

**Questions and Responses from the Department of Health Care Services (DHCS)
Medi-Cal Tribal and Indian Health Program Designee Annual Meeting on March 3, 2015
As of 5/1/15**

Please note this document will be updated as further information becomes available.

Section 1115 Waiver Questions

1. **Question:** When will home visitation and case management be reimbursed (Affordable Care Act, Section 2703)? Many Indian health programs are already providing these services. Will this be part of a waiver or a State Plan Amendment (SPA), and if so, what will it look like, and can we be part of that rollout?

DHCS Response: DHCS is currently working with stakeholders and the Centers for Medicare and Medicaid Services (CMS) and hopes to submit a SPA in the summer of 2015 for a January 1, 2016 effective date. DHCS is approaching this from a regional perspective. This will be phased-in in different areas over a period of time. DHCS is very interested in hearing from providers who are already providing these services; DHCS staff will ensure communication is provided to this group, including information on how to participate in this process. Information on upcoming meetings and webinars is available on the DHCS website at:

<http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx>

2. **Question:** Currently, podiatry services and chiropractic services are optional benefit exclusions and we cannot bill our code 18 Differential Rate if the service is not covered by the managed care plan; is there a process that will result in receiving the full Indian Health Services-Memorandum of Agreement (IHS/MOA) rate as required by federal law for American Indians for podiatry and chiropractic services?

DHCS Response: The Tribal Uncompensated Care (UCC) program for American Indians is an amendment to the Section 1115 Bridge to Reform waiver. Through the UCC program, clinics can claim the payment difference between what the managed care plan pays and the IHS/MOA rate through the UCC process. Please contact DHCS if there are issues with UCC reimbursement. The UCC program will be included in the next Section 1115 Waiver renewal submitted to CMS.

3. **Question:** What is the term of the 1115 Waiver Renewal?

DHCS Response: The term of the 1115 Waiver renewal is five years, October 2015 to October 2020.

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Audits and Investigations (A&I)

1. **Question:** Regarding the dental SPA 15-005, when was the requirement to adjust the Prospective Payment System (PPS) rate for Registered Dental Hygienists (RDHs) effective?

DHCS Response: A Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) may elect to provide a dental hygienist as a billable visit as of January 1, 2008. A PPS Alternate Payment Methodology (APM) worksheet (Form DHCS 3078) was sent to providers to adjust their PPS rate to account for the dental hygienist visits in the calculation of their PPS rate if the services were provided prior to January 1, 2008. If an FQHC or RHC did not provide the services of a dental hygienist before January 1, 2008 and later adds these services, a scope of service change must be filed to add the additional services, if the provider elects to bill dental hygienist services. Information related to the addition of dental hygienist services in SPA 08-003, Attachment 4.19B, Page 6T, can be found on our webpage at: <http://www.dhcs.ca.gov/formsandpubs/laws/Documents/StatePlan%Amendment%202008-003.pdf>

2. **Question:** When new MOA rates are published in the Federal Register, will A&I implement an auto adjustment to code 2 and 18, or do we have to request the adjustment? If required to submit a request, will an email suffice or are forms necessary?

DHCS Response: Yes, you may request an adjustment. You can send an e-mail to clinics@dhcs.ca.gov. You do not need to file form DHCS 3100 to adjust your code 2 and 18 rate if the request is related to the annual increase in your IHS/MOA rate. However, if the request to adjust your code 18 rate is related to a change in your managed care plan(s) then you must file form DHCS 3100 which can be found on our webpage at: <https://www.dhcs.ca.gov/formsandpubs/forms/Pages/AuditsInvestigationsForms.aspx>. The annual reconciliation request forms have a form to request a change to your code 2 and 18 rates during the annual reconciliation process.

3. **Question:** We are still awaiting the completion of the reconciliation and have received the 60% upfront settlement; however, are still waiting for final 40%. Are you getting more staff?

DHCS Response: Currently A & I does not have authority to hire additional staff. You can e-mail reconciliations@dhcs.ca.gov to request completion of your reconciliation if there is a financial hardship.

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4. **Question:** Is there a way to open a year that has closed?

DHCS Response: The final reconciliation audit report that is sent to the providers states the following, “The written notice of disagreement must be received by the Department’s Office of Administrative Hearings and Appeals within 60 calendar days from the day you receive this letter.”

The procedures that govern an appeal are contained in Welfare and Institutions Code, Section 14171, and California Code of Regulations, Title 22, Section 51016, et seq.

If an appeal is not sent to the Office of Administrative Hearings and Appeals within 60 days, we are unable to open a year that has been closed.

5. **Question:** Our appeal was denied, are there additional steps that would allow us to reopen the reconciliation year to make adjustments?

DHCS Response: If the appeal was denied there are not additional steps that allow us to reopen a year to make adjustments. A&I can only amend reports due to a mathematical error or error to the MOA rate or PPS rate. You can contact Office of Administrative Hearings and Appeals (OAHA) for additional information on denial of an appeal at 916-322-5603.

Additional information on the OAHA is available on the DHCS website at:

<http://www.dhcs.ca.gov/formsandpubs/laws/Pages/The-Office-of-Administrative-Hearings-and-Appeals.aspx>

6. **Question:** Rather than calculating how much of the current \$342 MOA rate gets billed to Partnership and Medi-Cal, splitting the claim and then auditing whether the total adds up to \$342, it would be much simpler for us and DHCS if we could just render a single invoice for \$342 to one payer. Since the goal of the wraparound billing process is to reimburse a flat rate, is there a way we can simplify the billing process and eliminate reconciliation costs?

DHCS Response: A&I cannot waive the requirement of the provider to bill the Medi-Cal Managed Care Plans. We cannot change the billing process as State law requires Providers to bill their Managed Health Care Plans first. The Medi-Cal wrap around payment is the last payer source. The providers must first bill all other third party payers (i.e. Medicare, private insurance, Medi-Cal Managed Care Plan).

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Dental

1. **Comment:** When DHCS makes the transition for our clinics to bill dental services to Denti-Cal, we ask DHCS to allow enough time to modify our billing systems if program changes are needed.

DHCS Response: DHCS is committed to working with the clinics to ensure that the transition to billing for Current Dental Terminology (CDT) codes is as seamless as we can make it. DHCS will provide updates to the clinics once DHCS has more information to share about precise modifications and timelines for this project. Technical assistance will be provided to help assist the clinics with the transition.

2. **Question:** Regarding changing forms, is there a standard form, a California form, or an American Dental Association (ADA) form currently used to bill Denti-Cal? Please use a standard billing form.

DHCS Response: Currently, the Medi-Cal dental program only uses a proprietary form for the purposes of receiving claims from dental providers. The preference for use of ADA form will be considered in our evaluation of how to best accomplish the local code conversion for dental services.

Managed Care Reimbursement Issues

1. **Question:** How will DHCS address disparities in managed care based on location and or plan such as issues with a) Service delivery – differences in available services within region; b) Access – network of providers available within region; c) Formulary – prescription coverage varies with plan, and d) Credentialing – lack of retro-active reimbursement, timely credentialing of providers it takes 90 – 120 days and we are unable to bill.

DHCS Response: DHCS's policy decision to expand managed care to rural areas was to improve access to care by having an organized delivery system. Rural expansion is still a work in progress and the Department is closely monitoring information and data to ensure the desired results. For Medi-Cal managed care health plans (MCPs) that are out of compliance with the DHCS/MCP contract, Corrective Action Plans (CAPs) can be imposed, as well as sanctions and penalties. The Department will continue to meet with MCP Chief Executive Officers (CEOs) and Chief Medical Officers (CMOs) to discuss accelerating the provider credentialing process. The Department will also remind MCPs of their responsibility to pay for

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services fee-for-service (FFS) during the credentialing period and when care in general is accessed. DHCS continues to request feedback from stakeholders on which MCPs and/or counties have members who are experiencing these issues. Please submit specific examples to MCQMD@dhcs.ca.gov.

- 2. Question:** Care levels have decreased. Prior to the managed care expansion, our members were able to get certain services, with the expansion, they are not getting the same benefits, some lost services, and some lost access to care. All plans should be required to provide the same essential benefits to all Medi-Cal beneficiaries. For tribal members who are guaranteed treatment in our tribal health facility, as we are guaranteed to provide those services, plans need to be aware these are federal regulations and need to provide the services and DHCS needs to ensure they make that happen. The state must point out to the plans the federal regulations and guarantees for American Indian patients and tribal health facilities.

DHCS Response: DHCS recognizes that your feedback as providers is very important in monitoring access and quality of care. Please submit examples to MCQMD@dhcs.ca.gov.

- 3. Question:** We have issues with credentialing locum tenens, it takes between 90-120 days. During this time, our clinic is unable to bill for services rendered to Medi-Cal beneficiaries, additionally, once credentialed, retroactive billing is not allowed. Clinics are losing a lot of money lost due to the credentialing process.

DHCS Response: DHCS has reminded MCPs of their responsibility to pay FFS for services during the credentialing period and when care in general is accessed. Please submit any new concerns or issues to MCQMD@dhcs.ca.gov.

- 4. Question:** Due to network inadequacy there are transportation barriers caused by distance/location of specialty providers. Sometimes requiring secondary transportation and our clinic is covering the cost. Is there a plan to enhance specialty network adequacy?

DHCS Response: DHCS is working with MCPs to clarify policy around Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services for Medi-Cal beneficiaries. To that end, in consultation with the Department of Managed Health Care (DMHC), DHCS is developing standard Evidence of Coverage (EOC) language for covered transportation benefits. The revised standard language will be released to MCPs in an All Plan Letter (APL).

DHCS is seeking to establish provider incentives and workforce expansions under its Section 1115 Medicaid Waiver renewal. MCPs also frequently implement

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incentive programs to attract new in-network providers. Please submit specific examples to MCQMD@dhcs.ca.gov.

- 5. Question:** In rural or semi-rural areas it takes 12-18 months, sometimes longer, to recruit a physician, and Anthem Blue Cross require six months to credential them. There needs to be a session with all of the plans and the Indian Health providers and all issues must be addressed, these are not all fiscal issues.

DHCS Response: DHCS will continue to meet with MCP CEOs and CMOs to discuss the issue of accelerating the provider credentialing process. The Department will work to schedule standing meetings between MCPs and Indian Health providers.

- 6. Question:** Anthem Blue cross requires a referral for an internist (to serve as a primary care physician), as they consider the internist as a specialist. This is a barrier to timely care. Can DHCS raise this issue with the plans?

DHCS Response: Providers should approach Anthem to discuss their concern. DHCS will also research this issue to determine any next steps.

- 7. Question:** There are geographic barriers with non-contracted OB hospital border providers resulting in barriers to care. How can this be resolved?

Example, woman about to deliver is sent to the ER of an out-of-state (OOS) border provider in close proximity rather than the CA Medi-Cal provider. Medi-Cal fee for service pays. If patient is admitted, the claim is denied. Additionally, when annual renewal process comes up, they are switched back to a plan and we have to fill out the exemption paperwork again.

DHCS Response: The Department will continue to monitor provider networks in the expansion areas, particularly in those counties that are contiguous to other state and/or international borders. DHCS will review MCP contracts to ensure out-of-state providers are treated equitably. The Department will continue to request feedback from stakeholders on which MCPs and/or counties have beneficiaries experiencing these issues. Specific examples would be helpful. Please submit them to MCQMD@dhcs.ca.gov.

Managed Care Questions (General)

- 8. Question:** Why does it take so long to credential when most everything is now automated, information is available on the internet why can you not make it universal?

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DHCS Response: DHCS is exploring alternatives, including automation, to streamline the credentialing process. MCPs must reach out to colleges and universities to verify information. Sometimes incomplete information is provided to MCPs which can delay the process.

9. **Question:** Will DHCS consider alternative credentialing models such as the Accreditation Association of Ambulatory Health Care (AAAHC) to improve timeliness of credentialing process? If the plans set up and share credentialing standards that we can follow in our clinics and would be acceptable to the plans; it would streamline process.

DHCS Response: DHCS allows MCPs to consider alternative credentialing models and is actively exploring alternatives to improve the overall timeliness of the credentialing process. DHCS encourages contact with the MCPs to request that this joint credentialing process occur.

10. **Question:** Multiple audits are disruptive, time-consuming, and costly; can there be reciprocity among the plans? When we were approved as a provider, California Health and Wellness (CH&W) come through, then Anthem Blue Cross, followed by the state, all three entities were looking at the same things; this seems redundant and waste of time for staff to be pulled away from their duties.

DHCS Response: MCPs can coordinate facility site reviews per Policy Letter 14-004. DHCS encourages contact with MCPs to request that this coordination occurs. DHCS is working to ensure that audit and survey activities are conducted simultaneously in an effort to reduce duplicative work and keep disruptions to a minimum. To that end, DHCS coordinates audits with MCPs and the DMHC to enable much of the work to be done concurrently. Furthermore, DHCS is engaging with our contracted MCPs to map a system that better coordinates audit activities and processes in an effort to alleviate administrative burdens on providers.

11. **Question:** Does DHCS managed care staff have information specific to American Indians that can be provided? Given our unique relationship, can DHCS generate reports that go to the tribes, applying metrics that are unique to tribal people? When DHCS is developing policy, if quality metrics specific to tribes are available, it will assist in the development of policy. DHCS may consider working with the Indian Health Service and their Resource and Patient Management System (RPMS), this will provide us with the IT tools necessary.

DHCS Response: DHCS will be stratifying the Healthcare Effectiveness Data and Information Set (HEDIS) and grievances data in the future and will be able to produce reports relating to the American-Indian Medi-Cal beneficiary experience.

12. **Question:** What is the definition of Network Adequacy? We are located in Sacramento County with five managed care companies and two more are coming. Plans coming to our community are not bringing additional providers with them; they are coming to a saturated community where there is a shortage of providers and waiting lists.

DHCS Response: Network adequacy refers to an MCP's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all health care services included under the terms of the contract. DHCS contracts with 22 MCPs to provide services to Medi-Cal members in 58 counties. Most MCPs are also regulated by the Knox-Keene Act under the purview of DMHC. DHCS and DMHC share responsibility of auditing MCP networks. MCPs are held to certain standards and are monitored ongoing.

In order to meet network adequacy, MCPs must:

- Have adequate providers (Primary Care Providers, Specialists, mental health professionals, substance abuse disorder providers, etc.) in its network
- Meet time and distance standards
 - 30 minutes or 10 miles of a member's residence unless the plan has a DHCS-approved alternative time and distance standard
- Have access to out-of-network providers if in-network providers are not sufficient or not available
- Have admitting and practice privileges at network hospitals and other facilities

13. **Question:** What can DHCS do to decrease referral times? For example, specialty referral timelines range from 6 to 12 months; sometimes requiring a second visit for an expired referral. We are located in an urban area and are unable to get access to a specialist; this is a barrier to timely and quality of care.

DHCS Response: DHCS contracts with MCPs include timely access requirements for emergency and non-emergency specialist visits. Referral times taking longer than six months do not meet the contractually required standards. DHCS is requesting specific information on any MCP members who may be experiencing such long waiting times to receive specialty care. DHCS will follow up with the MCP to ameliorate any issues. The Department will also review issues and concerns across all MCPs to determine if a statewide or regional approach is needed. Please submit specific examples to MCQMD@dhcs.ca.gov.

Tribal and Designees of IHPs Advisory Process

1. **Question:** The synopses in the tribal notices are too brief; more information is needed for a comprehensive review of what the issue is.

DHCS Response: DHCS will review the current process and format, and research viable alternatives that would address these concerns.

2. **Question:** Border communities and providers may have different issues or questions specific to Southern California, does DHCS hold regional meetings?

DHCS Response: Currently, no; however this will be taken under consideration.

3. **Question:** How can we get involved in the preliminary work for tribal notices for SPAs, waivers, and demonstration projects?

DHCS Response: DHCS recognizes the role of tribes; perhaps a core group of people from tribes can be included in the process. Adding a second meeting later in the year to revisit issues and provide an update on issues discussed today will be considered.

4. **Question:** Can California tie licensing requirements to the federal Indian Health Service area rather than be facility location specific? Our specific issue is with the pharmacy board, we moved only 15 miles and we had to go through a six month, very extensive application process and get a new license. State licensing staff was unclear what laws applied to us because we were not on a reservation. Can DHCS look at these issues as we build new clinics?

- Streamline process
- No licensure requirement
- Less expensive
- Assembly Bill (AB) 941

DHCS Response: DHCS does not handle the licensing of facilities. The process is overseen by the California Department of Public Health (CDPH). Once the licensing process is complete CDPH provides information to DHCS for the enrollment of the provider/facility. DHCS is aware that the process is not seamless and the Department is in communication with CDPH how about how to make the process better. If a particular issue is brought to DHCS' attention we can provide technical assistance to try and resolve the matter.

5. **Comments:** Assembly Bill (AB) 941 (Wood) will enable tribal clinics to set up satellite clinics off tribal land, but in a Federal service area. The clinic will be exempt from licensure. CRIHB would like DHCS to take a look AB 941 and would be very pleased to garner the support of DHCS and CDPH.

DHCS Response: DHCS staff review a list of bills annually and pull items of interest to the Department. Thank you for bringing this to the attention of DHCS. Staff will take a look at AB 941.