State of California—Health and Human Services Agency
Department of Health Care Services

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DIRECTOR

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DATE: May 11, 2015

ALL PLAN LETTER 15-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: DESIGNATED PUBLIC HOSPITALS: BILLING FOR BENEFICIARIES WITH CALIFORNIA CHILDREN'S SERVICES ELIGIBLE CONDITIONS AND/OR MEDI-CAL MANAGED CARE

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide information to Medi-Cal managed care health plans (MCPs) regarding the billing of inpatient services at Designated Public Hospitals (DPHs) for beneficiaries with California Children's Services (CCS)-eligible conditions who are also enrolled in an MCP. This APL applies the CCS Service Authorization Request (SAR) policies established under APL 13-012[1] to DPHs.

BACKGROUND:
CCS reimburses providers for services provided to Medi-Cal eligible children with specified conditions through Medi-Cal fee-for-service (FFS), with some exceptions. Payments to hospitals for these services align with the payment methodology utilized for all other Medi-Cal FFS providers.

Many Medi-Cal beneficiaries with CCS-eligible conditions are also enrolled in an MCP. CCS services are generally carved-out of the MCP contracts; however, there are some MCPs in certain counties that carve-in CCS services. For those MCPs in which CCS services are carved-out, the MCPs are responsible for providing medically necessary services that are not related to the CCS condition. For those MCPs in which CCS services are carved-in, the MCPs are responsible for covering CCS services in addition to all medically necessary services not related to the CCS condition.

Prior to this APL, inpatient services provided at DPHs to MCP beneficiaries for CCS-eligible conditions that were not covered by the MCPs were paid through Medi-Cal FFS. Payments were based on the number of days authorized on a CCS SAR. If an MCP beneficiary was hospitalized for a CCS-eligible condition, as well as a condition covered by the MCP, a provider was required to bill Medi-Cal FFS for the days covered by the

[1] APL 13-012 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-012.pdf.

CCS SAR and bill the MCP for the days covered by the MCP. This is called billing by payer source.

REQUIREMENTS:
Effective January 2, 2015, for days of service and for DPH stays, the following billing policy will apply for services provided to a Medi-Cal beneficiary with a CCS-eligible condition that is enrolled in an MCP in which CCS services are carved-out:

- If a beneficiary is admitted to a hospital for a CCS-eligible condition, the entire stay must be billed to Medi-Cal FFS, regardless of whether any services provided during that stay are covered by the MCP. The hospital will receive payment for the entire stay based on the applicable DPH Medi-Cal inpatient interim per diem rate. No billing will be allowed to the MCP;

- If a beneficiary is admitted to a hospital for a non-CCS-eligible condition, and subsequently receives services during the stay for a CCS-eligible condition, the full stay must be billed to Medi-Cal FFS. A SAR will be authorized back to the day of admission. The hospital will receive payment for the entire stay based on the applicable DPH Medi-Cal inpatient interim per diem rate. No billing will be allowed to the MCP; and

- When a beneficiary stay includes delivery and well-baby coverage under an MCP, the entire claim must be billed to the MCP. If, during the stay, the baby develops a CCS-eligible condition, the entire stay for the baby will require a SAR from the date of admission and must be billed to Medi-Cal FFS. MCPs must not be billed for the baby's stay. In this case, the hospital will receive two payments. One for the delivery and well-baby stay from the MCP and one for the baby under the applicable DPH Medi-Cal inpatient interim per diem rate.

Effective January 2, 2015, for days of service and for DPHs stays, the following billing policy will apply for services provided to a Medi-Cal beneficiary with a CCS-eligible condition who is enrolled in an MCP in which CCS services are carved-in:

- If a beneficiary is admitted to a hospital for either a CCS-eligible condition or a non-CCS-eligible condition, the entire claim must be billed to the MCP. The hospital will receive one payment for the entire stay from the MCP.

If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah C. Brooks

Sarah Brooks, Chief
Managed Care Quality and Monitoring Division
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