DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

MINUTES

DESIGNATED PUBLIC HOSPITAL (DPH) TAR-FREE PROGRAM TECHNICAL WORKGROUP CONFERENCE CALL MINUTES

Date: Monday, May 13, 2024

Time: 11:00am to 12:00pm

Meeting Location: Webex

TELECONFERENCE ATTENDEES ON BEHALF OF THE DEPARTMENT:

Name:	Organization:	Name:	Organization:
1. Dr. Timothy Van Natta	DHCS CAD	8. Lauren Palmer	DHCS CAD
2. Emily Perez	DHCS CAD	9. Cherease Baker	DHCS CAD
3. Dr. Steven Kmucha	DHCS CAD	10. Monique Doduc	DHCS CAD
4. Kyna Kemp	DHCS CAD	11. Desire Kensic	DHCS CAD
5. Richard Luu	DHCS CAD	12. Jason Perisho	DHCS OLS
6. Erik Labhard	DHCS CAD	13. Ahmad Asir	DHCS OLS
7. Janelle Jones	DHCS CAD		

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

Discussion: DHCS has expressed that future meetings will be held on an as-needed basis.

Agenda Item II: Self-Denied Medi-Cal Days Data

Discussion: With the maturity of the TAR-Free process, DHCS has decided to conclude the requirement of submitting Self-Denied Medi-Cal Days data. This change is effective immediately and to confirm, the Winter Denied Days quarter (January 1, 2024 - March 31, 2024), originally due on June 30, 2024, does not need to be submitted.

Agenda Item III: Change Healthcare - InterQual (IQ) Security Breach

Discussion: DHCS is aware of the security breach at Change Healthcare and understands that providers were unable to access their InterQual and conduct their daily reviews. Due to this incident, DHCS will be waiving the requirement of daily IQ reviews for the following Dates of Service (DOS): February 21-27, 2024. If your hospital had chosen to discontinue using Change Healthcare until additional infrastructures were built either internally or with Change Healthcare after February 27, 2024, please reach out to the DHCS Public Hospital Project inbox at: PublicHospitalProject@dhcs.ca.gov. Each scenario will be reviewed on a case-by-case basis with a possible DOS extension for waiving the IQ review requirement.

Please note: These dates of service will most likely not be reviewed until late 2024 or early 2025.

In addition, DHCS understands that enrolled hospitals may contract with their choice of contemporary evidence-based medical review platform/company. Although DHCS is currently contracted with IQ and MCG. DHCS will work with providers to facilitate open communication for successful reviews. If a hospital has decided to terminate and/or not renew their contract with Change Healthcare, please reach out to the DHCS Public Hospital Project inbox at: PublicHospitalProject@dhcs.ca.gov.

Agenda Item VI: MISCELLANEOUS/OPEN FORUM

Question: We understand that when a Medi-Cal beneficiary is incarcerated, inpatient care is covered by the Medi-Cal Inmate Program. We recently had an interaction with our local managed Medi-Cal provider in which a Medi-Cal beneficiary who had an ankle bracelet was considered "In custody." Can DHCS provide guidelines as to what constitutes being "in custody" so we can ensure we are working with the correct payor?

Answer: DHCS initially believes that this would not constitute custody as monitoring is not the same as custody; however, internal discussions and analysis are taking place, and the Clinical Assurance Division (CAD) does not have a final answer on the payor.

> **Update:** Following the meeting, CAD consulted with DHCS Office of Legal Services (OLS). Per DHCS OLS, individuals who are on house arrest, parole, probation, or are assigned community service are not living in a correctional facility, thus they are not considered inmates and Medi-Cal will still pay for their care.
> Medi-Cal – not the Medi-Cal County Inmate Program (MCIP) – should have financial responsibility following an inmate's release with ankle bracelet (control device) monitoring.

Question: What is the turnaround time for TAR-Free disputes?

Answer: Status update requests can be directed to the disputes' inbox at: phpdispute@dhcs.ca.gov

Question: Hospitals are continuing to experience missed opportunities for billing and payment of Administrative Days for beneficiaries pending Skilled Nursing Facilities (SNF) due to an unknown lag time when eligibility changes from Medi-Cal Managed Care to Fee-For-Service (FFS) Medi-Cal.

The requirement for FFS Medi-Cal includes (10) SNF placement calls; however, while in a Managed Care Plan (MCP), hospitals do not begin this process as beneficiaries are transported to a contracted SNF facility. Furthermore, it has been expressed that this process could take extended amounts of time due to unforeseen difficulties. Therefore, if the beneficiary is disenrolled from their MCP and is transferred into FFS Medi-Cal, hospitals are unable to claim/bill for Administrative Days for that period because the criteria is unmet as the (10) SNF placement calls were never initiated.

Answer: If disenrollment from a MCP occurred retroactively (i.e., during/after the month in question), then 10 daily calls would not be required as long as placement efforts are still being made. In addition, Case Management should document within the medical record that they are working with the MCP. If, in the following month, the hospital is aware that the beneficiary moved to FFS, then calls should be made.

Question: Hospitals are experiencing denials from beneficiaries receiving Long Term Acute Care where the stay begins as traditional Medi-Cal then transitions to Medi-Cal MCP. Hospitals have contacted their appropriate Medi-Cal field representative and were advised the stay should be the responsibility of Medi-Cal, as it was the primary coverage on admission. Following the discussion with their representative, the hospitals billed two claims; however, one claim paid for all days, but the other claim was denied, stating MCP was responsible for the days. While there were two different outcomes, Managed Care denied all months, even those that show the beneficiary is eligible for the health plan.

Answer: Hospitals will submit examples for review. DHCS will discuss this in length with additional staff in other divisions and report any recommendations.

Question: To continue the discussion above, additional hospitals have experienced an inability to bill entire stays when eligibility changes from FFS to MCP in the middle of an inpatient stay. Unfortunately, when the stay does not include admission to discharge, the hospital must split bill in accordance with multiple factors: Admin Days, Acute Days, etc.

For example, hospitals are receiving denials from the MCP because the admin date wasn't associated with the month of MCP eligibility. Therefore, because the hospital is split billing due to the inability to bill the entire stay, month-to-month eligibility Medi-Cal FFS is denying and recommending that the hospital bill the MCP. However, the hospital is denied from FFS due to the beneficiary being enrolled in the MCP for that month.

To assist with this issue, hospitals request an update in the claims processing system to examine the beneficiary's admit date and eligibility status, so that if the beneficiary is admitted with Medi-Cal FFS, then the entire claim should be approved, regardless of the dates of service and split billing.

Hospitals do not have access to see the "MCP Enrollment Pending" status for MCPs in the eligibility system.

Answer: DHCS asked for representative examples. DHCS will discuss this case in length with additional staff in other divisions and report any recommendations. Dr. Van Natta will investigate the month-long "MCP Enrollment Pending" status during the transition from FFS to MCP. DHCS will also discuss claims processing issues.

> **Update:** Following the meeting, CAD communicated with DHCS' Health Care Delivery Systems (HCDS, consisting of the Department's managed care divisions) and DHCS Health Care Finance (HCF). For Medi-Cal managed care finance-related questions, our recommendation is that the DPH finance departments first reach out to the involved Medi-Cal managed care plan (MCP) with which the hospital is in-network. For questions that remain insufficiently answered, we advise conveying the issue to your hospital association representatives with a request that they add the questions to the agenda for their monthly Hospital Associations meeting with HCF. The latter will invite HCDS representatives to assist HCF in responding to questions about reimbursement by the MCPs for hospital care provided to their members.

Comment from UC Irvine: To continue the discussion above, additional hospitals have expressed that when this situation occurs (eligibility changes from FFS to MCP in the middle of an inpatient stay), they also make sure to include diagnoses and procedures from the day of admission in the claims they send to MCP to make sure they are not underpaid due to split billing. They have experienced underpayment and have had to submit appeals, causing additional manual processes.

Answer: DHCS will pursue improvements to this increased occurrence.

Comment from Santa Clara Valley Medical Center: Hospitals have been experiencing difficulties with MCPs for the billing of behavioral and mental admissions and request a list to ease determination. Because psychiatric inpatient hospital services are covered by the County Mental Health Departments, it is difficult for non-medical hospital staff to determine whom to bill. Hospitals suggest that MCP management should create comments online regarding when authorization is not needed, to uncomplicate billing direction.

Answer: DHCS understands the difficulty of analyzing this gray area, sorting between behavioral and neurological admissions. Due to the magnitude of cases that fall into this area, a written list would not be helpful to providers for billing purposes. However, in FFS, we understand the reality of this gray area and, in some cases, have even provided reimbursements. DHCS will include this challenge during discussions with Managed Care associates. However, DHCS expresses that we are unable to direct the MCPs on their payment processes, and it is unlikely that this will be reflected in policy modifications.

Question: Hospitals have inquired about their rights regarding Medi-Cal MCP's inability to overturn a determination or reconsideration of a claim until the beneficiary is discharged, although the hospital has requested a peer-to-peer. If a beneficiary is receiving concurrent services, it is difficult for the hospital to wait until the beneficiary is discharged, for a reconsideration or an appeal.

Answer: DHCS directs hospitals to contact their MCP.