with the Out of Network Plan for further guidance.

Discussion: Providers express concern regarding the abilities of Managed Care plans disenrolling beneficiaries due to beneficiary previously enrolled in Medi-Cal fee for service. The disenrollment is causing providers to review retrospectively. Furthermore, providers have experienced additional losses when the beneficiary no longer meets InterQual criteria and needs to be placed under administrative

care. If beneficiary was disenrolled, they would not meet Medi-Cal criteria and would lack the ability to send referrals to a Skilled Nursing Facility (SNF).

Follow Up:
The Clinical Assurance Division has discussed this issue with our managed care partners. Managed Care enrollment is not normally retro but does occur. When this happens, the beneficiary is asked if any services have been provided in the month of question and if yes, they will normally not retro the eligibility to the previous month. If there are specific issues, please reach out to us and we can assist in further discussions.

Agenda Item VII: COVID admin days

Discussion: For patients waiting discharge to any level of care, or home, DHCS will permit admin days for those that are COVID-19 positive and must be cleared prior to discharge. No daily call lists are required but providers must note that patient is COVID positive.

Agenda Item VIII: Reminder – New AIIR policy

Discussion: DHCS informed providers that a change in the Provider Manual should be available September 16, 2021. Effective with dates of service on or after July 1, 2021, all rehab admissions will require "The Rule of 3 Ps":

- **P**re-admission screening: replacing the two week trial period
- Individualized Overall **P**lan of Care, and
- Inpatient Rehabilitation Facility **P**atient Assessment Instrument (IRF-PAI): This will replace the Functional Independence Measure (FIM) for admission criteria and patient progress

Designated Public Hospitals are required to have 15 hours of combined therapy each week which aligns with CMS policy.

Question: Does this new AIIR policy apply to the Medi-Cal County Inmate Program (MCIP)?

Answer – If the MCIP aid code is described as "limited to full scope inpatient hospital…then AIIR services are an allowable service with all other AIIR requirements being met. For those aid codes described as "restricted" AIIR services are not allowable as these aid code cover only pregnancy and/or emergency services. Aid code descriptions can be found via the link below

The Medi-Cal Provider Manual for AIIR can be referenced for further detail at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/tarcritaiir.pdf

The Medi-Cal Provider Manual for Aid Codes can be referenced for further detail at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes.pdf

Agenda Item IX: Quarterly Denied Medi-Cal Days

Discussion: The Spring Denied Medi-Cal Days data for dates of admission April 1, 2021 – June 30, 2021 is due on or before September 30, 2021. We will send out a reminder in the next week if your facility has not already submitted the data.

Agenda Item X: Congregate Living Facility Placement and Administrative Days

Discussion: DHCS will be working inter-divisionally to provide answers for policies relating to Congregate Living Facilities and applicable administrative days.

Discussion: It was suggested to DHCS that in addition to defining Congregate Living Facility placement, it would be helpful to know if policy change allows for Congregate Living Facility payment in facilities on a hospital license, or if it would be broader in scope.

Answer – Once policy is defined, the intent would be to allow a hospital to bill an administrative day under the hospital's general acute inpatient care NPI number allowing for reimbursement at the general acute care administrative day rate.

Agenda Item XI: Additional Items

Discussion: DHCS was asked to verify flexibilities related to COVID Administrative Days.

As a reminder, flexibilities are still in place and COVID positive beneficiaries with a restricted aid code may be billed as acute administrative days. While daily call lists are not required in correspondence to this flexibility, providers must have documentation that beneficiary is COVID positive.

Discussion: DHCS has been asked to verify the "Midnight Rule" for NICU infants that transfer to newborn nursery prior to midnight.

According to CMS Pub 15-1 2205

An inpatient at midnight is included in the census of your inpatient routine (general or intensive) care area regardless of the patient's location at midnight (whether in a routine bed, in an ancillary area, etc.), including a patient who has not yet occupied a routine care bed since admission. (See exception in §2205.2 regarding maternity patients.) When a patient occupies a bed in more than one routine care area in one day, the inpatient day is counted only in the routine care area in which the patient was located at midnight. In a case where the patient is located in an ancillary area at midnight, an

inpatient day is counted in the routine care area in which the patient was located before going to the ancillary area. If the patient was not located in a routine care area since admission, an inpatient day is counted in the routine care area to which the patient was assigned. See § 2805 regarding apportionment statistics for providers subject to the prospective payment system.

Discussion: DHCS was asked to confirm the following from December 2016 FAQs: Regardless of the admission order (whether observation or inpatient), providers may bill an acute stay as long as they were able to approve that day as an acute stay, and the beneficiary met IQ/MCG acute criteria.

DHCS confirmed this to be true.

Follow Up:

- DHCS will communicate with California Association of Public Hospitals and create written documentation for COVID flexibilities.

- DHCS will be working inter-divisionally on policies relating to Congregate Living Facilities and applicable administrative days.

Agenda Item XII: Next Meeting Date – Monday, December 6, 2021 at 11:00 am