CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

LONG-TERM CARE LEARNING SERIES: MANAGED CARE RESOURCES FOR LTC PROVIDERS

Date: December 17, 2024

Time: 9:00 a.m. – 10:30 a.m.

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Duration: 1 hour 29 minutes

Speakers:

- Kristin Mendoza-Nguyen
- Bambi Cisneros
- Stephanie Conde
- Alison Brown
- Stacy Nguyen
- Scott Robinson
- Yousaf Farook
- Wendy Magnacca

TRANSCRIPT:

00:00:00 – Kristin Mendoza-Nguyen – Slide 1

Thank you for joining today's Managed Care Resources for LTC Providers webinar. This is the last session in the DHCS LTC Learning Series. Next slide.

00:00:12 – Kristin Mendoza-Nguyen – Slide 2

Before we begin, just a few logistics. This session is being recorded. Participants are in listen-only mode and the materials that are presented today, the slides and the recording, will be posted to the webpage shortly. Please use the chat feature through the Q&A throughout the presentation to submit any questions to the presenters. Next slide.

00:00:35 – Kristin Mendoza-Nguyen – Slide 3

And then, before we begin, we do ask participants if you could add your organization to your Zoom name. We'd like to do this because it helps track with questions and responses. You can click the three little dots by your name and hit rename. Next slide.

00:00:53 – Kristin Mendoza-Nguyen – Slide 4

Great. I will now turn it over to Bambi Cisneros, the Assistant Deputy Director of Healthcare Delivery Systems, to provide a background of the LTC Learning Series and an overview of today's session.

00:01:12 – Bambi Cisneros – Slide 4

Great. Thank you so much, Kristin. Good morning and welcome, everyone. Thank you for joining us this morning in our last Long-Term Care Learning Series webinar. We have quite a lot to cover this morning, so I'll briefly share the background of the Long-Term Care Learning Series, which was really born from feedback that we received from our stakeholder landscape assessment that we conducted this summer.

We will then spend some time walking through the three newly developed resources for long-term care providers, in which we will highlight some key content. And these resources touch on topics related to Medi-Cal eligibility and managed care plan enrollment, authorizations, and billing and payments. We also have representatives from CalOptima and Community Health Group health plans to speak to their plans operations and share their suggestions and tips for providers navigating these processes.

And then, lastly, please feel free to use the chat if you have questions related to the content that's being presented here throughout the presentation. And we will respond

during the Q&A sessions, if possible, or follow up with you. We can move to the next slide, please.

00:01:12 – Bambi Cisneros – Slide 5

Before we dive into the resources for long-term care providers, we will briefly discuss the Long-Term Care Carve-In and the development of the Long-Term Care Learning Series. Go to the next slide, please.

00:02:26 – Bambi Cisneros – Slides 6

So, under CalAIM, DHCS really sought to standardize institutional long-term care services statewide, and we did so through a phased approach in 2023 and 2024. The goal was to increase access to comprehensive care coordination, care management, and a broad array of services for Medi-Cal plan members. And now, Medi-Cal members can receive the same long-term care services for Skilled Nursing Facilities, Intermediate Care Facilities for the Developmentally Disabled, and Subacute Care, no matter what county they live in, or if they have to move.

And then, one important distinction I'd want to call out on this slide is that for ICF/DD homes is that DHCS did maintain the existing Lanterman Act protections and infrastructure in place of the Regional Centers for ICF/DD members. So that was really important for us to do. Go to the next slide, please.

00:03:46 – Bambi Cisneros – Slides 7

So, one of the most important facets of transitions to managed care is Continuity of Care. Continuity of Care policies are really put into place to help preserve member access, while the managed care plan works to bring the member's existing provider, or in the case of the Long-Term Care Carve-In, the facility, in its provider network, so that members that are residing in an ICF/DD Home or a Subacute Care facility that transitioned to the Medi-Cal managed care plan after January 1st have been provided automatic Continuity of Care for 12 months. And that ensures that the member's home or facility will not change and that members could continue to reside in their home or facility, even if that home or facility is not currently contracted with their managed care plan.

And now, as we're approaching the end of 2024, we wanted to provide a reminder for ICF/DD Homes and Subacute Care facilities regarding the Long-Term Care Carve-In Continuity of Care policy. And that is that, while Continuity of Care is automatic for the first 12 months after a member transitions into a Medi-Cal managed care plan, that after the initial 12 months, the member, their authorized representative, or their provider has

to request an additional 12 months of Continuity of Care if that is needed. So, the first 12 months is automatic. Now that we're nearing the end of that 12-month period, if there is a need to extend Continuity of Care, the member, authorized representative, or their provider has to request that from the managed care plan.

And just as a reminder, that managed care plans are required to notify their members at least 30 days in advance when the Continuity of Care period is expiring, and then also provide a copy of that notice to the Home or facility. And so, we have linked here on this slide several APLs or All Plan Letters that describe the Continuity of Care policy that we're providing here for your reference. Move on to the next slide, please. Thank you.

00:06:00 – Bambi Cisneros – Slides 8

So, as part of our post-transition monitoring, we wanted to hear from our stakeholders how it's going and how the Department can support providers and facilities in navigating the transition. And so, with that, we developed the Long-Term Care Learning Series so that it's informed by our providers' and our stakeholders' experience.

And so, we started off by doing a landscape assessment, which included a series of 11 interviews with stakeholder groups that included the Managed Care Plans and their plan associations, long-term care providers and their providers associations, the Regional Centers and their associations, and then Long-Term Care Ombudsman Coordinators, as well as the Medicare-Medi-Cal Ombudsman program. And we have learned a lot from those great discussions.

So, in terms of learning from those discussions, it also directly informed the content of the Long-Term Care Learning Series. And so, we also wanted to share a little bit about what we learned from those interviews with you today. Thank you.

00:07:09 – Bambi Cisneros – Slide 9

So, at a high level, we learned that this transition really required a shift in how all stakeholders approached their day-to-day, for both managed care plans, as well as the providers. And we have also heard that implementation of the Carve-In is not yet smooth, but we are making progress. And we have also learned that communication and collaboration across all stakeholders varies widely. And managed care plans have mentioned that they have had to provide further education and training to long-term care providers who are new to managed care, given the complexities of the various processes in managed care, as well as where the providers were in terms of their health information technology capacities. And then, their long-term care providers have also shared that they continue to encounter challenges in navigating specific processes in

managed care because of the variances across the managed care plans and their processes. We can go to the next slide, please.

00:08:10 – Bambi Cisneros – Slide 10

So, in response to these challenges, the managed care plans took several approaches, and those approaches included having regular meetings among their stakeholders, which was really important for problem-solving and strengthening relationships with their providers. They've also worked on either pursuing new relationships or strengthening existing relationships with other entities, like counties or hospitals or Community Health Workers, which are key players in supporting the long-term care members.

And we're also aware that managed care plans are using a multi-pronged approach. So, for example, they have LTSS liaisons, hey also have population health management outreach specialists, social workers, et cetera. So, really, an all-hands-on-deck approach when engaging with long-term care providers that can help address gaps in understanding and communication.

Managed care plans are also providing regular trainings and education opportunities for providers that are new to managed care, and this helps to build foundational knowledge of how plans operate, and it also informs what questions providers need to ask plan partners as they are newly working with them or continue to work with them.

And then, lastly, we learned how important it is for there to be clear and streamlined messaging on policy, both from the managed care plans, communicating guidance on topics like billing, credentialing, as well as from the department when issuing cross-cutting policy.

And that leads us to why we have developed a Long-Term Care Learning Series and developed resources specifically for long-term care providers on the topics of eligibility and enrollment, authorizations, and billing and payments because we understand that it's challenging to navigate these processes across facility type and managed care plan.

However, do want to point out that it is essential for long-term care providers and plans to be in constant communication regarding their long-term care providers and policy and processes, and we hope these resources help provide that general understanding while they continue to work together. We can go to the next slide, please. Thank you.

00:10:32 – Bambi Cisneros – Slides 11 - 12

So, the primary objectives of today's webinar are to review the key information from the resources that were developed, and these resources include step-by-step processes,

helpful tips, and some helpful links as well. And then, we will also engage with our managed care plan guest speakers to discuss insights and best practices related to these resource topics. And then, while we're showing a snapshot of these resources, we are working on posting these resources this month, so you'll have these resources available to be able to go back and refer to.

And so, with that, I will now turn it over to Stephanie Conde, Branch Chief of the Managed Care Operations Division, and Alison Brown, Section Chief of the Medi-Cal Eligibility Division, to begin walking through the Medi-Cal Eligibility and Managed Care Plan Enrollment Resource.

00:11:33 – Stephanie Conde – Slide 12

Thank you, Bambi. Good morning, everyone. As Bambi said, I'm Stephanie Conde. I'm a Branch Chief with the Managed Care Operations Division. I'm going to begin by highlighting some key information from the Medi-Cal eligibility and managed care plan enrollment resource for our long-term care providers. Next slide, please.

00:11:57 – Stephanie Conde – Slide 13

This resource provides an overview of Medi-Cal eligibility and managed care plan enrollment information for long-term care providers. The information in this resource was informed by the interviews conducted as part of the stakeholder landscape assessment, as well as questions we continue to receive. Specifically, our aim was to summarize key information on Medi-Cal eligibility and managed care plan enrollment for members, provide guidance for how long-term care providers can support members navigating these processes, as well as include helpful links to various already existing Medi-Cal eligibility and managed care plan enrollment information. Next slide, please.

00:12:41 – Stephanie Conde – Slide 14

This slide highlights the sections in the resource. It starts with the basic process of applying for Medi-Cal, focusing on the verification steps and timelines. It transitions quickly to how members enroll in a managed care plan, detailing the various managed care plan county models and how a member would approach managed care plan enrollment based on the county they live in. We also provide an overview of managed care plan subcontracting and what that means for our members and providers. We include information on what a member should receive once they've been enrolled in a managed care plan, as this information is essential to successfully navigating managed care processes and members' rights. And the last section details ways in which long-

term care providers can support their residents as they navigate eligibility and managed care plan enrollment.

I'll hand it over to Alison to discuss the key eligibility information from the resource.

00:13:37 – Alison Brown – Slide 14

Good morning, everyone. My name is Alison Brown. I'm one of the Section Chiefs in the Medi-Cal Eligibility Division. Can we go to the next slide, please?

00:13:53 – Alison Brown – Slide 15

So, when applying for Medi-Cal, it can take up to 45 days for the application to process, and if eligibility for Medi-Cal is based on a disability, it can take up to 90 days. However, once an individual is approved, Medi-Cal coverage is available right away via Fee-for-Service Medi-Cal. A member continues to have Fee-for-Service Medi-Cal until they're enrolled in a managed care plan. While a member has Fee-for-Service Medi-Cal, long-term care providers need to bill Fee-for-Service. If the member has more than one plan option, the member has until the date listed in the My Medi-Cal Choice Packet to choose a managed care plan. If a member does not choose a managed care plan, Medi-Cal will choose a plan for the member. Next slide, please.

00:14:38 – Alison Brown – Slide 16

Providers can determine the member's eligibility status by checking the member's eligibility record via the Automated Eligibility Verification System or AEVS. It will also show which plan the member is enrolled in, but we will talk more about this on the next slide. As linked in the resource, if you need further information or want to refer members to more information on the eligibility process, please visit the steps to Medi-Cal DHCS webpage. I will now hand it back over to Stephanie.

00:15:10 – Stephanie Conde – Slide 16

Thanks, Alison. Next slide, please.

00:15:16 – Stephanie Conde – Slide 17

As mentioned, a member is enrolled in Fee-for-Service Medi-Cal until they are enrolled in a managed care plan. A member's managed care plan choice depends on the county in which the member resides, as well as if the member is a part of a Medicare Advantage plan. The next section includes a table describing the five managed care plan county models and if or how a member can choose a managed care plan. And then, for time's sake today, I won't go over each of those model types, but they are included in that table in the resource. Next slide, please.

00:15:53 – Stephanie Conde – Slide 18

If a member is enrolled in a Medicare Advantage plan and resides in one of the 17 matching plan policy counties, that member will be automatically enrolled in that matching Medi-Cal managed care plan. To find out which managed care plans operate in a given county, refer to the DHCS Medi-Cal Managed Care Plan by County document at the link in this slide deck or in the resource. And then, again, AEVS will have the most up-to-date information on that member and their plan enrollment. Next slide, please.

00:16:27 – Stephanie Conde – Slide 19

Managed care plans may delegate or subcontract certain functions to other plans or providers. In delegation, managed care plans, referred to as prime plans, may assign a member to another managed care plan or delegated subcontractor. For example, on the table on the slide, in Los Angeles County, LA Care is a prime plan and delegates members to Anthem Blue Cross and Blue Shield of California Promise Health Plan, who are it's delegated subcontractors. Health Net is a prime plan and partners with Molina Healthcare. To identify which managed care plan a member is assigned to, long-term care providers should check AEVS. The prime plan's provider should check AEVS, the prime plan's provider portal, member services, or that member's health plan ID card.

Additionally, managed care plans may subcontract services to a group of providers, referred to as Participating Provider Group, PPG, or Independent Practice Association, IPA. In this case, depending on the managed care plan, a provider may need to contract and bill the PPG or IPA. The Division of Financial Responsibility, detailed in the provider's contract with the managed care plan, will detail who the provider should bill. Providers should check the member's managed care plan portal or that health plan ID card to determine if they have been delegated to a PPG or IPA. Next slide, please.

00:17:59 – Stephanie Conde – Slide 20

After a member is enrolled in a managed care plan, the member will receive a confirmation letter from Health Care Options if they reside in a non-County Organized Health System (COHS) or non-single plan county. Health Care Options is the DHCS enrollment broker, and that confirmation letter does confirm the managed care plan and the effective enrollment date. The member will also receive a member handbook from the managed care plan, which does explain the evidence of coverage, detailing the services provided to the member in that plan, as well as the provided directory and important notices, including notice of action and adverse benefit determinations.

Managed care plans are required to post their Medi-Cal member handbook and provide a directory on their websites. Additionally, the managed care plan and Health Care Options will send this information in that member's preferred manner, including alternate formats such as preferred language, including a member's alternate formats, such as Braille, large print, or audio. If a member that you're working with has not received that handbook or it's not posted on the managed care plan website, please contact the managed care plan LTSS liaison.

I'll hand it back to Alison once again to discuss ways in which the long-term care providers can support members through eligibility and enrollment processes.

00:19:16 – Alison Brown – Slide 20

Thanks, Stephanie. If we can go to the next slide, please.

00:19:21 – Alison Brown – Slide 21

As LTC providers, there are a variety of ways in which you can support members navigating Medi-Cal eligibility and managed care plan enrollment, which are outlined in the resource. For today's presentation, I'll review just a couple of ways in which providers can support members enrolling in a managed care plan.

The first item we are highlighting relates to providers supporting residents when they apply for or maintain their Medi-Cal coverage. Firstly, anyone who knows of a potential applicant's need to apply for Medi-Cal can submit an application for the purpose of preserving the date of application. Potential applicants, who cannot act for themselves, shall not be denied or discontinued Medi-Cal coverage solely for the reason that there is no entity assigned to act for them. If there is no spouse, conservator, guardian, or executors, and the applicant is not considered competent, long-term care providers may be able to act on a resident's behalf by contacting their local county social services office and informing the office of the applicant's known circumstances. And you can refer to All County Welfare Directors' Letter 94-62 for more information on that process. Next slide, please.

00:20:36 – Alison Brown – Slide 22

Another issue that we see, is when a member resides in a different county, or they're placed in a facility in a different county from where they reside. In these cases, we recommend that long-term care providers become familiar with what's called the intercounty transfer process. As part of the intercounty transfer process, the member is responsible for notifying either the county they're leaving or have left or the new county in which they will reside of their change in residence. The member may report their

change in residence in-person, in writing, telephonically, or online. The county, notified by the member, then must initiate the intercounty transfer process within seven business days of notice with the non-notified county. The intercounty transfer then must be completed within 30 days after the member's initial notification.

Additionally, it's important to note that a member who is disenrolled from the managed care plan in the county where they moved from is entitled to the full scope of benefits they're entitled to in the new county via Fee-for-Service Medi-Cal until they are enrolled in a managed care plan in that new county. Long-term care providers can support members by acting as a liaison during the transfer and ensuring members continue to receive full care throughout. Next slide, please.

00:21:54 – Alison Brown – Slide 23

Sometimes a member who is transferring and in the midst of the intercounty transfer process is unable to enroll in a managed care plan due to a mismatch in their address and their county code and the DHCS Medi-Cal Eligibility Database System or MEDS. Long-term care providers can direct the member or their authorized representative to contact their local county office to update their address. Members with a mismatch address in MEDS will remain in Fee-for-Service until their address is updated.

I will now go ahead and turn it over to Kristin to begin the question-and-answer portion for this section.

00:22:33 – Kristin Mendoza-Nguyen – Slide 24

Great. Thank you, Alison and Stephanie. We had a number of questions come through the chat. One question specific on enrollment and eligibility is from Jennette Potter. What is the best process to handle discrepancies between AEVS and the plans regarding enrollment not being updated?

00:23:00 – Stephanie Conde – Slide 24

Hi, good morning. We can look into that. It just depends on what portion of AEVS you're looking to be updated. There's many data elements in there. Some are populated by the plan, and it's submitted to the department, but some are department-based data. So, I just would need to look into it a little bit more. So, I think the team can post in the chat, or you can actually post in the chat your email and we'll get in contact with you via a secure email to research a little bit further to see what you're looking at and what data points you're looking to get updated. So, if you can just post your email in the chat, that would be helpful.

00:23:48 – Kristin Mendoza-Nguyen – Slide 24

Great. Thank you, Stephanie. A question from Kimberly, from Momentum. When a member is trying to switch plans from Health Net to Molina, should the member contact Health Care Options, Molina, or Health Net? We're running into this issue currently. We contacted the Ombudsman for assistance since Health Care Options could not provide any direction. Any insights and next steps?

00:24:17 – Stephanie Conde – Slide 24

If you're trying to change from a prime plan to a delegate or vice versa, a delegate to a prime, you contact the prime plan. So, again, if you're having problems with that prime plan, the department would like to assist, but you should contact the prime plan to switch plans.

00:24:44 – Kristin Mendoza-Nguyen – Slide 24

There were a couple questions also in the chat requesting the MCP Liaison List. So you can contact the email that's in the chat provided to get a copy. Any other questions? I'm just scrolling through.

Okay. There was one question from Stephanie Wanat. One issue I've been having with managed care plans is that they are not honoring the DHCS Authorized Representative forms that we have completed. One plan, in particular, is requiring us to have the CMS Authorized Representative form and have a legal document showing that we are allowed to speak on behalf of the client. Is there a process that the MCP should follow in regards to honoring already approved Authorized Representatives submitted to Medi-Cal?

00:25:50 – Stephanie Conde – Slide 24

Alison, if you can jump in on the Department processes for Authorized Rep, and then I can jump in from the managed care plan perspective.

00:26:01 – Alison Brown– Slide 24

Yeah, just from an Authorized Representative perspective, there should not be any reason why Authorized Representative forms would not be accepted, unless the person was not considered competent to act on their own behalf. That's the one circumstance where an Authorized Representative form would not be appropriate and a different process would be used. But otherwise, the Authorized Representative forms are the appropriate forms.

00:26:31 – Stephanie Conde – Slide 24

And then, just from a managed care plan perspective, the managed care plans do have a verification process, and so that may be what they're asking you to follow. And again, there's PI or there's reasons why there's processes followed by our managed care plan. So, it is a verification process and each of the plans have a little bit of a different process. But yeah, they do have processes, and you would need to follow those in order to be input as any type of caregiver or guardian.

00:27:11 – Kristin Mendoza-Nguyen – Slide 24

Another question from Cindy Arteaga. Why are some members not able to delegate a managed care plan?

00:27:25 – Stephanie Conde – Slide 24

Kristin, can you read that again? I'm not sure I understand.

00:27:28 – Kristin Mendoza-Nguyen – Slide 24

Why are some members not able to delegate a managed care plan?

00:27:33 – Stephanie Conde – Slide 24

Okay. I think if I can restate that a little bit, some members are not able to go to the delegated plan or their prime plan, and it may be based on their Medicare Advantage plan. I don't know the slide number, but I talked about it briefly that there's a Medi-Cal matching plan policy. It's in 17 counties right now, and if you have a Medicare Advantage plan, and there is a matching Medi-Cal plan, you do need to match until you change your Medicare Advantage plan. The Advantage plan is the lead plan in the alignment, and so you would be directed to change your Medicare plan before you can change that Medi-Cal plan and either go to that prime or that delegate.

00:28:24 – Kristin Mendoza-Nguyen – Slide 24

Question from Totally Kids. If a parent of a minor does not complete or provide the necessary documents for the Medi-Cal application for more than six months, who do we contact, since the application is denied due to not providing the necessary documents, when there are urgent needs?

00:28:43 – Alison Brown– Slide 24

I think, for the most part, when it comes to minors, the entity that is considered to have legal responsibility over the minor, is the entity that would need to provide those documents. So, typically, if a parent or guardian of a minor does not want to participate

in the Medi-Cal process, we are unable to proceed with that application or with processing that eligibility determination if that parent is unwilling to provide that information.

00:29:20 – Kristin Mendoza-Nguyen – Slides 24 - 25

Thank you, Alison. I'm now going to transition to the next portion of our webinar to talk about the next resource. So I will now hand it over to Stacy Nguyen from the Managed Care Quality and Monitoring Division to review the LTC authorizations resource.

00:29:41 – Stacy Nguyen – Slide 25

Thank you, Kristin. Good morning, everyone. My name is Stacy Nguyen. I'm the Branch Chief of the Managed Care Monitoring Branch within Managed Care Quality and Monitoring Division. Today, I'll be going over some key information regarding the Long-Term Care Authorizations Resource for Providers.

00:30:02 – Stacy Nguyen – Slide 26

The Medi-Cal Long-Term Care Authorization Resource here outlines the high-level authorization process. We do recognize that each managed care plan has its own process. We try our best to include helpful tips, such as questions to ask each plan that might help the long-term care providers gather information to help them navigate each plan's individual process. The resource also includes a checklist to help providers successfully submit long-term care authorizations, as well as including a quick long-term care authorization reference guide with some key information. Go to the next slide.

00:30:47 – Stacy Nguyen – Slide 27

So, step one is submitting the authorization request. Providers can typically submit long-term care authorizations on the managed care plan's online portal by fax or by phone. A form is also typically required and asks for all necessary information, like member diagnoses and service information. Requested coverage information is to include the physician's order or signature, noting that the ICF/DD home service authorization requires the clinical review and a recommendation from the coordinating Regional Center as well.

So, we also highlighted some questions that providers can ask managed care plans to get the information needed to navigate this step in the process. Since plans have different authorization submission requirements, it's important to ask what the preferred method is, whether that's mailing the form or completing it electronically. And also, additional documentation may be required from each one, so it's important to also

clarify what those are at this step of the process. Providers will also want to verify the process for requesting an authorization for urgent services well ahead of when it's actually needed. We will discuss some common reasons for submission denials with managed care plans after this section. Next slide, please.

00:32:20 – Stacy Nguyen – Slide 28

After you have the information you need to submit an authorization, it's also essential to review for completeness and accuracy. So the quick checklist on the slide and in the resource can help serve as a double check on your submissions. Next slide.

00:32:42 – Stacy Nguyen – Slide 29

So, once the authorization request is submitted, the managed care plan will then review the authorization request. Managed care plans will conduct a clinical review to evaluate the request against established medical criteria. Also, this will include a clinical review, often by nurses who are familiar with clinical care and the medical criteria guidelines. Authorizations for members transitioning from acute care hospitals need to be responded to by the MCPs or by the managed care plans within 72 hours, and this does include the weekends.

A few questions for managed care plans included in the resource include: how can providers track the request? If a plan requests additional information, who is the point of contact, and what's the best way to reach out? This can also help to avoid any delays when the plan needs more information. And lastly, how and when will providers be notified of the decision? Next slide.

00:33:49 – Stacy Nguyen – Slide 30

Step three is regarding MCPs or managed care plans issuing the authorization decision. So, the managed care plan should respond and make a decision on the authorization request as expeditiously as the member's condition requires. For routine authorizations, they must respond within five working days and make a decision within 14 calendar days from receipt of the authorization request. For expedited authorizations, the managed care plan must make a decision within 72 hours of the authorization request, and this includes authorizations for members who are transitioning from an acute care hospital to any setting.

If the managed care plan denies the authorization request, the provider or the member and their authorized representative may appeal the decision. So, if there's a denial to appeal, the member or member's authorized representative may apply for an independent medical review. If the managed care plan is Knox-Keene licensed, the

member or member's representative may request a state hearing as well. And it's important to ask the plan about the appeal process and if additional information or any documentation is required. Next slide.

00:35:18 – Stacy Nguyen – Slide 31

And we also included a quick reference. So, the last section of this resource is a quick reference table, which outlines the authorization periods, medical necessity, and any additional requirements across each long-term care benefit. We've also included in the source links here, as for the information referenced. Ultimately, we hope that this table provides helpful information that supports providers navigating the authorization process, so that it can lead to timely, compliant, and appropriately-authorized care for the Medi-Cal members.

00:35:58 – Stacy Nguyen – Slides 31 - 32

I will go ahead and hand it back to Kristin to facilitate a discussion on the long-term care authorizations with our managed care plan guest speakers from Community Health Group and CalOptima. We're very excited to have them here to discuss this topic, and I will go ahead and hand it over to you, Kristin. Thank you.

00:36:17 – Kristin Mendoza-Nguyen – Slide 32

Thank you, Stacy. So, we're going to open it up for a plan panel. We have some folks from Community Health Group and CalOptima to discuss some promising practices around long-term care authorizations, specifically. So, I would welcome Yousaf, Scott, and Wendy to join and turn on their videos, and then we can proceed to the panel questionnaire. Next slide, please.

00:36:44 – Kristin Mendoza-Nguyen – Slide 33

Okay. So the first question is for CalOptima. What are the top common reasons for an authorization to be denied or sent back to the LTC provider? Specifically, what guidance or instructions have you provided to LTC providers that has helped to decrease the amount of LTC authorization follow-up? So let’s see if Scott or Wendy, are on.

00:37:11 – Scott Robinson – Slide 33

Yeah, I can take that one, Kristin.

Good morning, everybody. It seems the top reasons for denials are submitting the authorization request form late. The ARF can be submitted within 21 days of admission, and many times, I'd say about one-third of the ARF submissions are beyond 21 days, and that would be a reason for denial. Other reasons would be incomplete

documentation that's being submitted with the ARF or the ARF isn't completed accurately, dates may be missing, or the PASRR information isn't complete. All of the documents that we require are on the authorization request form that can be accessed through our website at caloptimahealth.org. So, those are the primary reasons for denial: inaccurate documentation, lack of documentation, and late submissions.

00:38:25 – Kristin Mendoza-Nguyen – Slide 33

Great. And then, could you expand, Scott, on any guidance or instructions you provided to support LTC providers?

00:38:34 – Scott Robinson – Slide 33

Oh, absolutely. So, our LTSS department is organized with nurse case managers and medical authorization assistants, and they support anywhere from five to ten long-term care facilities. So, they are your liaison to help you with education and training and requesting more information on what you can do to submit timely and accurate authorization. So, they spend a lot of time with each of the facilities, training and re-educating staff on what is needed, in reaching out to business office managers to get the appropriate information. Another real helpful addition to this is, if we can get access to your electronic medical record system, we can actually go in there and view the documents and get what we need, and that can expedite authorizations too.

00:39:38 – Kristin Mendoza-Nguyen – Slide 33

Thanks, Scott. And then, any for Yousaf, from your guys' perspective, from CHG, do you have any other additional LTC authorization tips or best practices that you've seen?

00:39:54 – Yousaf Farook – Slide 33

Thank you, Kristin and Scott. As I look at our process, to add onto what Scott had already mentioned, one of the common themes that we see is the documentation that sometimes is provided is from the original admission, were missing the most recent progress notes, or documentation that are required to evaluate the current needs of the member. So, if the facility is submitting documentation that might be a month, two months old, all long-term members are supposed to be seen at least once a month by a provider and a note should be in the member's medical record. So, getting the most recent documentation to the health plan is very helpful.

Additionally, having or knowing who the teams are, or who are the case managers, or the long-term support staff individuals that are working on these cases from managed care side. So, if I'm a long-term care facility, I should know who my contacts are, who do

I have to have those relationships with, so when I do have a question, when my authorization is getting kicked back or request is getting kicked back because I didn't provide enough, the right information, or I didn't include the right form, who do I need to call and connect with, so they can essentially walk me through that process.

And I know a lot of times, there's turnover or staff at the facility side who might be new and might not be familiar with. I can let you know that at Community Health Group, we have a dedicated inpatient case management team, and each facility has one assigned case manager, which is the essentially one point of contact that the facility needs to reach out to for any issues related to authorizations. So, if they have those relationships, these individuals can do visits at the facilities, sit down with the staff, explain the process and the expectations around turnaround times. And nine out of ten times, our case managers able to authorize or issue that authorization while they're on site.

And another barrier that I see is sometime the documentation in the medical record doesn't match the member's actual physical needs or capabilities. And sometimes, because of that disconnect, our case managers have to get involved with the physicians or different team members at the facilities to demonstrate that there are still long-term care needs for the member and they meet that eligibility criteria. So, I hope that helps shed some light on some additional things that the long-term care facilities can do to reduce any barriers to obtaining authorizations.

00:43:18 – Kristin Mendoza-Nguyen – Slide 33

Great. Thank you both. Yousaf, I think you touched on one of the issues that I know has come up in a lot of different spaces in terms of turnover. I think turnover, both on the plan side as well as the provider side, is something that continues to be a challenge, I think, because of the knowledge sharing in terms of the processes and the best practices. Given that, how do you all communicate? And this is for both of you. Any guidance to providers, either on a regular basis or if it gets updated or changed, on the LTC authorization processes? And how do they know if it's been updated, and how do you work with them?

00:43:58 – Yousaf Farook – Slide 33

Scott, I'll let you go first.

00:43:59 – Scott Robinson – Slide 33

Well, thanks, Yousaf. Obviously, we've recognized that turnover is a continuing problem, not only on our side, but also on the SNF side. And in the past, we'd had quarterly webinars and meetings with all of our contracted providers. It fell off during the COVID

pandemic, but we've reinstituted that now. So, we're having quarterly webinars, where we can update the facilities and teams with new guidance on authorization request processes and new forms that are being rolled out. So, we want to make it very collaborative and communicative, where, like Yousaf said, they have the dedicated liaison, we've got our dedicated nurse case managers and medical authorization assistants that are available every day to help guide through all the documentation that is needed and do any training that's necessary. So, we do it on a individual level and then on more of a macro level with all of our facilities.

00:45:13 – Yousaf Farook – Slide 33

And I would like to add that recently, we implemented, change our process on NEMT requests. For example, our facilities sometimes submit documentation, or we're submitting these PCS forms and information was missing. We implemented a portal solution where the PCS form could be filled out by the facilities on our portal. So, we sent our dedicated staff member to each facility and essentially had them educate the current team about the use of the portal and making sure that they, one, had the login information, they know where to go to submit the request for regular authorization, along with transportation authorizations. And additionally, we also have SNF's group, our physician group that were contracted with that are managing these members. So, the information is relayed to the facilities through our inpatient team, through our provider relations team, through our physicians who are directly contracted with us to help manage these members at various levels.

We also hold quarterly meetings with the facilities, where the administrators and the key individuals come to those meetings. Unfortunately, a lot of times, the frontline staff that are actually doing the day-to-day work are not able to attend those meetings. So, to get that information in front of those individuals, the best solution that we have found is having our inpatient case management team essentially going into those buildings and meeting with those frontline staff and updating them, giving them the updated forms if there are changes, and setting those communication pathways between the facility, the frontline staff, and us because if we understand that if we do not provide the right guidance, the right resources to the facilities, they can provide the care to our members in a expeditious manner. So, it's in both of our interests to make sure that we're all on the same page.

00:47:37 – Kristin Mendoza-Nguyen – Slide 33

Great. Thank you, Yousaf and Scott. Sounds like a multipronged approach on all fronts, depending on the providers as well, and whether if you've had a relationship with them

in the long run or if they're brand new. I think there's different strategies that would be helpful for all folks to consider, or also continue also providing to their provider groups. Thank you for sharing.

00:48:03 – Kristin Mendoza-Nguyen – Slides 33-34

I'm going to pivot to the Q&A portion for authorizations. So, I'm going to kick off the Q&A because we did receive one question in the registration form on authorizations. And so, this is particularly from Pat from CHA, from the California Hospital Association, specifically about therapy services. So, therapy services needed to attain and/or maintain maximum functioning are part of the SNF per diem inclusive services. Services outside the per diem rate, like non-routine therapy services, would follow MCP processes and may need authorization. So, I would welcome, I think, Stacy, if you want to comment on the per diem question about the services.

00:48:59 – Stacy Nguyen – Slides 34

Thank you, Kristin. I think you touched on the per diem inclusive services piece just now. Services outside of the per diem rate, like non-routine therapy service, would follow the managed care plans' processes and may need that authorization. This might include physical therapy, occupational therapy, and speech therapy. And then, the school nursing facility would also need to send a separate authorization for non-routine services.

00:49:32 – Kristin Mendoza-Nguyen – Slides 34

And then, I would welcome Yousaf or Scott, if you have any best practices to share on those.

00:49:40 – Yousaf Farook – Slide 34

I can take that. So, we do receive requests for therapy for our members that are in long-term care. Essentially, in those cases, when therapy is needed, as long as there's a physician order and the current documentation supports that the therapy could help strengthen the individual. Because our long-term members are in the facility for a long period of time, and sometimes, for them to be able to just ambulate within the facility and have enough range of motion available to take care of activities of daily living, we understand the importance of therapy. And as long as we have the physician order and the proper documentation, we would authorize a short-term therapy to see how the member progresses.

So, we would just simply change the authorization from long-term authorization to a skilled authorization for a short period of time. Once the therapy has been concluded or deemed no longer necessary, then the level of care is changed back to long-term care. That's one way to take care of that. The other, I have seen members where they want to go to an outpatient therapy section instead of in the facility. And some of our facilities here locally in San Diego do have outpatient therapy programs where we can authorize outpatient therapy separately, meaning the members still remains at the long-term level of care, but they're receiving therapy on the outpatient setting, per se, and they get their needs met. I hope that helps.

00:51:34 – Kristin Mendoza-Nguyen – Slides 34

Great, thank you, Yousaf. And we had a question specifically for Scott from CalOptima, from someone in the chat, from Jennette. If the patient is in LTC, under custodial care, and the ARF is submitted, how do we handle the ARF only being approved for ICF?

00:51:56 – Scott Robinson – Slide 34

I would need to get back to you on that answer.

00:52:10 – Kristin Mendoza-Nguyen – Slide 34

Let's see. There's a question in the chat from Brenda. Is it possible authorizations from Molina, Anthem, and Kaiser can be approved without requiring new authorization every time patient goes to the hospital and back? It requires a lot of back-and-forth for approvals. Stacy, do you want to comment on that one? We might have to take that one back, but it was from Brenda in the chat.

00:52:34 – Stacy Nguyen – Slide 34

Yeah, thank you. I think we might have to take that one back. I know it's typically plan-specific, so we may have to check in with the plans, or if any of the plans are online, I would welcome you to chime in as well.

00:52:56 – Bambi Cisneros – Slide 34

Yeah. I would agree there, Stacy. I think some plans will do a new authorization. Other plans will do a reauthorization. So, I think what we would say here is if you would please work directly with the managed care plan you're working with just because that could differ.

00:53:19 – Kristin Mendoza-Nguyen – Slides 34 - 34

I don't see any other questions. If there's any other questions for our panelists, please feel free to drop them in the chat. I know we'll be welcoming you guys back on the next session after we walk through the billing payment though. Okay, I don't see any other questions, so I'm going to turn it, Bambi, actually back to you to walk us through the next one. And then, Yousaf and Scott, thank you. We'll see you for the next panel opportunity after this.

00:53:47 – Bambi Cisneros – Slide 35

Thank you, Kristin, Scott, and Yousaf. Okay, so we will move on to the billing and payment resource section. Go on to the next slide, please.

00:54:01 – Bambi Cisneros – Slide 36

So, the Managed Care Billing and Payments Resource will provide an overview of the standard billing process, and then how providers can receive payment. So this particular resource will break down the billing and payment down into a step-by-step process. And so, the first page of the resource will include a diagram of the billing process. And we thought to include this diagram because, although, as we shared here, that managed care plans may have different billing processes, there is still a basic billing and payment process that is common to all and is really essential to understanding the process.

Having this general understanding of the process will make it easier to identify when and where there may be differences in how managed care plans approach parts of the billing and payment process. And similar to the previous resources, we also include long-term care provider-specific information and guidance in the form of practical tips and questions for providers to consider raising with each managed care plan as they work together. Go to the next slide, please.

00:55:11 – Bambi Cisneros – Slide 37

Step one for claim submission. So, after a service has been rendered, the provider has to submit a claim to the managed care plan in accordance with their timely filing policy. And so, as the plans have shared here, to avoid delays, claims should be, and authorizations to that end, should be clean, which means that they are error-free and don't require additional information or follow-up from the provider. And so, how would a provider know what information is needed to submit a clean claim?

Well, managed care plans are required to publish guidance to providers on how they should approach billing and payment. So, it is important for providers to review this information for timely filing policies and instructions for submitting clean claims. And

additionally, the billing and payment guidance should also detail the various acceptable methods of submission for claims, which include information on clearinghouses.

And so, when working with the managed care plan, a few questions providers can ask them are: where can I find resources to assist me with submitting claims? And then, outside of the managed care plan's LTSS liaison, who else can I reach out to for help with submitting claims? So, important just to know who the key contacts are at the plans, although the LTSS liaison can serve as a really great resource.

And so, to ensure that providers have all the information that they need to bill that managed care plan, it's important to clarify where claim submission, guidance, and resources live, and if there are other contacts, so that way the providers can reach out for help when submitting claims. And if they are unsure or unclear about the process, then they can work with the plan and request the details for how to resubmit as needed. Go to next slide, please.

00:57:03 – Bambi Cisneros – Slide 38

In the resource, we have also listed some common issues and included tips on how providers can avoid claim rejections or denials. Sometimes a provider may submit, for example, a second claim if they feel that the original was denied inappropriately or not properly processed, or there has been a delay in processing or payment. However, we do want to caution that that resubmission may lead to a denial of both claims and, subsequently, cause additional delays. So, it is important to check the status of a claim before submitting another one. That would be considered a duplicate. Providers would verify the status of a claim by checking with the managed care plan, either via their provider portal or mechanism for claims tracking, or reaching out to the managed care plan to request this information.

And then, another tip that we're sharing here, pertaining to duplicate claims, is to appeal the denied claim rather than resubmitting. Again, just with the purpose of not wanting to unintentionally cause additional delays and having denials for both claims.

We've also noticed that another common issue that results in a claim denial is when there's incomplete provider information. So, for providers, please do verify that all provider information is complete and correct, which includes the provider's NPI and TIN number, phone number, and address. Go to the next slide, please.

00:58:47 – Bambi Cisneros – Slide 39

So, moving forward with the theme of claim submission. So, even though Medi-Cal Fee-for-Service moved to using the National Uniform Billing codes for long-term care claims

in the Fee-for-Service environment, want to note here that Medi-Cal managed care plans are not required to use these codes. Each plan may require a different set of billing codes, dependent on the long-term care benefit and distinct services. And because codes reported on a claim may directly impact whether a claim is denied and the amount that is paid, it is important for providers to verify which billing codes are accepted for each managed care plan.

To stay up to date on billing codes, we do recommend providers regularly review each plan's published billing guidance, and also subscribing to any managed care plan newsletters, and continuing to attend meetings or trainings, or office hours that the plans are offering in terms of provider training and education. Also, it is important to capture the member's other insurance, if they have any. And so, what we have shared the link here to an All Plan Letter that has information on the coordination of Medicare and Medi-Cal benefits, which we're calling the long-term care crossover billing policy.

And then, as mentioned previously, to ensure that providers have all the information they need to be successful with billing managed care plans, providers should review each plan's billing guidance and reach out to the plan with any billing questions. Go to the next slide, please.

01:00:29 – Bambi Cisneros – Slide 40

So, once a claim is submitted and passes the initial review for billing errors, it goes down to further processing for claims adjudication. So, the managed care plan will be reviewing the claim, which includes reviewing authorization information on the claim to determine if and how the provider will be paid. Tracking submitted claims then is essential for ensuring continuity of care and timely payment.

And so, for these reasons, managed care plans are encouraged to allow providers to access electronic billing systems or provider portals, regardless of contracting status, so that way providers can track their claim status. And do understand that some managed care plans are only granting full provider portal access to contracted providers. And so, if provider portal access is not possible for non-contracted providers, we do expect managed care plans to provide technical assistance and support, so that providers can get the information they need to track their claims and billing information.

And so, if the claim is determined unpayable, then the managed care plan then applies the reimbursement rate, and then any applicable member cost sharing to determine the final payment. And then, if the claim is determined to not be payable, the managed care plan will deny the claim. And so, again, really important to refer to the plan's billing guidance or contact the plan for any questions on the claims' adjudication process. And

then, for providers, we do encourage you to look at our Managed Care Boilerplate Contract. That has information on what the adjudication requirements are that DHCS places on managed care plans. Go to the next slide, please.

01:02:20 – Bambi Cisneros – Slide 41

So, step three when it comes to payment. After adjudication, if a managed care plan determines that a payment is owed to the long-term care provider, the managed care plan will send the payments in the provider's preferred manner. So, I want to emphasize here that managed care plans cannot provide payments in the form of gift cards. Again, it's the payment in the provider's preferred manner. The managed care plan will also send the remittance advice to the provider. And the remittance advice includes payment information and the reason codes with descriptions that explain any adjustments or, if it's denied, the reason for denial. And it is important for plans to provide the completed remittance advice so that providers can meet their reconciliation and also auditing requirements that providers are subjected to.

And so, when working with managed care plans, questions that providers could ask to help support their navigation throughout this process are pertaining to remittance advice, could be asking the managed care plans, how you will be receiving that remittance advice, and then what remittance advice code guidance or crosswalks could be provided to help you then work through your claims corrections or resubmission process? And so, this information is important feedback for providers that they can then take and incorporate into their billing process. Go to the next slide, please.

01:03:56 – Bambi Cisneros – Slide 42

So, providers may receive payments by Electronic Funds Transfer if the claims are submitted electronically. And so, to ensure that a provider can receive a payment seamlessly via this Electronic Fund Transfer and to avoid any payment issues or delays, again, want to emphasize here that providers should verify that their information is accurate and complete. So, for example, having the complete provider name, NPI, tax ID number, and billing zip code, and just making sure that information is up-to-date with a managed care plan. And we also want providers to verify this information in the managed care plan's provider portal and on the EFT form. Again, just making sure all of the information matches across the various forms.

And then, long-term care providers can appeal decisions regarding claims that they feel has been incorrectly denied or reimbursed inaccurately. And so, if a provider feels that that is the case, then they should engage in the managed care plan's dispute resolution or claims appeal process. So, managed care plans are contractually required to have a

provider dispute resolution process and inform providers of that process. So, providers should reach out to the managed care plan to make sure that they have the information that they need to really just navigate through this appeal process, including what the timelines are for filing and any documentation requirements that need to be submitted to the managed care plan. Go to the next slide, please.

01:05:37 – Bambi Cisneros – Slide 42 - 43

And we do suggest, as the final payment reconciliation tips, that providers consider building the practice of payments reconciliation into their operations. Payment reconciliation can help providers ensure that all the payments are received as expected, which will then minimize errors and financial losses. And so, in the resource, we provided some reconciliation tips for providers to keep in mind.

And I do want to highlight the third tip here, that it's important to establish clear and open communication channels with the managed care plans, because having a transparent and collaborative relationship with each managed care plan will really help to ensure the fastest issue resolution, improved payment accuracy and timelines, and ultimately result in timely and higher quality member care.

01:06:39 – Bambi Cisneros – Slide 43 - 44

And so, with that, that wraps up the payment and billing guidance tips that you can expect to see in the resource guide. And so, now I will pass it back to Kristin to facilitate the Q&A with our managed care plan presenters. Thank you.

01:06:56 – Kristin Mendoza-Nguyen – Slide 44

Thank you, Bambi. And then, I will welcome Yousaf and Wendy. Welcome. So, we will proceed with the next panel, focused on billing and payment promising practices. Next slide.

01:07:12 – Kristin Mendoza-Nguyen – Slide 45

So, the first question, similar to the authorizations, but this is focused on billing and payment, what are the most common reasons an LTC claim is denied? And what steps or considerations would you recommend to LTC providers to help prevent these types of denials?

01:07:36 – Yousaf Farook – Slide 45

I can start us off. So, I connected with our claims department, and it seems like the most common reason why claims are generally denied is due to lack of an authorization on file. As I look further into what could be leading to no authorization on record, a lot of it

has to do with those members that are in long-term care facilities, and they end up going to the emergency room or the hospital, and then they come back without an authorization.

And different health plans, and I can speak to Community Health Group. If a member does go from a long-term care facility to an emergency room and is there less than 24 hours, and there's no change in condition, the member can come right back under the same authorization and continue to receive long-term care at the facility, and authorization is not affected. But if a member does end up getting admitted and there's change of condition, which leads to a requirement of a different level of care, the health plan most likely would want to review that request and issue a different authorization for appropriate level of care. So, when the member does go back to that facility, maybe now they need IV, antibiotic, or other skilled services, and we need to issue a skilled authorization. And sometimes, either the facility takes the member without the skilled auth or they just did not request the authorization.

So one of the things that I also wanted to remind the long-term care providers is that sometimes, the authorization time periods by themselves are not enough. You do have to look at the units that are being authorized. So if, let's say, we have an authorization that's open from January 1st to January 31st, 31 days, that's what you see, the two dates. But there's only 15 units authorized. What that simply means is that we're authorizing 15 days to be utilized within that time period. So, looking at not just the date fields, but also the units that are being authorized is also an important factor and the right level of care. If a member now has been getting skilled services, then there should be an authorization for that skilled service with the appropriate units and the appropriate codes in the authorization record.

I think a good practice for long-term care facilities would be to, anytime a member does leave the building and goes out to a hospital ER and comes back, connect with the health plan or the case manager or the long-term support service or liaison, so they can review the case to determine. Generally, we tell all of our providers, "You got 72 hours." If member went out and they came back in, reach out to us within 72 hours, so we can review the case and correct the authorization, so that way when the claim does come in, often the claims match and it gets paid without any issues. So those are some of the things that I learned from our claims department, some of the common reasons.

Another one that they mentioned was the billing NPIs. Sometimes the NPIs or the provider information on the claim itself is incorrect or doesn't match our records, because sometimes facilities do change their NPIs, and if the systems or health plans are

not notified of those changes and the claim systems are not updated to look for that particular NPI, those could lead to rejections or denial of claims.

01:12:07 – Kristin Mendoza-Nguyen – Slide 45

Okay, thank you, Yousaf. And then, Wendy or Scott, similar things that you see on your end or any other best practices for providers to consider?

01:12:19 – Wendy Magnacca – Slide 45

Hi, everyone. This is Wendy from CalOptima. A couple of things that we do track in our denials that I still think some of the facilities struggle with is just making sure that you follow the billing guidelines. We tend to follow pretty closely the LTC UB-04 provider guidelines that are published by DHCS. When we run data to see some of the denials regarding billing, it's the cost value code, as we call it now. So, you need the value code 24. You need the cost value code that you're putting in to be in the right format, right? Some people put them in as dollars or cents, and that's not appropriate. And then, the cost value code that you use in box 39 must match your revenue code. We're still seeing where the cost value code is one code, but it doesn't align with the revenue code that's being billed. And so, that causes for unnecessary denials. We're still seeing some providers are using a three-digit revenue code when, in fact, if you're sending claims electronically, it is required that you use a four-digit revenue code. That will cause unnecessary rejections or denials.

And then the third thing that I noted, when we are looking at the denial data from a claims' perspective, is that the authorization and the dates billed aren't matching. If you're going to authorize a start date from this date to an end date, this date, the claim submitted or the series of claims you submit, the dates have to fit within that authorization. We use a term, split billing, but maybe you're overlapping your claims, where the dates that are included in the billing will cross sometimes two to three different authorizations, and we cannot match and pay based on that type of a billing. So, we ask that you please make sure that the submission you're sending matches within the date parameters and the level of care of your authorization, so that you don't get unnecessary rejections back, and it doesn't cause more work on your end or our end as well, because we really are trying to get our claims processed and out the door as quickly as possible to make sure you're getting your payments timely.

01:14:55 – Kristin Mendoza-Nguyen – Slide 45

Then, lastly, you both spoke about this. There's lots of technical guidance and billing guidance that plans provide to providers. How do you communicate guidance to the

providers? Especially because, being a facility or a Home, you may contract with multiple plans. So, can you guys speak to the communication and how you help relay plan-specific roles to your provider network groups?

01:15:22 – Yousaf Farook – Slide 45

Sure. So, for Community Health Group, obviously, it starts with the contract. Once the contract has been signed, there's a provider training that is done by a provider relations team, who walk the provider through that billing process and requirements around authorizations, and things of that nature. Additionally, we have a provider manual, which is provided, that provides guidance on how to request authorization and bill for those services. Then, we send out provider alerts anytime there's changes.

I know just recently, last year, we standardized all of the codes for subacute and long-term care. So, we sent out provider alerts along with our teams, the inpatient teams, who hand-delivered some of these documents to our providers. So, the individuals that are actually billing or to get that information in the right hands is a key because sometimes these provider alerts could be going to the corporate office or somewhere else, and it might not get in front of the individual that really needs that information. So using our field teams to go to the facilities and meet with those individuals has been the best practice for us and getting that information out to the providers so they know what the expectations are. I'll stop here and turn it over to Wendy.

01:17:03 – Wendy Magnacca – Slide 45

Yeah. To add to that, CalOptima also put together a PowerPoint presentation, including links. And we held two different training sessions, where the community was invited to attend. And so, someone from claims, in this case, it was myself, I joined our provider relations team, and we did an online training and shared the presentations with the providers. On top of that, provider relations does disseminate out these training documents as well. And every time we receive an update, we update the training, and then I attend the quarterly or monthly meetings, whichever is appropriate. And we present the changes and the updates that have come through. So very active in that.

I know our provider relations team is very open to receiving information or concerns that come in from the providers. They then reach out to the contacts and claims. There's one of two contacts and claims that will work directly with provider relations on these issues. We get on phone calls. We work on any of the concerns and issues and advise the best we can at that point. We do refer back to the provider guidelines, however, because that is what we're following, the DHCS publishes. And so we work very closely with our provider relations team to make sure that that information's always updated.

Then we do run reports of denials to see what the tracks and trends are, and if it's something that we believe provider relations can help impact, we pass that information along. And I know that times they have reached out to specific providers based on that data to help them understand what they may not be doing correctly, and what is resulting in either a denial or a rejection of the claim.

If I can add one more thing, going back to additional tips and best practices. Just want to make sure everybody's aware or have read through the APLs for long-term SNF and ICF/DD 24-009 through 24-011, regarding the share of cost and some of the requirements that have come down with that. So, please make sure that you read through that. I know from the CalOptima perspective, we are building in a process to validate the remark section, Box 80, against the share of cost being billed. That's a requirement that has now come down by DHCS, that we're validating share of cost. So if that information's not there, you could cause yourself additional delay. If you're not clear on what that is, please reach out to your LTSS Liaison and ask about that, because I would hate to see unnecessary delays or rejections due to your claims if you are not familiar with the APLs and they ask on those. I'll stop there.

01:19:56 – Kristin Mendoza-Nguyen – Slide 45

Great. Thank you, Wendy. Thank you, Yousaf. Any other last things to add before we pivot to Q&A? Okay. There was a question that came in the chat about timely filing from Katie. Is timely filing the same for LTC as it is for clinics and hospitals?

01:20:24 – Wendy Magnacca – Slide 45

That's a tough one. I know CalOptima allows 12 months with no step down on our submission. That's something that internally was decided back in February with the Change Healthcare issues and submission of claims, and we're still following that guideline. So, right now, we're allowing all provider types 12 months from the last date of service to submit a claim.

01:20:52 – Kristin Mendoza-Nguyen – Slide 45

Thank you, Wendy. It sounds like, to be safe, always go back to your plans to verify their requirements since there may be some nuances in terms of the operations. Yousaf?

01:21:07 – Yousaf Farook – Slides 45 - 46

I would add, sometimes just going back to that contract, because the contract might spell out exactly the requirements, how long you have to file that claim.

01:21:23 – Kristin Mendoza-Nguyen – Slide 46

There were a number of billing/payment questions, I know. Thank you. Bambi's been responding in the chat to folks. We did receive a scenario question from Erika Gonzalez. So, bear with me as I try to help synthesize this. So it's an LTC billing question. The first plan denies the claim because a different health plan is at risk, and so they bill the other health plan that was at risk, but then that claim is also denied. So, the eligibility is showing a certain plan, but both have submitted appeals, and they're both being denied at both plans. So, effectively denials on both fronts. What is considered to be the next step in those scenarios, and maybe whether if it's CHG or CalOptima or any DHCS folks. Bambi, if you want to help. This question was from Erika Gonzalez from Generations Healthcare in the chat.

01:22:28 – Bambi Cisneros – Slide 46

Yeah, thank you, Kristin. And thank you, Erika, for the question. I'm not sure I quite understand what "at risk" is. I assume this question is about when there's a delegated relationship between the primary plan and the secondary plan. And so, in this case, it's going to be plan-specific. I would recommend that you work with the primary plan and go through their provider dispute resolution process. And I am seeing some posts in the chat as well from managed care plans that are just jumping in and just saying to go through that process. And it sounds like that is what we would encourage the providers to do.

01:23:07 – Kristin Mendoza-Nguyen – Slide 46

Yeah, great. Thanks, Bambi. There is a question about claim denials from Irina in the chat that just came in. The bed hold claim denied due to authorization not matching. The TAR requested without a discharge date, and the claim has a discharge date, but we are not billing for it. Please advise?

01:23:43 – Bambi Cisneros – Slide 46

Do any of our plan partners have some tips to help Irina out on this particular situation? I think this really just goes back to just making sure the authorization is in line with what the plans are needing to be able to approve.

01:24:01 – Yousaf Farook – Slide 46

Correct. So, at Community Health Group, when we receive a request for a bed hold, we automatically authorize seven days of a bed hold for our policy. And the date span might even be wider than that. We might leave 10 days open, but there's seven units on

that authorization. So to allow for some flexibility, because sometimes we don't have the discharge date. So, keeping the authorization record open for at least 10 to 15 days, and then making sure there's enough units on the authorizations helps reduce some of that, those type of denials.

But I would say, go back to your health plan contacts or the case managers that you're working with to help solve that issue of the authorization not matching the claim. And sometimes that requires a little bit of back and forth, but just talking to somebody at the health plan, explaining the problem with that particular authorization. At Community Health Group, we're all in one building, so I can literally, say if Healthcare Services Division receives a request, I can take that walk over to my claims area and sit down with my claims director and hash it out and get something resolved for our providers, because they're very important to us and we want to make sure that they're not experiencing claim issues.

01:25:45 – Scott Robinson – Slide 46

And from the CalOptima side, going back to the bed hold authorization, the most common reasons for denial are late submissions and inaccurate documentation of dates. But if it gets past that to claims, I'm not sure what happens on the claim side. So, maybe Wendy could address that.

01:26:13 – Wendy Magnacca – Slide 46

From a CalOptima perspective, on the claim side, we actually stick to and follow what the authorization says. We don't make any type of determination outside of the authorization. So, again, I cannot emphasize enough, the claims people are not clinical in nature. That's not something we should and choose to take on. So, Scott, you're right. We follow the authorization to a tee. And if the authorizations are accurate and have the correct information in it, and you bill according to the auth, then there shouldn't be an issue.

01:26:48 – Kristin Mendoza-Nguyen – Slide 46

Okay. Thank you both. I'm going to close out the Q&A, and then hand it off to Bambi to help close this out. I know we have just a few minutes to wrap things up.

01:27:05 – Bambi Cisneros – Slides 47 - 48

Great. Thank you so much, Kristin. And thank you to our plan presenters as well, who jumped in and shared all of the great information and knowledge, and resources that

they have as well. Just to wrap up here, wanted to thank you all for your thoughtful questions and discussion, and I'll just share our quick next steps before we close out.

01:27:26 – Bambi Cisneros – Slides 48 - 49

So, looking ahead, we wanted to reiterate that DHCS continues to regularly monitor Medi-Cal managed care plans to ensure that they are taking the appropriate action to carry out their contract obligations pertaining to provider networks, timely payments, and member grievances. I'm seeing a lot of them being active on the chat as well, so thank you to our managed care plans. The plans do submit data to DHCS on a quarterly basis for DHCS review. So, we have our regular channels in which we work with managed care plans that we'll continue to do. And then, I think we have some resources that we can share in the next slide. Again, sharing the links to the SNF, ICF/DD, and the Subacute Care webpages. And as we mentioned earlier, we will be posting the three resources, as well as the slide deck and recorded presentation on these webpages.

01:28:26 – Bambi Cisneros – Slides 49 - 50

And so, this was our last session of the Long-Term Care Learning Series. Wanted to thank you for your engagement, support, and advocacy. As with all transitions, we've encountered some challenges, but have done our best work to meet those challenges and continue to push our way forward in the way that we work with our Medi-Cal managed care plans. So, just wanted to say that we are part of the work that we've accomplished together. And then, if you have additional questions that were not addressed during this webinar, please email the long-term care transition inbox. We left the email here for you. And once again, on behalf of DHCS, we wanted to thank you for your time and participation today. Thank you so much.